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.

190 Currie Hall Parkway, Kent, Ohio 44240 • Office: 330.673.5812 Fax: 330.673.7162 • www.kentpsychological.com

Kent Psychological Associates, LLC

DATE ____________________

ADULT BACKGROUND INFORMATION

NAME ________________________________ DOB ____________ AGE ______ SSN ____-____-______
GENDER ____________ PRONOUNS: ☐ he/him/his ☐ she/her/her ☐ they/them/theirs ☐ ze/hir/hirs
ADDRESS ________________________________ CITY __________________ ZIP ______________
PHONE (H) (____) __________________ (W) (____) ____________________
EMERGENCY CONTACT: ________________________ PHONE ______________ RELATION ______
FAMILY PHYSICIAN: ______________________________ PHONE ________________
REFERRED BY: ____

HOUSEHOLD INFORMATION: *Who do you live with?*

NAME	RELATIONSHIP	AGE	GENDER	OCCUPATION
____________	____________	_____	____	____________
____________	____________	_____	____	____________
____________	____________	_____	____	____________
____________	____________	_____	____	____________
____________	____________	_____	____	____________

Other important people in your life ____

DEVELOPMENTAL HISTORY:

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

____Frequent moves
____Parents divorce
____Parents remarriage
____Parents separated
____Family illness
____Alcohol/Drugs
____Legal problems
____Parent conflict
____Parent job loss
____Financial stress
____Death of family member
____Physical abuse/Neglect
____Sexual abuse
____Domestic violence
____Emotional problems
____Other ____
____Other issue (You wish to discuss with counselor in person)

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

____Premature birth
____Nervous
____Eating problems
____Learning problems
____Poor coordination
____Visual difficulties
____Leaving loved one
____Small for age
____Avoiding others
____Fidgety/restless
____Talking/refusing
____Speech problems
____Trouble w/ police
____Fear leaving home
____Behavioral prob.
____Ran away
____Bedwetting
____Head injury
____Picked on
____Sleepwalking
____Feeling rejected
____Repeated grade
____"Worry wart"
____Fighting
____Birth Defect
____Abuse/neglect
____Bad dreams
____School behavior
____Strong willed
____Few friends
____Overweight
____Shy

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

Spouse/Significant Other/Partner	____Good	____Fair	____Poor	____Problem for you	____N/A
Father	____Good	____Fair	____Poor	____Problem for you	____N/A
Mother	____Good	____Fair	____Poor	____Problem for you	____N/A
Brother	____Good	____Fair	____Poor	____Problem for you	____N/A
Sister	____Good	____Fair	____Poor	____Problem for you	____N/A
Son	____Good	____Fair	____Poor	____Problem for you	____N/A
Daughter	____Good	____Fair	____Poor	____Problem for you	____N/A
In-Laws	____Good	____Fair	____Poor	____Problem for you	____N/A
Employer	____Good	____Fair	____Poor	____Problem for you	____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 ___________

RELATIONSHIP HISTORY

Sexual Orientation ______________________

A) In a relationship☐ *If not in a relationship please see section B*

____ Married ____Significant Other ____ Remarried ____Other ______________________

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/significant other/partner:
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

B) Not in a relationship☐
____ Single ____ Separated ____ Divorced ____ Widowed ____Other ______________________

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
____Problems w/family, friend's
____Preoccupation w/alcohol, drugs
____DUI or DWI charges
____Memory Blackouts
____Periods of abstinence
____Financial problems
____Withdrawal symptoms
____Legal problems
____Physical problems
____Loss of control

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 __________

____Developmental Disabilities __________

____Obesity __________

____Degenerative dis. __________

____Mental health probs. __________

____Suicide __________

____Cancer __________

____Diabetes __________

____Epilepsy __________

____High blood press. __________

____Heart trouble __________

____Other __________

MEDICAL CONDITIONS AND SYMPTOMS

Past/Now		Past/Now		Past/Now	
___ ___	Arthritis	___ ___	Can't work under pressure	___ ___	Distractibility
___ ___	Anxiety	___ ___	Color Blind	___ ___	Laxatives used
___ ___	Anger Outbursts	___ ___	Exhaustion	___ ___	Leg Cramps
___ ___	Asthma	___ ___	Fainting spells	___ ___	Loose bowel/gas often
___ ___	Backaches	___ ___	Fast pulse	___ ___	Loses temper easily
___ ___	Binging	___ ___	Heart medicine	___ ___	Moody often
___ ___	Barbiturates	___ ___	Hormones	___ ___	Memory problems
___ ___	Epilepsy	___ ___	Poor digestion	___ ___	Muscle twitching
___ ___	Cancer	___ ___	Poor appetite	___ ___	Much sweating
___ ___	Chronic Pain	___ ___	Treated for a mental cond.	___ ___	Moist palms
___ ___	Chest Pain	___ ___	Other drugs, alcohol	___ ___	Nervous breakdown
___ ___	Constipation	___ ___	Shaking	___ ___	Nervousness
___ ___	Depression	___ ___	Smoking packs/day ___	___ ___	Nerve Medication
___ ___	Diabetes	___ ___	Craving for sweets	___ ___	Overeating
___ ___	Diarrhea	___ ___	Fatigue	___ ___	Overworked
___ ___	Depersonalization	___ ___	Headaches	___ ___	Pain medication
___ ___	"Going Crazy" sensations	___ ___	Heart trouble	___ ___	Palpitation
___ ___	Difficulty going to sleep	___ ___	Hallucinations	___ ___	Perfectionist
___ ___	Difficulty staying asleep	___ ___	Hearing voices	___ ___	Stomach medicine
___ ___	Dizziness	___ ___	Hypertension	___ ___	Worries, feels insecure
___ ___	Drug reactions	___ ___	Hand tremors	___ ___	Reduced sex drive/lack of
___ ___	Early morning wakening	___ ___	Hay fever	___ ___	Upset stomach
___ ___	Emotional upsets	___ ___	Insulin medication	___ ___	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.

