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
____Other _____
____Other issue (You wish to discuss with counselor in person)
____Alcohol/Drugs
____Legal problems
____Parent conflict
____Parent job loss
____Financial stress
____Death of family member
____Physical abuse/Neglect
____Sexual abuse
____Domestic violence
____Emotional problems

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	____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	_____	____Cancer	_____
____Allergies	_____	____Diabetes	_____
____Developmental Disabilities	_____	____Epilepsy	_____
____Obesity	_____	____High blood press.	_____
____Degenerative dis.	_____	____Heart trouble	_____
____Mental health probs.	_____	____Other	_____
____Suicide	_____		

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

KENT

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.*

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

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

⇐ AND ⇒

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.

NDERSTAND:

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.

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

_____ _____ _____
ignature of Client/Parent/Guardian Date Relationship to Client

EVOCATION OF CONSENT:
hereby withdraw my consent for any further release of information as of the date indicated below:

_____ _____ _____
ignature of Client/Parent/Guardian Date Relationship to Client

'HE RECIPIENT: This information has been disclosed to you from confidential records protected by Federal Law. You are prohibited from making any further osure 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 y Kent Psychological Associates, LLC immediately.

KENT PSYCHOLOGICAL ASSOCIATES

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 ValiantApptReminder@reminderXchange.com
(You cannot reply back to these numbers.)

PMDD Checklist

Is this your first pregnancy or first child (Y/N) _____

How many times have you been pregnant _____

How many deliveries _____

History of miscarriage _____ How many_____

History of abortion _____ How many _____

History of adoption _____

If you recently gave birth, what is the gestational age your baby was born (ie. 38weeks) _____

Were their any complications with you or the baby with this birth (Y/N)_____

Please explain _____

How would you rate your medical staff & birthing experience during delivery

Poor _____ Fair _____ Good _____ Excellent _____

How would you rate your medical staff and experience during your stay after delivery

Poor _____ Fair _____ Good _____ Excellent _____

Did you spend time in the NICU with your baby (Y/N) _____

If so, how long was your child's stay _____

What was your experience with the NICU

Poor_____ Fair_____ Good _____ Excellent _____

Did you struggle with infertility (Y/N) _____

Did you conceive via IVF or IVI (Y/N) _____

Have you had multiple births (ie. Twins, triplets) (Y/N) _____

Have you experienced the loss of a child through still birth (Y/N) _____

Have you ever experienced the loss of a child after birth (Y/N) _____

Who does your support system consist of regarding caring for the baby

_____

Is your partner involved (Y/N) _____ Name: _____

What do you feel is your ability to care for your baby (Please rate 1 to 10) _____

1 not at all confident in my ability.....10 extremely confident in my ability

What do you feel is your partner's ability to care for your baby (Please rate 1 to 10) _____

1 not at all confident in my ability.....10 extremely confident in my ability

If in a partnership, have you discussed and agreed upon parental roles (ie. Who gets up at night, who changes the baby, etc) (Y/N) _____

Are you comfortable with this agreement _____

Do you use a baby monitor (Y/N) _____

Does the baby sleep on the same floor as you (Y/N) _____

Do you co-sleep _____ baby sleep in your room _____ baby sleep in their own room _____

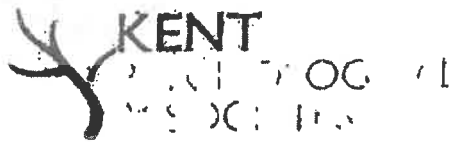
Please check one above

What does baby sleep in (ie: crib, pack and play, bassinet, rock & play, etc.) _____ _____ _____

Do you breastfeed _____ or bottle feed _____ *Please check one*

Do you currently or did you have difficulties breast feeding (Y/N)_____

Have you participated in lactation services (ie: support group, lactation consultation) _____



Edinburgh Postnatal Depression Scale (EPDS)

Name: _____ *Today's Date:* _____

____*Pregnancy* ____ *Pregnancy Loss* ____ *Postpartum* ____ *days/weeks/months*

Please circle the answer which comes closest to how you have felt in the <u>past 7 days</u>

1. I have been able to laugh and see the funny side of things.

   0 As much as I always could
   1 Not quite so much now
   2 Not so much now
   3 Not at all

2. I have looked forward with enjoyment to things.

   0 As much as I ever did
   1 Somewhat less than I used to
   2 A lot less than I used to
   3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong.

