

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

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: CTRL.Staff@gmail.com

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/State/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:

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

Are your problems affecting any of the following?

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Handling everyday tasks | <input type="checkbox"/> Self esteem | <input type="checkbox"/> Relationships | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Work/School | <input type="checkbox"/> Housing | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Recreational activities | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Health | |

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:

Name: _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship	Family Mental Health Problems	Who?
Mother				Hyperactivity	
Father				Sexually Abused	
Stepmother				Depression	
Stepfather				Manic Depression	
Siblings				Suicide	
				Anxiety	
				Panic Attacks	
				Obsessive-Compulsive	
Spouse/partner				Anger/Abusive	
Children				Schizophrenia	
				Eating Disorder	
				Alcohol Abuse	
				Drug Abuse	

- Parents legally married or living together Mother remarried: Number of times _____
 Parents temporarily separated Father remarried: Number of times _____
 Parents divorced or permanently separated

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

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

- | | | | |
|---|-------------------------------------|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Surgery | <input type="checkbox"/> Serious accident | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Abortion | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> 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 No Are 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 No Have 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/Pseudoephedrine
- 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 |