GENERAL CONSENT

SMART | HEALTH & WELLNESS CENTERS

Patient Name: _____ **DOB**: _____ **Today's Date**: _____

Assignment of Benefits. I authorize Smart Neuro Health & Wellness Centers, (SNHWC) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that SNHWC will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment. I consent for SNHWC to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, SNHWC may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at SNHWC's expense.

Patient Initials: _____

Electronic Prescription. I understand SNHWC utilizes electronic prescribing technology and facilitates the electronic transmission of prescription information between providers and pharmacists. All triplicate refills between appointments will be charged $20.

No Show. If you have a scheduled appointment and fail to show for the appointment on time, you may be charged $90 for failing to cancel the appointment with at least 24 hour prior notice.

Phone Calls. By providing contact information, I authorize SNHWC, it's assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/ employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of Others in Care. I authorize SNHWC to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials**: _____

May We Contact You By Phone and Leave a Message about your Care?

Primary Phone #:_____

- ☐ Leave message with contact number only
- ☐ Leave message with detailed information
- ☐ Do not leave message

Secondary Phone #:_____

- ☐ Leave message with contact number only
- ☐ Leave message with detailed information
- ☐ Do not leave message

Patient Financial Policy

I acknowledge receipt of the "Patient Financial Policy." **Patient Initials**: _____

Notice of Privacy Practices

I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials**: _____

Minor Patient Photograph

I consent for SNHWC to photograph the minor patient for identification purposes only. **Patient Initials**: _____

_____

Print Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

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Patient Name: _____ **DOB**: _____ **Today's Date**: _____

ALLERGIES (*include medications, foods, xray dyes*) or ☐ NONE KNOWN

Name of Allergen	Type of Reaction	Approximate Date

CURRENT MEDICATIONS (*including prescription, over the counter and herbal medications*) or ☐ NONE

Name of Medication	Dose (mg)	How often taken	Reason for taking medication	Physician Prescribing

PHARMACY (*list pharmacy most frequently used for prescriptions*)

Name: _____**Phone #**: _____ **FAX #**:_____

Address: _____ **City**: _____**State/Zip**:_____

GENERAL HISTORY

Question	Answer
Please describe reason for your visit today:	
What are the main symptoms causing problems for you:	
When did the problem begin:	
Any stresses in your life contributing to your problem:	
Describe the course of your illness:	☐ the problem is getting worse with time ☐ the problems come and go, at times I feel back to my usual state of health ☐ I have ups and downs but the problem never goes away
Has the problem occurred previously:	☐ Yes ☐ No If YES, what treatment did you receive?
The problem causes me not to function well at:	☐ work ☐ home ☐ home social life ☐ school ☐ manage my daily life

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SOCIAL HISTORY

Preferred Name:		**Occupation:**	☐ Currently Employed ☐ Not Employed Where: _____
Religious Preference:		**Employment Length:**	
Hobbies:		**Have any of these occurred**	☐ Fired from a job ☐ Conflicts with Co-workers
Highest Level of Education:	☐ Completed High School ☐ College ☐ Post Graduate	**At your current employment:**	☐ Satisfied with employment ☐ Significant job related stress
Marital Status:	☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Living with Family	**Do you Smoke:**	☐ Yes ☐ No ☐ Former Smoker Is Yes, Amount: _____
Do you have children:	☐ Yes ☐ No **Ages**: _____ Are they still living at home? ☐ Yes ☐ No	**Problems in the past with:**	☐ Alcohol ☐ Drugs _____
Experiencing the following:	☐ Marital / Relationship Conflicts ☐ Conflicts with Children	**How much do you drink:**	☐ Daily _____ ☐ Weekly _____ Attend 12 step program: ☐ Yes ☐ No
Current Living Situation:		**Have you tried to stop**	☐ Yes ☐ No Why did you resume:
Legal History:		**Have you had:**	☐ Black-Outs ☐ DWI / Arrest ☐ IV Drug Use ☐ Health problems from use ☐ Dependence on prescription medication

