Clinical Training & Research Institute
PATIENT INFORMED CONSENT AND CONTRACT FORM

By signing below, I understand that:

- I request treatment for myself or of the dependent listed below by: Sandra Morrow, MD; Travis K Svensson, MD; Sapna Upadhyay, LCSW and other support staff, clinical interns and student clinicians at Clinical Training & Research Institute which may include testing, medication, individual or group psychotherapies as clinically indicated.

- I request that my insurance carrier(s) and/or claimant(s) be provided with any clinical information necessary to facilitate payment of my care benefits at Clinical Training & Research Institute.

- I request that my treatment team at Clinical Training & Research Institute coordinate care with my primary care provider(s) and other clinical specialists, as needed, with my signed consent documented on the medical/mental health release form provided to me.

- I agree to provide **48 business hours (2 business days)** notice should I need to cancel my appointment. I understand that I am responsible for payment for appointments missed without the requisite number of hours cancellation notice. The charges vary between providers. In the event of an emergency, these charges may be waived. For more information, please discuss this with you clinician.

- I understand that telephone authorization of refills for prescriptions may be provided as a courtesy when clinically appropriate. Refill requests must be made by fax and by the pharmacy. For more information, please contact your pharmacist for details. Please allow at least two weeks before taking your last dose to request a refill. Amphetamine stimulants and opiates pain medications will not be refilled over the phone or by fax.

- I understand that is the patient's responsibility to provide necessary paperwork for prior authorization of non-formulary drugs not usually covered by the patient's insurance carrier(s). Our clinical team will be happy to assist the patient to complete and submit these forms during the next clinical office visit. Please contact your insurance carrier for required forms.

- I agree to notify this office immediately of any changes to my insurance coverage. The timely filing period for most insurance carrier is within 90 days of the date of service. I understand that I am responsible for payment for those services billed outside of this 90 day window.

- I understand that as a new patient in this practice that I will be required to review the HIPAA Notice of Privacy Practices and understand that my consent may be required for requests to release protected health information. I have reviewed the notice, understand, and agree to follow the requirements.

NOTICE TO CONSUMERS THAT MEDICAL DOCTORS ARE REGULATED BY THE MEDICAL BOARD

OF CALIFORNIA (800) 633-2322 www.mbc.ca.gov

_____

Patient Name | Authorized Signature | Date

_____

Cell Phone | Home Phone | Email Address

CLINICAL TRAINING & RESEARCH INSTITUTE

Psychiatry, Pain & Addiction Medicine
Address: 25 Edwards Ct. #105, Burlingame, CA 94010
Main Phone Line: (650) 342-1966, After Hours: (415) 424-4543
Email Address: CTRI.Staff@gmail.com

Consent for Use or Disclosure of Health Information

At **Clinical Training & Research Institute,** we have the utmost respect in protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes such as recall notices, reminder calls, and treatment news.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions other use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I hereby authorize the following people to obtain and discuss my medical information:

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

I hereby authorize the following physicians to obtain and discuss my medical information:

NAME _____ PHONE _____ ADDRESS _____

NAME _____ PHONE _____ ADDRESS _____

NAME _____ PHONE _____ ADDRESS _____

Patient Signature Printed Name Date

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name _____ Date of Birth _____

Phone _____ E-mail _____

Address _____ City/State/Zip _____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name _____ Facility Phone _____

Facility Address _____ Facility Fax _____

City/Sate/Zip _____

This authorization is valid for the release of all medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following medical group:

Clinical Training & Research Institute
25 Edwards Court, Suite 105
Burlingame, CA 94010
Phone (650) 342-1966; Fax (650) 685-6552

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ Date _____

Adult Intake Form

Name: _____ Date: _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

Please check all of the behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Other:_____
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational activities
- ☐ Self esteem
- ☐ Housing
- ☐ Sexual activity
- ☐ Relationships
- ☐ Legal matters
- ☐ Health
- ☐ Hygiene
- ☐ Finances

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe:_____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe:_____

☐ Yes ☐ No Have you recently been physically hurt or threatened by someone else? If yes, please describe:_____

☐ Yes ☐ No Have you gambled in the past 6 months? If yes, let us know the following

☐ Yes ☐ No Have you ever felt the need to bet more and more money?

☐ Yes ☐ No Have you ever had to lie to people important to you about how much you gambled?

Therapist Notes:

Rev. 4/2005

Name: _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times _____
☐ Father remarried: Number of times _____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

Therapist Notes:
Init: ____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

Therapist Notes:
Init: ____

Name: _____

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

☐ Yes ☐ No Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

☐ Yes ☐ No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe: _____

Therapist Notes:
Init: ____

MEDICAL INFORMATION

Date of last physical exam: _____

Have you experienced any of the following medical conditions during your lifetime?

☐ Allergies	☐ Asthma	☐ Headaches	☐ Stomach aches
☐ Chronic pain	☐ Surgery	☐ Serious accident	☐ Head injury
☐ Dizziness/fainting	☐ Meningitis	☐ Seizures	☐ Vision problems
☐ High fevers	☐ Diabetes	☐ Hearing problems	☐ Miscarriage
☐ Sexually transmitted disease	☐ Abortion	☐ Sleep disorder	☐ Other: _____

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

_____

Allergies and/or adverse reactions to medications: ☐ None

If yes, please list: _____

Therapist Notes:
Init: ____

Name: _____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center (which one? _____)

To which cultural or ethnic group do you belong? _____
If you are experiencing any difficulties due to cultural or ethnic issues, please describe:_____
_____

How important are spiritual matters to you? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much
☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporated into your counseling?

