BORIS A. KHAIMOV, D.O.

CHILD, ADOLESCENT & ADULT PSYCHIATRY

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PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____ SEX: M_____ F _____
PATIENT ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
SOCIAL SECURITY NUMBER: _____ - ____ - _____ HOME PHONE: ( ) _____
CELL PHONE: ( ) _____ WORK PHONE: ( ) _____
DATE OF BIRTHY: _____/_____/_____
PATIENT RELATIONSHIP TO INSURED: SELF ____ SPOUSE ____ CHILD ____ OTHER___
PATIENT STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ OTHER _____
PRIMARY CARE PHYSICIAN: _____ PHONE: ( ) _____
EMERGENCY CONTACT: _____ PHONE: ( ) _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY #: _____
NAME OF INSURED: _____ DATE OF BIRTH: _____/____/_____
SOCIAL SECURITY #: _____ NAME OF EMPLOYER: _____

PRESENTING PROBLEM

Please describe your reasons for seeking counseling. Include date/month the problem started. Any ideas about hurting self/others?

Was there an event which made issues or problems surface? Y _____ N _____
If yes, please describe: _____

Please indicate how current symptoms have affected the level of impairment in the following categories and indicate anticipated impairment at discharge.

Impairment Level (circle one)

CATEGORIES	No Impairment	Mild Impair-ment	Moderate Impair-ment	Marked Impair-ment	Extreme Impair-ment	Anticipated Impairment at Discharge (Impairment Level)
Marriage/Relationship with Family	1	2	3	4	5	
Job/School Performance	1	2	3	4	5	
Disability/Leave/Job Jeopardy	1	2	3	4	5	
Friendships/Peer Relationships	1	2	3	4	5	
Financial Situation	1	2	3	4	5	
Hobbies/Interests/Activities	1	2	3	4	5	
Physical Health	1	2	3	4	5	

IMPAIRMENT LEVEL (circle one)

CATEGORIES	No Impair-ment	Mild Impair-ment	Moderate Impair-ment	Marked Impair-ment	Extreme Impair-ment	Anticipated Impairment at Discharge (Impairment Level)
Activities of Daily Living (personal hygiene, bathing)	1	2	3	4	5	
Eating Habits	1	2	3	4	5	
Weight Loss	_____ lbs	Weight gain	_____ lbs	Current Weight	_____ lbs	Height _____
Sleeping Habits	1	2	3	4	5	
		Difficulty Falling Asleep	Difficulty Staying Asleep	Waking Early Morning		
Sexual Functioning	1	2	3	4	5	
Ability to Concentrate	1	2	3	4	5	
Ability to Control Temper						
						SCORE:

MEDICAL HISTORY

Please list any prescription and/or over the counter medications you currently use:

Name _____ Dosage _____ Frequency _____
Name _____ Dosage _____ Frequency _____
Name _____ Dosage _____ Frequency _____

Please list any conditions, past or present, that you have been treated for: _____
_____

When was your last physical examination? _____
What was the doctor's name? _____ Phone # _____

FAMILY HISTORY

Describe any medical or psychiatric conditions of your parents or siblings:

Mother _____ Father _____
Sister(s) _____ Brother(s) _____

HABITS	Amount Currently Using	Most Ever Used	Allergies
Coffee (cups per day)	_____	_____	_____
Cigarettes (packs per day)	_____	_____	_____
Alcohol	_____	_____	_____

PSYCHIATRIC HISTORY

Have you received psychiatric or psychological treatment of any kind before? Yes _____ No ____

If you checked yes to the above question, please answer the following:

What type of care did you receive: Inpatient _____ Outpatient _____ Both _____
When were you in treatment? (dates): _____
Where were you in treatment? _____
How long were you in treatment? _____
Who was your therapist or doctor? _____
Did your doctor prescribe medicine at that time? Yes _____ No _____

If yes, what was prescribed (including dosages if known)? _____
_____
_____

SUBSTANCE ABUSE HISTORY

Have you ever abused drugs or alcohol?
If yes, please describe.

