



Dear New Patient,

Thank you for choosing Kent Psychological Associates, LLC as your mental health care provider. If for any reason you are unable to keep your appointment, kindly call 24 hours in advance.

We ask that you please complete the following:

- Complete the paperwork attached to this letter and bring it with you for your first appointment.
- Arrive 20 minutes early for your appointment-there will be additional paperwork to do here.
- Please be prepared to pay your co-pay at the time of each visit.
- Call your insurance, verifying your out-patient mental health coverage including:
  - What is your annual deductible (amount that you are required to pay before your benefits start each year)? Deductible amounts almost always start over on Jan. 1 of each new year.
  - What is your office co-pay (amount you are required to pay at each office visit)?
  - The number of visits allowed per year (out-patient mental health code 90834)?
  - If your visits will be covered by an Employee Assistance Program, please contact your Human Resources Dept. for your referral/authorization.
  - Is a referral required from your primary care physician before your first visit?

If you have concerns or questions you can reach our business office Monday through Friday between the hours of 9 a.m. and 4 p.m. We look forward to meeting you.

Kent Psychological Associates, LLC

DATE \_\_\_\_\_

**ADULT BACKGROUND INFORMATION**

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
 PHONE (H) (\_\_\_\_) \_\_\_\_\_ (W) (\_\_\_\_) \_\_\_\_\_ MARITAL S M W D  
 REFERRED BY: \_\_\_\_\_  
 EMERGENCY CONTACT: \_\_\_\_\_ PHONE \_\_\_\_\_ RELATION \_\_\_\_\_  
 FAMILY PHYSICIAN: \_\_\_\_\_ PHONE \_\_\_\_\_

**FAMILY INFORMATION:**

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>AGE</u>	<u>SEX</u>	<u>OCCUPATION</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**DEVELOPMENTAL HISTORY:**

Please check the following which were problems in the family of origin:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Frequent moves   | <input type="checkbox"/> Alcohol/Drugs    | <input type="checkbox"/> Death of family member |
| <input type="checkbox"/> Parents divorce  | <input type="checkbox"/> Legal problems   | <input type="checkbox"/> Physical abuse/Neglect |
| <input type="checkbox"/> Parents remarriage   | <input type="checkbox"/> Parent conflict  | <input type="checkbox"/> Sexual abuse           |
| <input type="checkbox"/> Parents separated  | <input type="checkbox"/> Parent job loss  | <input type="checkbox"/> Domestic violence      |
| <input type="checkbox"/> Family illness   | <input type="checkbox"/> Financial stress | <input type="checkbox"/> Emotional problems     |
| <input type="checkbox"/> Other _____  |   |   |
| <input type="checkbox"/> Other issue (You wish to discuss with counselor in person) |   |   |

Clarify information about your development up to age 18. Check those that apply.

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Premature birth     | <input type="checkbox"/> Avoiding others   | <input type="checkbox"/> Bedwetting       | <input type="checkbox"/> Birth Defect    |
| <input type="checkbox"/> Nervous             | <input type="checkbox"/> Fidgety/restless  | <input type="checkbox"/> Head injury      | <input type="checkbox"/> Abuse/neglect   |
| <input type="checkbox"/> Eating problems     | <input type="checkbox"/> Talking/refusing  | <input type="checkbox"/> Picked on        | <input type="checkbox"/> Bad dreams      |
| <input type="checkbox"/> Learning problems   | <input type="checkbox"/> Speech problems   | <input type="checkbox"/> Sleepwalking     | <input type="checkbox"/> School behavior |
| <input type="checkbox"/> Poor coordination   | <input type="checkbox"/> Trouble w/ police | <input type="checkbox"/> Feeling rejected | <input type="checkbox"/> Strong willed   |
| <input type="checkbox"/> Visual difficulties | <input type="checkbox"/> Fear leaving home | <input type="checkbox"/> Repeated grade   | <input type="checkbox"/> Few friends     |
| <input type="checkbox"/> Leaving loved one   | <input type="checkbox"/> Behavioral prob.  | <input type="checkbox"/> "Worry wart"     | <input type="checkbox"/> Overweight      |
| <input type="checkbox"/> Small for age       | <input type="checkbox"/> Ran away          | <input type="checkbox"/> Fighting         | <input type="checkbox"/> Shy             |

How would you rate your present relationship with the following? If it does not apply put N/A.