MEDICAL HISTORY

Primary Care Physician:		**Date of most recent Labs:**	
Date of last appointment:		**Have you been Hospitalized:**	☐ Yes ☐ No Describe:
Have you had any of the following:	☐ Heart Disease ☐ Hypertension ☐ Lung/Respiratory Disease ☐ Diabetes ☐ Thyroid Disease ☐ Kidney Disease ☐ Asthma ☐ Seizures ☐ Arthritis ☐ Chronic Pain ☐ Cancer ☐ Head Injury / Concussion ☐ Other: _____		

PSYCHIATRIC HISTORY

Psychiatric Hospitalizations:	☐ Yes ☐ No Dates: Which Hospital:	**Suicide Attempts:**	☐ Yes ☐ No Dates: Method:
Have you ever experienced abuse:	☐ Yes ☐ No If, YES: ☐ Physical ☐ Verbal / Emotional ☐ Sexual	**Are you currently working with a Therapist:**	☐ Yes ☐ No If, YES: Therapist Name: Frequency:

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FAMILY HISTORY

Is there a history in your family of:	YES	NO	Affected Relative(s) and age when condition started
Heart Disease / Heart Attack			
Diabetes			
Cancer			
High Blood Pressure / Hypertension			
Stroke			
Depression / Anxiety			
Other Significant Disease			

SURGICAL HISTORY *(include all surgery in your lifetime)* or ☐ NONE

Type of Surgery	Date	Hospital or City if known

GYNECOLOGICAL HISTORY

Regular Menstrual Cycle:	☐ Yes ☐ No Last Date:	**Menopause:**	☐ Yes ☐ No Start Date:
Menarche (Age when started)		**Birth Control**	☐ Yes ☐ No Start Date:
# of Pregnancies		**# of Deliveries**	

MOOD QUESTIONAIRE

Question: Has there even been a period of time when you were not your usual self and...	Yes	No
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
...you were so irritable that you shouted at people or started fights or arguments?		
…you felt much more self-confident than usual?		
…you got much less sleep than usual and found you didn't really miss it?		
…you were much more talkative or spoke much faster than usual?		
…thoughts raced through your head or you couldn't slow your mind down?		
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
…you have much more energy than usual?		
…you were much more active or did many more things than usual?		
…you were more social or outgoing than usual (example: you telephoned friends in the middle of the night)?		
…you were much more interested in sex than usual?		
…you did things that were unusual for you or that other people might have thought excessive, foolish or risky?		
…spending money got you or your family into trouble?		
How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? ☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem		
Have any of your blood relatives (i.e. children, parents, etc.) had manic-depressive illness or bipolar disorder?		
Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		

Antidepressant Medication History

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Patient Name: _____ **DOB**: _____ **Today's Date**: _____

In the below grid, please indicate (*with an X to the left of the Drug name*) which medications that you have previously taken:

Previous Usage	Medication	Side Effect Experienced
	Amitriptyline/Elavil®/Endep®	☐Tremors ☐Indigestion/Nausea ☐Fatigue ☐Elevated Heart Rate ☐Sexual
	Imipramine/Tofranil®	☐Tremors ☐Indigestion/Nausea ☐Fatigue ☐Elevated Heart Rate ☐Sexual
	Desipramine/Norpramin/Pertofrane	☐Tremors ☐Indigestion/Nausea ☐Fatigue ☐Elevated Heart Rate ☐Sexual
	Trimipramine/Surmontil®	☐Tremors ☐Indigestion/Nausea ☐Fatigue ☐Elevated Heart Rate ☐Sexual
	Clomipramine/Anafranil®	☐Tremors ☐Indigestion/Nausea ☐Fatigue ☐Elevated Heart Rate ☐Sexual
	Maprotilene/Ludiomil®	☐Tremors ☐Indigestion/Nausea ☐Fatigue ☐Elevated Heart Rate ☐Sexual
	Doxepin/Sinequan®	☐Tremors ☐Indigestion/Nausea ☐Fatigue ☐Elevated Heart Rate ☐Sexual
	Nortriptyline/Pamelor/Aventyl	☐Tremors ☐Indigestion/Nausea ☐Fatigue ☐Elevated Heart Rate ☐Sexual
	Protriptyline/Vivactil®	☐Tremors ☐Indigestion/Nausea ☐Fatigue ☐Elevated Heart Rate ☐Sexual
	Fluoxetine/Prozac®	☐Indigestion/Nausea ☐Irritability ☐Fatigue ☐Sexual
	Trintellix	☐Indigestion/Nausea ☐Irritability ☐Fatigue ☐Sexual
	Citalopram/Celexa®	☐Indigestion/Nausea ☐Irritability ☐Fatigue ☐Sexual
	Fluvoxamine/Luvox®	☐Indigestion/Nausea ☐Irritability ☐Fatigue ☐Sexual
	Paroxetine/Paxil®	☐Indigestion/Nausea ☐Irritability ☐Fatigue ☐Sexual
	Sertraline/Zoloft®	☐Indigestion/Nausea ☐Irritability ☐Fatigue ☐Sexual
	Escitalopram/Lexapro®	☐Indigestion/Nausea ☐Irritability ☐Fatigue ☐Sexual
	Viibryd/Vilazodone	☐Indigestion/Nausea ☐Irritability ☐Fatigue ☐Sexual
	Venlafaxine/Effexor	☐Tremors ☐Nausea ☐Dizziness ☐Raised Blood Pressure ☐Anxiety
	Duloxetine/Cymbalta®	☐Tremors ☐Nausea ☐Dizziness ☐Raised Blood Pressure ☐Anxiety
	Pristiq	☐Tremors ☐Nausea ☐Dizziness ☐Raised Blood Pressure ☐Anxiety
	Fetzima/Levomilnacipran	☐Tremors ☐Nausea ☐Dizziness ☐Raised Blood Pressure ☐Anxiety
	Bupropion/Wellbutrin®	☐Weight Gain ☐Nausea/Vomiting ☐Sweating ☐Insomnia ☐Anxiety
	Mirtazapine/Remeron®	☐Weight Gain ☐Nausea/Vomiting ☐Sweating ☐Insomnia ☐Anxiety
	Nefazodone/Serzone®	☐Weight Gain ☐Nausea/Vomiting ☐Sweating ☐Insomnia ☐Anxiety
	Trazodone/Desyrel®	☐Weight Gain ☐Nausea/Vomiting ☐Sweating ☐Insomnia ☐Anxiety
	Amoxapine/Asendin®	☐Weight Gain ☐Nausea/Vomiting ☐Sweating ☐Insomnia ☐Anxiety
	Phenelzine/Nardil®	☐Insomnia ☐Muscle Aches ☐Low Blood Pressure ☐Dizziness ☐Anxiety
	Selegiline/Eldepryl®	☐Insomnia ☐Muscle Aches ☐Low Blood Pressure ☐Dizziness ☐Anxiety
	Selegiline transdermal	☐Insomnia ☐Muscle Aches ☐Low Blood Pressure ☐Dizziness ☐Anxiety
	Tranylcypromine/Parnate®	☐Insomnia ☐Muscle Aches ☐Low Blood Pressure ☐Dizziness ☐Anxiety
	Isocarboxazid/Marplan®	☐Insomnia ☐Muscle Aches ☐Low Blood Pressure ☐Dizziness ☐Anxiety
	Aripiprazole/Abilify®	☐Dizziness ☐Fatigue ☐Nausea/Vomiting ☐Weight Gain ☐Tardive Dyskinesia
	Lithium/Eskalith®/Lithobid®	☐Nausea/Vomiting ☐Dizziness ☐Fatigue ☐Tremors ☐Weight Gain ☐Kidney Damage
	Thyroid Hormone/Synthroid®	☐Insomnia ☐Anxiety ☐Fever/Hot Flashes ☐Increased Heart Rate ☐Weight Gain
	Latuda	☐Dizziness ☐Fatigue ☐Nausea/Vomiting ☐Weight Gain ☐Stomach Pain ☐Shaking
	Seroquel	☐Dizziness ☐Fatigue ☐Nausea/Vomiting ☐Weight Gain ☐Stomach Pain ☐Insomnia
	Lamictal	☐Dizziness ☐Tremors ☐Double Vision ☐Nausea/Vomiting ☐Pain
	Geodon	☐Rash ☐Anxiety ☐Depression ☐Nausea/Vomiting ☐Weight Gain