____

ADDITONAL 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
			This column office use only.

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	Somewhat difficult	Very difficult	Extremely difficult
D	D	D	D

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Name ____________________ Date ____________________

GAD-7

Over the <u>last 2 weeks</u>, 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____=______ + ____ + ____)

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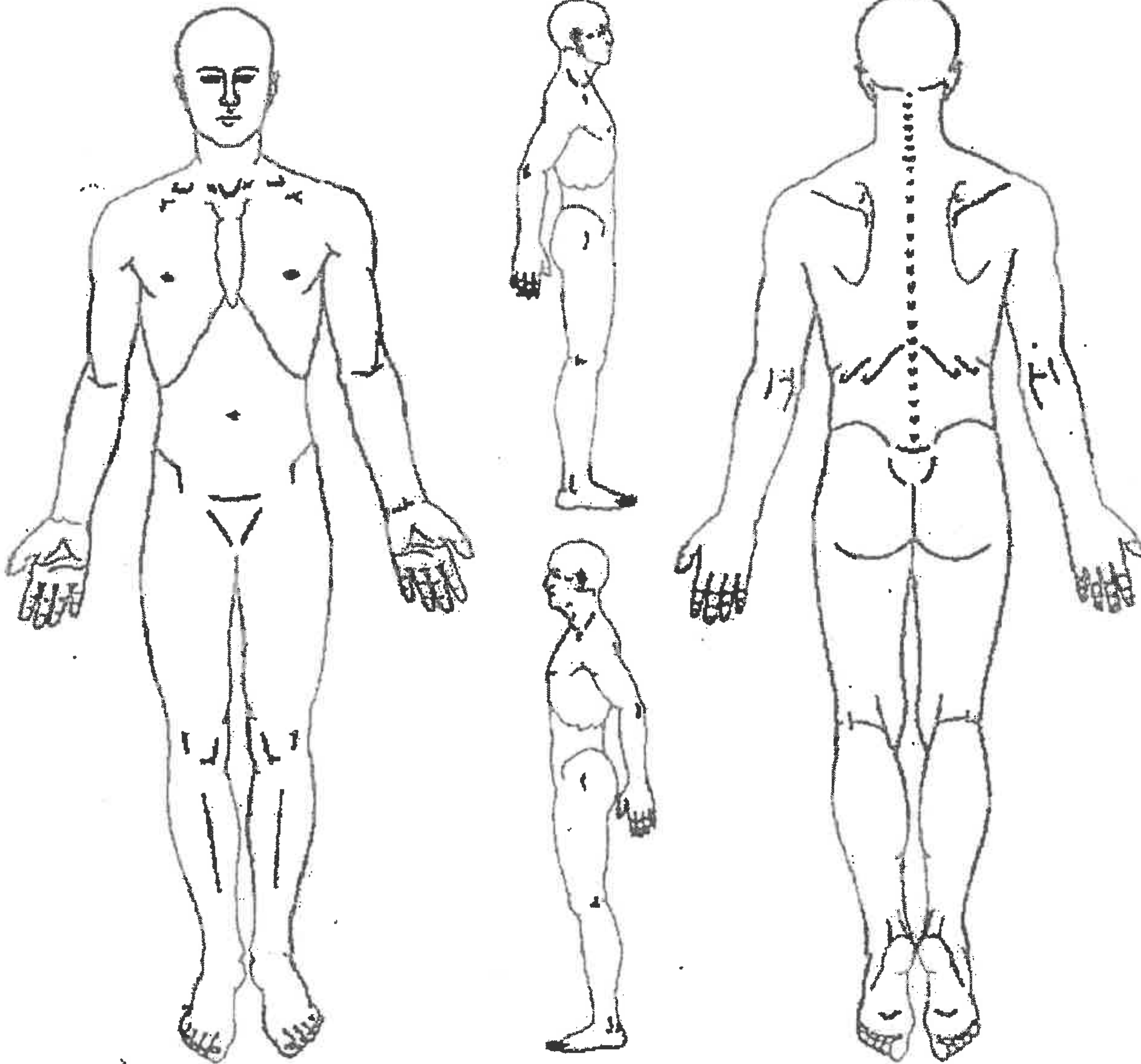
Name:____ Date:________________

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 B – BURNING N – NUMBNESS
P – PINS & NEEDLES S – STABBING 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
Recommendations
Discharge Summary
Service/Treatment Plan
Summary of Treatment

REQUESTED INFORMATION FROM PRIMARY CARE PROVIDER INCLUDES THE FOLLOWING:

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

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

REVOCATION 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

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.)

CRISIS RESOURCES

24 HOUR CRISIS HOTLINES

- Crisis Intervention Services – Coleman Behavioral Health - (330) 296-3555
- Town Hall II- (330) 678-HELP
- Akron Children's Hospital Psychiatric Intake Response Center (PIRC) (330) 543-7472
- Crisis Text Line: Text "4HOPE" to 741741 within Ohio. Free and confidential.

EMERGENCY:

- 911

PSYCHIATRIC EMERGENCY SERVICES (WALK-IN):

Portage County:

- Crisis Intervention Services – Coleman Behavioral Health - (330) 296-3555

Summit County:

- Summa Akron City Hospital Emergency Room- (330) 375-3361
- Akron General Medical Center Emergency Room- (330) 344-6611
- Akron Children's Hospital Behavioral Health Emergency Service - (330) 543-7472

ANSWERING SERVICE:

- Kent Psychological Associates- (330) 376-6801

  (Answering service will take your information for one of our clinicians to call you back.)