- |          |                               |                               |                               |  |                              |
|----------|-------------------------------|-------------------------------|-------------------------------|--|------------------------------|
| Spouse   | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Father   | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Mother   | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Brother  | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Sister   | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Son      | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Daughter | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| In-Laws  | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |
| Employer | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | <input type="checkbox"/> Problem for you | <input type="checkbox"/> N/A |

**EDUCATIONAL HISTORY**

High school attended \_\_\_\_\_ Highest grade completed \_\_\_\_\_  
College/vocational/technical training yes \_\_\_ no \_\_\_ #year's \_\_\_ Degree \_\_\_

**OCCUPATIONAL HISTORY**

Are you presently employed? \_\_\_ yes \_\_\_ no Type of work \_\_\_\_\_ How long? \_\_\_\_\_  
Have you had problems gaining employment? \_\_\_ yes \_\_\_ no  
How many jobs have you held in the last 5 years? \_\_\_\_\_  
Are you a veteran? \_\_\_ yes \_\_\_ no If yes, what branch of service? \_\_\_\_\_  
Date entered \_\_\_\_\_ Date discharged \_\_\_\_\_ Type of discharge \_\_\_\_\_

**MARITAL HISTORY**

\_\_\_ Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Remarried \_\_\_ Widowed

\_\_\_ Marriage Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_ Separation Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_ Divorce Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_ Widowed Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Are you considering separation or divorce? \_\_\_ yes \_\_\_ no  
Are you a divorced custodial parent? \_\_\_ yes \_\_\_ no  
Are you married raising minor children? \_\_\_ yes \_\_\_ no

Do you and your spouse:

Agree on the methods of discipline of the children \_\_\_ yes \_\_\_ no  
Share common values in the rearing o the children \_\_\_ yes \_\_\_ no  
Feel the parent/child interaction is positive \_\_\_ yes \_\_\_ no  
Spend quality time as a family \_\_\_ yes \_\_\_ no

In your present relationship do you:

Enjoy good communication with each other \_\_\_ yes \_\_\_ no  
Feel satisfied with your sexual relations \_\_\_ yes \_\_\_ no  
Spend private couple time with each other \_\_\_ yes \_\_\_ no  
Share similar interests and values \_\_\_ yes \_\_\_ no

**PRIOR MENTAL HEALTH HISTORY**

Have you ever had prior mental health treatment? \_\_\_ yes \_\_\_ no (If no, skip)

Date \_\_\_\_\_

Was this person a: \_\_\_ Psychiatrist \_\_\_ Psychologist \_\_\_ Clinical social worker \_\_\_ Clinical Counselor  
\_\_\_ Minister \_\_\_ Other

Have you ever been hospitalized for emotional problems? \_\_\_ yes \_\_\_ no (If no, skip)

Name of hospital \_\_\_\_\_ Location \_\_\_\_\_ Date \_\_\_\_\_ How long \_\_\_\_\_

Doctor who treated you \_\_\_\_\_ Medications given \_\_\_\_\_

Do you still take any psychotropic medications? \_\_\_ yes \_\_\_ no Which ones? \_\_\_\_\_

**ALCOHOL/DRUG HISTORY**

Do you have a history of alcohol/drug abuse? \_\_\_ yes \_\_\_ no (If no, skip)

If you are using alcohol or drugs has this resulted in:

\_\_\_ Marital problems \_\_\_ Memory Blackouts \_\_\_ Legal problems  
\_\_\_ Problems w/family, friend's \_\_\_ Periods of abstinence \_\_\_ Physical problems  
\_\_\_ Preoccupation w/alcohol, drugs \_\_\_ Financial problems \_\_\_ Loss of control  
\_\_\_ DUI or DWI charges \_\_\_ Withdrawal symptoms

**LEGAL HISTORY**      \_\_\_yes \_\_\_no

Check those that apply to you:

\_\_\_Trouble with law as a juvenile  
\_\_\_Trouble with the law as an adult

\_\_\_Have legal matter pending  
\_\_\_Have you ever been in jail?