Patient Name: _____ DOB: _____

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Depression Symptom Checklist

☐ Patient has no Depression Symptoms to report

Symptom	Recent	Past
Depressed or sad mood	☐	☐
Loss of interest or pleasure in things I'm normally interested in	☐	☐
Difficulty falling asleep	☐	☐
Difficulty staying asleep or waking up too early	☐	☐
Sleeping too much	☐	☐
Increased appetite / Weight Gain	☐	☐
Decreased appetite / Weight loss	☐	☐
Fatigue / Poor energy level	☐	☐
Decreased activity (work, social, physical, sexual)	☐	☐
Poor concentration or slowed thinking	☐	☐
Thoughts of suicide	☐	☐
Excessive Feelings of guilt or worthlessness	☐	☐
Decreased sex drive or interest	☐	☐

General Anxiety Symptom Checklist

☐ Patient has no Anxiety Symptoms to report

Symptom	Recent	Past
Excessive anxiety or worry for no good reason	☐	☐
Trembling, twitching or feeling shaky	☐	☐
Muscle tension or muscle aches	☐	☐
Easily Fatigued	☐	☐
Dry mouth	☐	☐
Dizziness or lightheadedness	☐	☐
Nausea, diarrhea or other stomach problems	☐	☐
Frequent urination	☐	☐
Feeling keyed up or on edge	☐	☐
Irritability	☐	☐
Trouble falling asleep	☐	☐

Impulsivity Symptom Checklist

☐ Patient has no Impulsivity Symptoms to report

Symptom	Recent	Past
I tend to do things on impulse which end up being damaging to me or others	☐	☐
I have mood swings (depression, irritability, anxiety, anger) lasting up to several hours	☐	☐
I have tried to commit suicide	☐	☐
I have made cuts, burns or other injuries to myself without wanting to kill myself	☐	☐
My relationships always seem to work out wrong	☐	☐
My mood often swings from being either overconfident to having very low self esteem	☐	☐
I have a hard time sympathizing with others' pain	☐	☐
I often feel others do not understand me	☐	☐
I tend to get very hurt or angry when I'm criticized or rejected by someone	☐	☐
I tend to need a lot of reassurances or approval from others	☐	☐
I am very concerned about my appearance	☐	☐
Others often expect too much of me	☐	☐

Panic Attacks Symptom Checklist

☐ Patient has no Panic Attacks Symptoms to report

Symptom	Recent	Past
Panic attacks / anxiety attacks	☐	☐
Persistent worry that I will have a panic attack	☐	☐
Heart pounding or racing heart	☐	☐
Trembling or shaking	☐	☐
Sweating	☐	☐
Choking	☐	☐
Nausea or stomach problems	☐	☐
Feeling of unreality	☐	☐
Numbness or stomach problems	☐	☐
Feeling of smothering or shortness of breath	☐	☐
Fear of dying	☐	☐
Fear of going crazy or doing something uncontrolled	☐	☐
Chest pain or discomfort	☐	☐
Dizziness, unsteady feelings or faintness	☐	☐
Flushes, hot flashes or chills	☐	☐
Avoiding situations or places that may cause panic or severe anxiety	☐	☐

Mania Symptom Checklist

☐ Patient has no Mania Symptoms to report

Symptom	Recent	Past
Euphoric or high mood	☐	☐
Irritable mood	☐	☐
Decreased need for sleep without feeling tired	☐	☐
Increased energy level	☐	☐
Increased activity (work, social, physical, sexual)	☐	☐
Thoughts sped up or racing thoughts	☐	☐
Increased talkativeness / too socially outgoing	☐	☐
Making decisions too impulsively	☐	☐
Going on spending sprees	☐	☐