Please describe your strengths, skills, and talents? _____
_____
Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):_____
_____

Therapist Notes:
Init: ____

MISCELLANEOUS INFORMATION

Employment

Employer: _____ Position: _____
Length of time in this position:_____ Job Duties:_____
Stress level of this position ☐ Low ☐ Medium ☐ High
Other jobs you have held: _____

Education

☐ Yes ☐ NoAre you currently attending school?

☐ High School Graduate? Or ☐ GED? Year _____
☐ Associate's Degree Year _____ Major area of study _____
☐ Undergraduate Degree Year _____ Major area of study _____
☐ Graduate Degree Year _____ Major area of study _____

Military Service

☐ Yes ☐ NoHave you been/are you currently in the military? (If no, skip remainder of this section)

Branch _____ Date of Discharge _____ Type of Discharge _____ Rank _____
☐ Yes ☐ No Were you in combat?

Legal

☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? If yes, please explain_____
_____

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings? If yes, please explain _____

Therapist Notes:
Init: ____

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

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

SUBSTANCE ABUSE QUESTIONNAIRE

NAME: _____ DATE: _____

Please carefully read through the list below of different types of drugs/chemicals. Please put an X by any of the substances that you have used, even if only one time. Please be honest. Thank you.

___Alcohol

___Nicotine
- __Cigarettes
- __Smokeless Tobacco
- __Cigar

___Antidepressants
- __Paxil
- __Prozac
- __Zoloft
- __Effexor
- __Celexa
- __Remeron
- __Other: _____

___Dissociative Anesthetics
- __Ketamine
- __PCP/Angel Dust

___Hallucinogens
- __LSD/Acid
- __Mescaline/Peyote
- __Psilocybin/Magic Mushrooms

___Antipsychotics/Anticonvulsants
- __Haldol
- __Tegretol
- __Depakote
- __Topomax
- __Lithium
- __Zyprexa
- __Other: _____

___Over-The-Counter Medications
- __Aspirin, Tylenol
- __Ephedrine/Psuedoephedrine
- __Antihistamines: Benadryl
- __Cough Medicines: Robitussin, Nyquil
- __Cold Medicines: Sudafed
- __Other: _____

___Anabolic Steroids

___Cannabinoids
- __Marijuana
- __Hashish

___Inhalants/Whippets/Huffing
- __Nitrites: Amyl, Butyl, Rush/Poppers
- __Solvents: Glue, Gasoline
- __Gases: Nitrous Oxide, Paint
- __Other: _____

___Sedative, Hypnotic, or Anxiolytic
- __Barbiturates: Phenobarbital, Nembutal
- __Benzodiazepines: Ativan, Valium Klonopin, Xanax, Librium
- __Rohypnol/Roofies
- __GHB
- __Methaqualone/Quaalude
- __Ambien, Sonata
- __Other: _____

___Opioids & Derivatives
- __Codeine
- __Morphine
- __Opium
- __Heroin
- __Fentanyl
- __Oxycodone
- __Hydrocodone: Lortab, Vicodin
- __Propoxyphene: Darvon, Darvocet
- __Methadone
- __Other: _____

___Stimulants
- __Amphetamines: Ritalin, Adderall, Dexedrine
- __Cyalert
- __MDMA/Ecstasy
- __Cocaine/Crack
- __Methamphetamine/ICE/Crank
- __Other: _____

Please list any other substances that you have used that are not listed above: _____

_____

_____

Today's Visit

Name: _____ Date: _____ Time: _____

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

PHQ9 total score ☐

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

GAD7 total score ☐

If you checked off any problems, how difficult have these 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 ____

Any change on your current medications? No ___ Yes, which one? _____

SELF ASSESSMENT

INSTRUCTIONS: Answer the following questions for the last 12 months of your drinking or drug use.

1.	When I drink, I often drink more than the 1-2-3 guidelines.	**YES NO**
2.	Occasionally, I use illegal drugs or use a prescription drug to get high.	**YES NO**
3.	It now takes more drugs or alcohol for me to get high or intoxicated than when I first started.	**YES NO**
4.	I function best in groups when I am making high-risk drinking or drug choices.	**YES NO**
5.	Have you wanted or needed to cut down on your drinking or drug use in the last year?	**YES NO**
6.	In the last year, have you ever drunk or used drugs more than you meant to?	**YES NO**
7.	Have you had a feeling of guilt or remorse after drinking or drug use?	**YES NO**
8.	Have you failed to do what was normally expected from you because of drinking or drug use?	**YES NO**
9.	Have you been unable to remember what happened the night before because you had been drinking or using?	**YES NO**
10.	Have you needed a drink (or drug) in the morning to get yourself going after a heavy drinking (or drug using) episode?	**YES NO**
11.	Have you tried to cut back on your drinking or drug use but could not?	**YES NO**
12.	Sometimes when I start drinking or using drugs, it is like something takes over and I get drunk or high without meaning to.	**YES NO**