**MEDICAL HISTORY**

Date of last physical exam \_\_\_\_\_ Family physician \_\_\_\_\_

Describe your chief medical/physical complaint(s) \_\_\_\_\_

\_\_\_\_\_

Do you have any special problems with hearing, speech, vision?      \_\_\_yes \_\_\_no

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Are you on any medications?      \_\_\_yes \_\_\_no

If so, please list: \_\_\_\_\_

\_\_\_\_\_

Describe any side effects \_\_\_\_\_

\_\_\_\_\_

Do you have any allergies?      \_\_\_yes \_\_\_no

If yes, please describe \_\_\_\_\_

List any serious illnesses, injuries, or surgeries \_\_\_\_\_

\_\_\_\_\_

Place an X in the left column if this condition exists. In the right column write self, father, mother, brother, sister, aunt, uncle, etc.

\_\_\_Alcoholism      \_\_\_\_\_  
\_\_\_Allergies      \_\_\_\_\_  
\_\_\_Mental retardation      \_\_\_\_\_  
\_\_\_Obesity      \_\_\_\_\_  
\_\_\_Degenerative dis.      \_\_\_\_\_  
\_\_\_Mental health probs.      \_\_\_\_\_  
\_\_\_Suicide      \_\_\_\_\_

\_\_\_Cancer      \_\_\_\_\_  
\_\_\_Diabetes      \_\_\_\_\_  
\_\_\_Epilepsy      \_\_\_\_\_  
\_\_\_High blood press.      \_\_\_\_\_  
\_\_\_Heart trouble      \_\_\_\_\_  
\_\_\_Other      \_\_\_\_\_

**MEDICAL CONDITIONS AND SYMPTOMS**

Past/Now

- Arthritis
- Anxiety
- Anger Outbursts
- Asthma
- Backaches
- Binging
- Barbiturates
- Epilepsy
- Cancer
- Chronic Pain
- Chest Pain
- Constipation
- Depression
- Diabetes
- Diarrhea
- Depersonalization
- "Going Crazy" sensations
- Difficulty going to sleep
- Difficulty staying asleep
- Dizziness
- Drug reactions
- Early morning wakening
- Emotional upsets

Past/Now

- Can't work under pressure
- Color Blind
- Exhaustion
- Fainting spells
- Fast pulse
- Heart medicine
- Hormones
- Poor digestion
- Poor appetite
- Treated for a mental cond.
- Other drugs, alcohol
- Shaking
- Smoking packs/day \_\_\_\_
- Craving for sweets
- Fatigue
- Headaches
- Heart trouble
- Hallucinations
- Hearing voices
- Hypertension
- Hand tremors
- Hay fever
- Insulin medication

Past/Now

- Distractibility
- Laxatives used
- Leg Cramps
- Loose bowel/gas often
- Loses temper easily
- Moody often
- Memory problems
- Muscle twitching
- Much sweating
- Moist palms
- Nervous breakdown
- Nervousness
- Nerve Medication
- Overeating
- Overworked
- Pain medication
- Palpitation
- Perfectionist
- Stomach medicine
- Worries, feels insecure
- Reduced sex drive/lack of
- Upset stomach
- Itchy skin

**CURRENT SOURCES OF STRESS**

Please list your most significant sources of stress or worry.

1. \_\_\_\_\_
2. \_\_\_\_\_

What is the main goal you wish to attain in seeking services? \_\_\_\_\_

Envision how your life would be different if you could manage some of these problems better.