Substance Abuse Symptom Checklist

☐ Patient has no Substance Abuse Symptoms to report

Symptom	Recent	Past
I've felt alcohol or drugs were causing a problem for me	☐	☐
I have felt guilt about my abuse	☐	☐
I have had a desire (or made unsuccessful attempts) to cut down or control my use	☐	☐
Others have annoyed me about my use	☐	☐
I've used alcohol or drugs more often or in larger amounts than I intended	☐	☐
I've had to increase my use of alcohol or drugs to get the desired effect	☐	☐
I've had problems with withdrawals (shakes, nervousness insomnia, etc.) when I've cut down or stopped using drugs or alcohol	☐	☐
I've been to a meeting of Alcoholics Anonymous or Narcotics Anonymous	☐	☐

Patient Name: _____ DOB: _____

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Eating Disorder Symptom Checklist

☐ Patient has no Eating Disorder Symptoms to report

Symptom	Recent	Past
Insistence on maintaining body weight below expected for age and height	☐	☐
Intense fear of gaining weight or becoming fat even though underweight	☐	☐
I feel fat even when others see me as underweight	☐	☐
Eating binges	☐	☐
Feeling lack of control of eating during eating binges	☐	☐
Vomiting or using laxative to prevent weight gain	☐	☐
Being over-concerned about body weight or shape	☐	☐

Unusual Thoughts Symptom Checklist

☐ Patient has no Unusual Thoughts Symptoms to report

Symptom	Recent	Past
Hearing voices that sound real even though they are not actually there	☐	☐
Vivid voices in my head that do not seem like my ideas	☐	☐
Feeling that others might be putting thoughts in my head	☐	☐
Feeling others might be able to read my thoughts	☐	☐
Others feeling I am too suspicious or paranoid	☐	☐
Feeling others might be talking about me	☐	☐

PTSD Symptom Checklist

☐ Patient has no PTSD Symptoms to report

Symptom	Recent	Past
I have had a traumatic experience that would have seriously stressed anyone	☐	☐
History of relatives hurting me physically or touching me in sexual areas	☐	☐
History of unwanted sexual contact	☐	☐
I have memories or dreams of stressful event that I have trouble putting out of my head	☐	☐
I have flashbacks of past events, or I act/feel like I am re-living a past stressful event	☐	☐
I try to avoid situations or people that remind me of a severely stressful event in the past	☐	☐

Obsessive Compulsion Symptom Checklist

☐ Patient has no Obsessive Compulsion Symptoms to report

Symptom	Recent	Past
Excessive doubting or repeated/forced unreasonable thoughts/images/sounds	☐	☐
Urges to check things, wash things or count repeatedly	☐	☐
Excessive concern about coming into contact with germs/dirt	☐	☐
Excessive concern with right/wrong or morality	☐	☐
Excessive need for things to be exact or symmetrical	☐	☐

Attention Issues Symptom Checklist

☐ Patient has no Attention Issues Symptoms to report

Symptom	Recent	Past
Disorganization	☐	☐
Inattention	☐	☐
Daydreaming	☐	☐
Forgetfulness	☐	☐
Difficulty completing tasks	☐	☐
Poor school / work performance	☐	☐
Hyperactivity	☐	☐
Inability to focus	☐	☐

Medical Checklist

Symptom	Yes	Symptom	Yes
Fatigued / Tired	☐	Numbness	☐
Fever / Chills	☐	Weakness	☐
Weight Loss	☐	Cough	☐
Weight Gain	☐	Shortness of Breath	☐
Chest Pain	☐	Wheezing	☐
Irregular Heartbeat	☐	Abdominal Pain	☐
Swelling in Feet / Ankles	☐	Loss of Appetite	☐
Dizziness	☐	Nausea	☐
Fainting	☐	Vomiting	☐
Headache	☐	Diarrhea	☐
Memory Loss	☐		