Coastal Behavioral Health New Client Packet

New Client Information

Last Name:_____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone: _____Circle One: Home/Cell/Work

Alternate Phone: _____Circle One: Home/Cell/Work

Best Time to Call:_____ Can we leave a message? ☐ Yes ☐ No

E-mail:_____

Date of Birth:_____ Age:_____ Social Security:_____

Referred by:_____

Referral Phone:_____ Referral E-mail:_____

Emergency Contact Name:_____

Relationship:_____ Phone:_____

_____ _____

Signature (Adult Client or Minor Client 16 or older) Date

_____ _____

Signature (Parent/Guardian of Minor) Date

New Client Health History Self-Report Form

Name:_____ Date of Birth:_____

Family Physician:_____ Phone:_____
Are you willing to sign a release of information to speak with your physician? ☐ Yes ☐ No

Is there another physician needed to coordinate care with? Name:_____
Are you willing to sign a release of information to speak with this physician? ☐ Yes ☐ No
Contact Information:_____

Date of Last Exam:_____ Height:_____ Weight:_____

Allergies to Food, Medication, Other:_____

Have you ever or do you currently have problems with any of the following? Check all the apply.

Yes	No		Yes	No	
☐	☐	Skin problems	☐	☐	Eating
☐	☐	Wounds not healing/easy bruising	☐	☐	Alcohol
☐	☐	Glaucoma/Vision	☐	☐	Street/Illicit Drugs
☐	☐	Gum(s)/Teeth	☐	☐	Narcotic and/or Pain Medication
☐	☐	Hearing	☐	☐	Sexual Function
☐	☐	Headaches	☐	☐	Black outs/fainting/seizures
☐	☐	Head injury/loss of consciousness	☐	☐	Sleeping too much
☐	☐	Numbness/Tingling	☐	☐	Sleeping too little
☐	☐	Thyroid	☐	☐	Nausea/vomiting
☐	☐	Blood sugar/diabetes	☐	☐	Difficulty walking or standing
☐	☐	Sickle cell disease	☐	☐	Liver disease/yellow jaundice
☐	☐	Heart disease/chest pain	☐	☐	Kidney functioning
☐	☐	High blood pressure	☐	☐	Previous transplant:_____
☐	☐	Anemia/low blood count	☐	☐	Fatigue
☐	☐	HIV/AIDS	☐	☐	Joint pain/arthritis
☐	☐	Shortness of breath/Asthma/COPD	☐	☐	Cancer:_____
☐	☐	Weight ☐Gain ☐ Loss _____ lbs in _____ (days/week/month)	☐	☐	Stroke

Do you currently use caffeine? ☐ Yes ☐ No
Do you currently smoke cigarettes, e-cigarettes, or other tobacco products? ☐ Yes ☐ No
Do you currently use alcohol? ☐ Yes ☐ No

Describe amount and how often: _____

Have you ever been hospitalized for any medical reasons such as illness, accidents, surgeries or tests?

Reason for hospitalization	Where were you hospitalized?	When were you hospitalized?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications are you currently taking? Include herbal remedies, vitamins, over-the-counter medications, and psychiatric medications.

Name of Medication	For what reason?	Who prescribes this?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Psychiatrist:_____ Phone:_____
Are you willing to sign a release of information to speak with your physician and/or psychiatrist?
☐ Yes ☐ No

Have you taken any psychiatric medications in the past?

Name of Medication	For what reason?	Who prescribed this?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you received psychiatric care in the past (psychiatrist, social worker, nurse, counselor, counseling from religious institution, psychological testing, or neuropsychological testing)?

☐ Yes ☐ No

If yes:

For what reason?	When?	Where?	Were you hospitalized?
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

Have you every attempted suicide in the past or engage in self-harm behaviors (e.g., cutting)?

☐ Yes ☐ No

If yes, please list when and help (if any received): _____

_____

Family Health and Psychiatric History

Has anyone in <u>your family</u> ever experienced the following?