ADDITIONAL INFORMATION: Please add any special information you feel which might be helpful in assisting in your treatment. \_\_\_\_\_

Your signature below indicates that you understand the questions and could ask for assistance if needed.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date



**Dear Client: Please list all of your medications below or provide the office with a copy of your current medication list. Many medications have side effects. It is important for your clinician to be aware of all of your medications (prescription, over-the-counter, and supplements) in order to determine if your medications may be contributing to any of the symptoms you are experiencing.**

## **Medication List**

Client name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medication	Dosage	Frequency	Date Added/Discontinued
			<i>This column office use only.</i>

Name \_\_\_\_\_

Date \_\_\_\_\_

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING    0 + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_  
=Total Score: \_\_\_\_\_

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all D	Somewhat difficult D	Very difficult D	Extremely difficult D

Name \_\_\_\_\_

Date \_\_\_\_\_

## GAD-7

Over the **last 2 weeks**, how often have you been bothered by the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T\_\_\_\_=\_\_\_\_ + \_\_\_\_ + \_\_\_\_)



Name: \_\_\_\_\_

Date: \_\_\_\_\_

## PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: A – ACHE

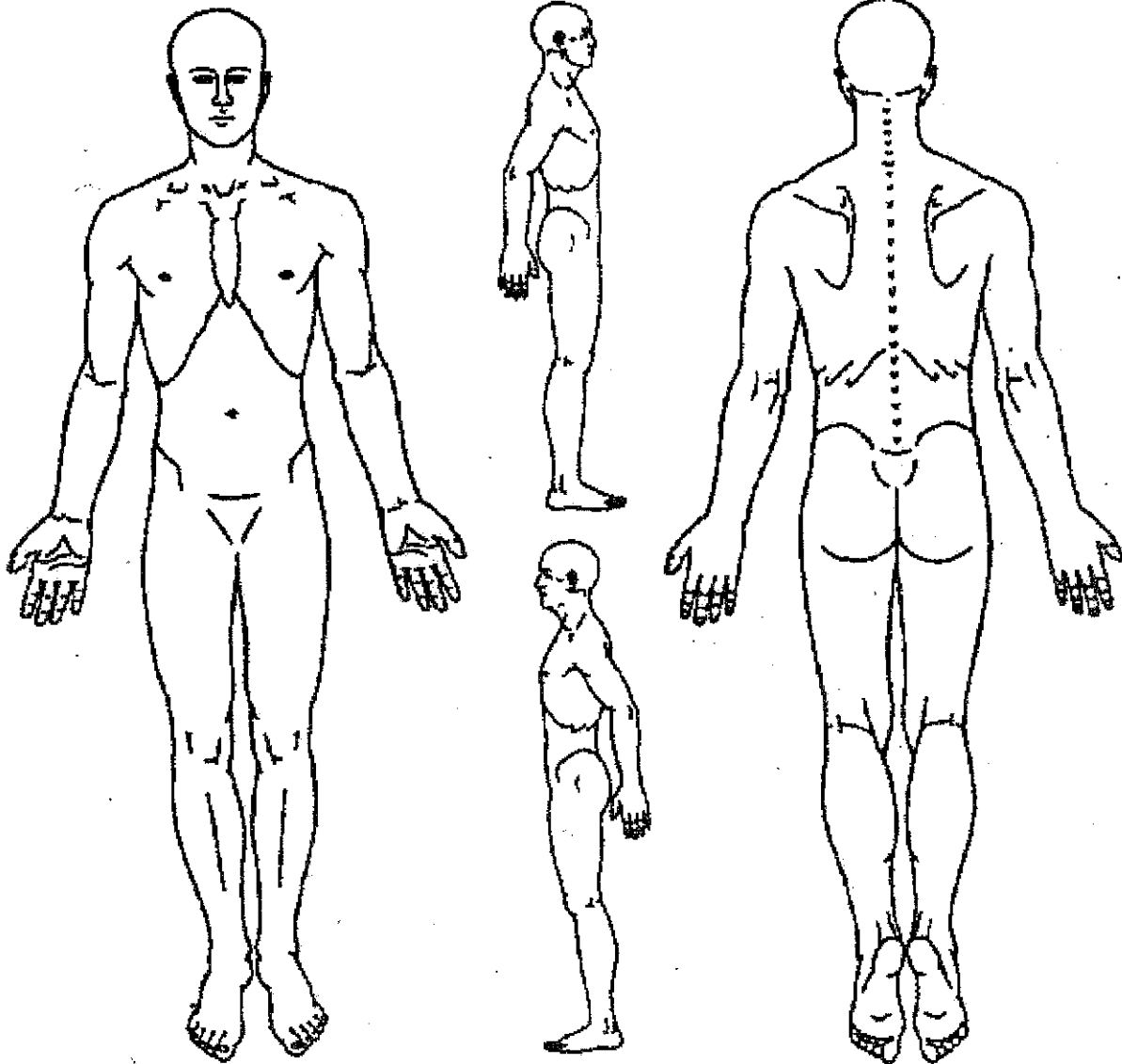
P – PINS & NEEDLES

B – BURNING

S – STABBING

N – NUMBNESS

O – OTHER



## PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain										Worst Possible Pain
0	1	2	3	4	5	6	7	8	9	10

**Authorization for Release of Health Information Pursuant to HIPAA  
Kent Psychological Associates, LLC**

***Dear Client: Your health insurance requires us to request consent to coordinate care with your primary care provider. We consider coordination of care an important part of providing high quality care. Please complete the following authorization that allows us to exchange information with your primary care provider. If you are uncomfortable with such exchange of information, please check the box below indicating your refusal to allow us to exchange information with your primary care provider.***

- I prefer NOT to allow exchange of information between Kent Psychological Assoc. and my primary care provider.  
 I do not have a primary care provider.

CLIENT \_\_\_\_\_ DOB \_\_\_\_\_ Last four SSN # \_\_\_\_\_

**I THE UNDERSIGNED AUTHORIZE THE EXCHANGE OF INFORMATION BETWEEN:**

My Behavioral Health Provider:  
Kent Psychological Assoc. LLC  
190 Currie Hall Parkway, Suite A  
Kent, Ohio 44240  
Phone: 330-673-5812 Fax: 330-673-7162



My Primary Care Provider:  
Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**INFORMATION TO BE RELEASED BY KENT PSYCHOLOGICAL ASSOCIATES INCLUDES THE FOLLOWING:**

Diagnosis	Service/Treatment Plan
Recommendations	Summary of Treatment
Discharge Summary	

**REQUESTED INFORMATION FROM PRIMARY CARE PROVIDER INCLUDES THE FOLLOWING:**

History and Physical	Medical Evaluation
Service/Treatment Plan	Current Medications/Medication History
Treatment/Office Visit Notes	

**THE EXCHANGE OF INFORMATION IS FOR THE SPECIFIC PURPOSE OF:**

Ensuring proper coordination of care with your primary care provider.

**I UNDERSTAND:**

1. This authorization will expire on \_\_\_\_\_ (date, event, or condition not to exceed 1 year). If not dated, then this authorization will automatically expire 1 year from the date of signing.
2. I may revoke this authorization at any time by signing the "Revocation of Authorization" portion of this form, below, and providing a copy to the releasing party or by providing any other form of written revocation to the releasing party. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization.
3. Signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization.
4. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA upon its release to the recipient.

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of records designation above, which may include treatment for mental illness (ORC5122.31), alcohol/drug abuse (42 CRF Part 2), and/or Human Immune Deficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS) test results or diagnoses (ORC3701.24.3).

\_\_\_\_\_  
Signature of Client/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client

**REVOCAION OF CONSENT:**

**I hereby withdraw my consent for any further release of information as of the date indicated below:**

\_\_\_\_\_  
Signature of Client/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client

TO THE RECIPIENT: This information has been disclosed to you from confidential records protected by Federal Law. You are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. If you have received this information in error please notify Kent Psychological Associates, LLC immediately.



Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_

- I give my permission for Kent Psychological Associates to call and if necessary leave a reminder message for upcoming appointments.

I would like reminders by (choose one):

- Text to: \_\_\_\_\_
- Phone call to: \_\_\_\_\_
- Email to: \_\_\_\_\_

- I do not want reminder calls.

Reminder calls are a courtesy only. Any missed appointments remain the client's responsibility. Reminders are made the day before the appointment including Sundays.

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Date

For your information:

Phone calls will come from 949-298-4668

Texts will come from 695-29

Emails will come from ValantApptReminder@reminderXchange.com

(You cannot reply back to these numbers.)