   0 No, not at all
   1 Hardly ever
   2 Yes, sometimes
   3 Yes, very often

4. I have been anxious or worried for no good reason.

   3 Yes, often
   2 Yes, sometimes
   1 No, not much
   0 No, not at all

5. I have felt scared or panicky for no good reason.

   3 Yes, often
   2 Yes, sometimes
   1 No, not much
   0 No, not at all

6. Things have been too much for me.

   3 Yes, most of the time I haven't been able to cope at all
   2 Yes, sometimes I haven't been coping as well as usual
   1 No, most of the time I have coped well
   0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping.

   3 Yes, most of the time
   2 Yes, sometimes
   1 Not very often
   0 No, not at all

8. I have felt sad or miserable

   3 Yes, most of the time
   2 Yes, quite often
   1 Not very often
   0 No, not at all

9. I have been so unhappy that I have been crying.

   3 Yes, most of the time
   2 Yes, quite often
   1 Only occasionally
   0 No, never

10. The thought of harming myself has occurred to me.

    3 Yes, quite often
    2 Sometimes
    1 Hardly ever
    0 Never

TOTAL SCORE _____

Edinburgh Postnatal Depression Scale (EPDS)
(J.L. Cox, J.M. Holden, R. Sagovsky, Department of Psychiatry, University of Edinburgh)

KENT PSYCHOLOGICAL ASSOCIATES

Perinatal Anxiety Screening Scale (PASS)

Name: _____ DOB: _____ Date: _____

☐ ANTENATAL ☐ POSTNATAL Weeks pregnant: _____ Baby's Age: _____

Over the past month, how often have you experienced the following? Please tick the response that most closely describes your experience for every question.

	Not At All	Sometimes	Often	Almost Always
1. Worry about the baby/pregnancy	0	1	2	3
2. Fear that harm will come to the baby	0	1	2	3
3. A sense of dread that something bad is going to happen	0	1	2	3
4. Worry about many things	0	1	2	3
5. Worry about the future	0	1	2	3
6. Feeling overwhelmed	0	1	2	3
7. Really strong fears about things; eg: needles, blood, birth, pain, etc.	0	1	2	3
8. Sudden rushes of extreme fear or discomfort	0	1	2	3
9. Repetitive thoughts that are difficult to stop or control	0	1	2	3
10. Difficulty sleeping even when I have the chance to sleep	0	1	2	3
11. Having to do things in a certain way or order	0	1	2	3
12. Wanting things to be perfect	0	1	2	3
13. Needing to be in control of things	0	1	2	3
14. Difficulty stopping checking or doing things over and over	0	1	2	3
15. Feeling jumpy or easily startled	0	1	2	3
16. Concerns about repeated thoughts	0	1	2	3
17. Being 'on guard' or needing to watch out for things	0	1	2	3
18. Upset about repeated memories, dreams, or nightmares	0	1	2	3

Continued on Back

	Not At All	Sometimes	Often	Almost Always
19. Worry that I will embarrass myself in front of others	0	1	2	3
20. Fear that others will judge me negatively	0	1	2	3
21. Feeling really uneasy in crowds	0	1	2	3
22. Avoiding social activities because I might be nervous	0	1	2	3
23. Avoiding things which concern me	0	1	2	3
24. Feeling detached like you're watching yourself in a movie	0	1	2	3
25. Losing track of time and can't remember what happened	0	1	2	3
26. Difficulty adjusting to recent changes	0	1	2	3
27. Anxiety getting in the way of being able to do things	0	1	2	3
28. Racing thoughts making it hard to concentrate	0	1	2	3
29. Fear of losing control	0	1	2	3
30. Feeling panicky	0	1	2	3
31. Feeling agitatied	0	1	2	3
Global Score				

Reference:
Somerville, S., Dedman, K., Hagan, R., Oxnam, E., Wettinger, M., Byrne, S., Coo, S., Doherty, D., Page, A.C. (2014). The Perinatal Anxiety Screening Scale: development and preliminary validation. *Archives of Women's Mental Health*, DOI: 10.1007/s00737-014-0425-8

KENT PSYCHOLOGICAL ASSOCIATES

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.)