Substance	Amount	Frequency	When? (First use, last use)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If yes, have you ever received substance abuse treatment of any kind before?
Yes _____ No _____

Do you have a history of blackouts, seizures or withdrawal symptoms?
Yes _____ No _____

Please describe anything else you would like Dr. Khaimov to know:

PATIENT/PARENT OR GUARDIAN SIGNATURE:

IF PATIENT IS UNDER THE AGE OF 18, THE PARENT OR GUARDIAN MUST SIGN FOR CONSENT.

Two questions for screening:

1. Have any of your blood relatives been diagnosed as "manic depressive" or as having "bipolar disorder"? _____ Yes _____No
2. Have you ever had far more energy than usual, slept very little and engaged in activities that may have been risky or dangerous? _____ Yes _____No

MOOD DISORDER QUESTIONNAIRE (MDQ)

Section One

Answer YES or NO to each of the following questions:

Has there ever been a period of time when you were not yourself and…	YES	NO
1. 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?		
2. You were so irritable that you shouted at people or started fights or arguments?		
3. You felt much more confident that usual?		
4. You got much less sleep than usual and found that you really didn't miss it?		
5. You were much more talkative or spoke much faster than usual?		
6. Thoughts raced through your head or you couldn't slow your mind down?		
7. You were so easily distracted by things around you that you had trouble concentrating or staying on track?		
8. You had much more energy than usual?		
9. You were much more active or did many more things than usual?		
10. You were much more social or outgoing than usual…for example; you telephoned friends in the middle of the night?		
11. You were much more interested in sex than usual?		
12. You did things that were unusual for you or that other people might have thought were excessive, foolish or risky?		
13. You spent so much money that it got you or your family into trouble?		

If you answered YES to more than one of the questions in Section One, continue to Section Two.

Section Two

14. Did any of the situations you said yes to ever happen during the same period of time?
_____ YES _____ NO

Section Three

Choose only 1 response:

15. How much of a problem did any of these situations cause you: i.e., being unable to work; having family, money or legal problems; getting into serious arguments or fight?

_____ It was no problem
_____ It was a minor problem
_____ It was a moderate problem
_____ It was a serious problem

CONFIDENTIALITY

All information between Doctor and patient is held strictly confidential **unless:**

1. The patient authorizes release of information **with** his/her signature;
2. The patient presents a physical danger to self;
3. The patient presents a danger to others;
4. Child/Elder abuse is suspected.

In cases 3 and 4, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

FINANCIAL TERMS

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and your Provider will be paid directly by the carrier. The patient will be responsible for any applicable deductibles and co-payments. If you are not eligible at the time services are rendered, you are responsible for payment. For those patients without health plan/insurance coverage, payment arrangements are to be made prior to your first visit.

CANCELLED/MISSED APPOINMENTS

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with ***less than 24 hours notice,*** the patient will be billed according to the scheduled fee of **$125.00**.

APPEALS AND GRIEVANCES

I acknowledge my right to request reconsideration in the case that outpatient care (number of visits) is not authorized (Appeal). I understand that I would request an Appeal through my Provider and that I risk nothing in exercising this right. I also acknowledge that I may submit a Grievance to the Provider or Clinical Group Administrator at any time to register a complaint about any aspect of my care. If I am not satisfied with the response I receive, I may submit the Grievance directly to VBH.

CONSENT FOR TREATMENT

I further authorized and request that Dr. Boris Khaimov carry out psychological examinations, treatments and/or diagnostic procedures which no or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

RELEASE OF INFORMATION

I authorize the release of information for claims, certifications/case management/quality improvement and other purposes related to the benefits of my Health Plan. Releases of information to providers, family or anyone other than the above mentioned, requires a separate form.

I understand and agree to all of the above information.

_____ _____

Patient Name (Please Print) Witness (Signature)

_____ _____

Patient/Parent or Guardian Signature
(If patient is under the age of 18, a parent or guardian must sign for consent).

Date