Yes	No		Yes	No	
☐	☐	Depression	☐	☐	Heart disease or hypertension
☐	☐	Bipolar Disorder or Manic Depression	☐	☐	Diabetes
☐	☐	Suicide Attempt or Completion	☐	☐	Thyroid
☐	☐	Anxiety or nerves	☐	☐	Stroke
☐	☐	Panic Attacks	☐	☐	Dementia/Senility
☐	☐	Alcohol Use Issues	☐	☐	Asthma/COPD
☐	☐	Drug Use Issues	☐	☐	Seizures
☐	☐	Schizophrenia	☐	☐	Cancer:_____
☐	☐	Other:_____			

Please identify family member and disease/illness below:

_____

_____

Do you need assistance in any of the following activities of daily living?

Yes	No		Yes	No		Yes	No	
☐	☐	Bathing	☐	☐	Dressing	☐	☐	Meal Preparation
☐	☐	Hygiene	☐	☐	Ambulation	☐	☐	Household/environment
☐	☐	Eating	☐	☐	Maintenance	☐	☐	Money Management
☐	☐	Toileting	☐	☐	Driving			

Describe assistance needed:_____

_____

Please list significant individuals in your life: _____

_____

_____ _____

Signature of client completing this form Date

Licensed Psychologist Signature Date

_____

Signature of parent or guardian (if applicable) Date

Cancellation of Appointments and No Show:
Coastal Behavioral Health requires 24-hour notice if you wish to cancel an appointment out of respect to other clinicians utilizing offices and other clients who can be scheduled in your place. Missed appointments or appointments cancelled less than 24 hours in advance are subject to the following charges. These must be paid prior to additional psychotherapy services being provided. Completion of the Credit Card Payment Form will allow Coastal Behavioral Health to automatically collect these fees prior to the next session.

The no show/cancellation with less than 24-hour notice fee is half of the payment expected at the time of service.

As well as incurring a fee for inadequate notice, three consecutively missed appointments may result in termination of services.

Payment Information:
Coastal Behavioral Health currently accepts Medicare. Your Coastal Behavioral Health provider will discuss fees with you prior to your appointment. The full fee, full co-payment, or full co-insurance payment is due at the time of service. Checks, cash, and major credit card (Visa, Discover, Master Card, American Express) are current accepted forms of payment.

Initial _____

Reminders
Coastal Behavioral Health provides phone or e-mail reminders. If Coastal Behavioral Health fails to leave a reminder you are still responsible for no show/less than 24-hour cancellation fee.

Please indicate your preferred reminder type:
☐ Phone ☐ E-mail ☐ Text message ☐I do not wish to receive any reminders

For Phone Reminders:
Coastal Behavioral Health will make a reminder phone call 1 to 2 business days prior to your appointment.

Preferred Phone Number: _____

For E-mail Reminders:
Coastal Behavioral Health offers free-of-charge e-mail reminders 1 to 2 business days prior to your scheduled appointment.

Online appointment requests and e-mails are not an acceptable way to communicate an emergency.

Preferred E-mail address: _____

For E-mail Reminders:
Coastal Behavioral Health offers text message reminders 1 to 2 business days prior to your scheduled appointment. Please note text-messaging fees may apply.

Preferred Phone Number for texts: _____

General Information
You are responsible for keeping your contact information (e.g., phone number, e-mail address, address) up to date. Please inform your provider of any contact information changes. Also please keep your provider informed of any changes in medications or medical providers. It is imperative Coastal Behavioral Health has the most current information on file for you.

Your file will be considered closed after 2 months of no contact. You can request to resume services at cbhflorida.com under "request an appointment" or by calling at 954-271-3397.

Using E-mail for Contact
Coastal Behavioral Health uses a secure e-mail server to send and receive e-mails from clients. The client has sole responsibility for the security of e-mails he/she sends or receives. Coastal Behavioral Health is not responsible for breech of confidentiality, privacy, or security of e-mails that clients send or receive.

E-mail is only to be utilized for the following:

- Requesting appointment (please provide 2 to 3 preferred dates and times and preferred method of contact to confirm appointment)

- Cancelling an appointment
- Confirmation of appointment
- Updating contact information or medical information
- Providing clients with "super bill" for insurance company

Initial:_____

Online appointment requests and e-mails are not an acceptable way to communicate an emergency. If you are experiencing an emergency please go to the nearest emergency room or call 911.

_____ _____
Client Signature (or Parent/Guardian) Date

_____
Client Name (Printed)