

PATIENT INFORMATION

NAME: LAST	FIRST	MIDDLE	MAIDEN	BIRTHDATE:
STREET ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE:	CELL PHONE:	WORK PHONE:	EMAIL: (do not provide if you do not wish to be contacted via email)	
Please check all methods we may use to contact you: <input type="checkbox"/> No Preference <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Email We usually call cell numbers first, but if unavailable we may call alternative numbers provided or email you unless specifically instructed not to. For specific instructions, please list below:				
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED			
KNOWN DRUG ALLERGIES & REACTIONS:				

RESPONSIBLE PARTY INFORMATION

(person paying for visits - please note that we may need to contact responsible parties regarding payment for visits)

RESPONSIBLE PARTY:	RELATIONSHIP TO PATIENT:	HOME PHONE:	CELL PHONE:
ADDRESS:	CITY:	STATE:	ZIP CODE:

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:	RELATIONSHIP TO PATIENT:	HOME PHONE:	CELL PHONE:
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WORKERS COMPENSATION REFERRALS ONLY

WORKERS COMPENSATION COMPANY:	CLAIM NUMBER:	ADJUSTER NAME:
ADJUSTER PHONE:	ADJUSTER FAX:	ADJUSTER EMAIL:

FINANCIAL AGREEMENT

I understand that this is a "FEE FOR SERVICE" practice and that payment in full is due at the time of service. I understand that Dr. Holmberg is not a provider for any insurance company and that it is my responsibility to find out how to submit claims to my insurance company for reimbursement. I understand that if I have an unpaid balance for over 120 days and Dr. Holmberg's office is unable to collect payment from me or my responsible party, Dr. Holmberg has the right to refer me to another provider. I understand that if I miss an appointment without giving any notice, I will be charged the full fee for that appointment. I understand that if I cancel less than 24 hours in advance, I will be charged a \$50 cancellation fee. I further understand that I will be charged a \$35.00 fee for any returned checks written and that my account will be placed on a "no checks" status for 1 year.

Signature: _____ Date: _____

SELF PAY PATIENTS HAVE THE RIGHT TO DENY THEIR HEALTH INSURANCE COMPANY ACCESS TO THEIR PATIENT HEALTH INFORMATION. Some medications as well as mental health visits may require a prior authorization in order for your insurance company to pay for them. In order to complete a prior authorization, insurance companies may request treatment records or a letter of necessity which usually requires disclosure of sensitive personal health information. As a self paying patient, you have the right to deny your insurance company access to those records unless you are submitting claims for reimbursement or expecting them to pay for a medication related to your treatment at this office. If you do not want your health insurance company to have access to your personal health information, please let us know so you can fill out the proper form. Otherwise please sign below.

I authorize the office of Trent C. Holmberg, MD to release any personal health information necessary to process claims or complete prior authorizations requested by my insurance company.

Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ)

Patient Name: _____ Date of Birth: _____
 Physician: _____ Date: _____

Currently I am: on medication for depression not on medication for depression in counseling

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/staying asleep, 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 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

- A. How difficult have these problems 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
- B. In the past two years have you felt depressed or sad most days, even if you felt okay sometimes?
 Yes No

Anxiety Symptoms Rating Scale

Symptoms	Rating Scale: 0 = not at all 10 = couldn't be worse
<u>Worries:</u> May include worries about personal safety, safety of others, safety of family, future, natural disasters, social acceptance, being liked, being abandoned, not being able to control what happens, bad things happening, little things that happen during the day.	0 1 2 3 4 5 6 7 8 9 10
<u>Fears:</u> May include the following symptoms: performance anxiety, avoids fear-inducing situations. May be fearful of: heights, social situations, separating from parent, being followed, being hurt by others.	0 1 2 3 4 5 6 7 8 9 10
<u>Panic symptoms (cardiovascular):</u> May include the following symptoms: increased heart rate, increased blood pressure, irregular breathing, getting lightheaded, chest pain/pressure, feelings of not being able to get enough air into your lungs.	0 1 2 3 4 5 6 7 8 9 10

Disability Scale*

Directions: Rate your current disability due to current symptoms of all medical and mental health conditions. 0 = n/a

Work: the symptoms have disrupted your work	0 1 2 3 4 5 6 7 8 9 10
Social Life: the symptoms have disrupted your social life	0 1 2 3 4 5 6 7 8 9 10
Family Life: The symptoms have disrupted your family life/home responsibilities	0 1 2 3 4 5 6 7 8 9 10

*Sheehan Disability Scale. Sheehan D.V., Harnett-Sheehan K. Raj B.A.
 The Measurement of Disability. International Clinical Psychopharmacology 1996, 11 (suppl 3): 89-95



Trent C. Holmberg, M.D.

Behavioral Health Personal History Questionnaire

This form will help your doctor to get the most complete picture of your background and present problems as well as make your evaluation as thorough as possible. If there is a question you cannot or do not wish to answer, please leave it blank.

Did someone refer you to Dr. Holmberg? Yes No If yes, by who? _____

Name of individual completing this form: _____

CURRENT PROBLEM(S)

Describe the problem(s) you are seeking treatment for:	Doctor Comments:	
When did this/these problem(s) start?		
What do you think caused this/these problem(s)?		
Why are you seeking treatment now?		
What have you tried so far to help you solve your problem(s)?		
What goals do you hope to achieve by seeking treatment?		
List current mental health treatment. List provider name, specialty and date of last visit:		
Current Medications and Dosages:		Response or Side Effects

Today's Date:

Patient Name:

Date of Birth:

Past Mental Health History

List any treatment or counseling you have had:		Doctor Comments:
Provider/Type	Dates:	
Was this helpful?		
Yes/No		
Yes/No		
Yes/No		
Past Mental Health Medications Only	Response or Side Effects:	
Did you suffer from mood problems before age 25? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If you answered yes, please methods and dates:		
Have you had recent thoughts of hurting yourself or others? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you had any past mental health hospital stays? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Any drug and alcohol abuse treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If you answered yes to either of the above, list location and dates:		
Answer this section if you had or do have any drug or alcohol use: <input type="checkbox"/> None		
How many drinks (equal to one ounce of alcohol) do you have in a week?		
Have you ever....		
1. Consumed alcohol or used drugs more than you meant to in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Wanted to cut down on your drinking or drug use in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Been annoyed by others criticizing your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Felt guilty about your drinking or drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Circle if you have ever used:</u>	<u>Circle if you have ever had:</u>	
Alcohol	Alcohol-related seizures	
Cocaine	Alcohol-related hallucinations	
Ecstasy	Alcohol-related blackouts	
Heroin	Severe alcohol withdrawal	
Opiates/Oxycontin	Alcohol poisoning	
Sedatives/Downers		
Marijuana		
Meth	Other severe alcohol or drug-related symptoms:	
Inhalants		
Bath Salts		
Hallucinogens		
Other: _____		

Today's Date:

Patient Name:

DOB:

CHILDHOOD

During childhood or teenage years did you experience:			
Mood Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Difficulty in School	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anxiety	Yes <input type="checkbox"/> No <input type="checkbox"/>	Drugs and Alcohol	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hyperactivity	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skipping School	Yes <input type="checkbox"/> No <input type="checkbox"/>
Poor Attention	Yes <input type="checkbox"/> No <input type="checkbox"/>	Poor Grades	Yes <input type="checkbox"/> No <input type="checkbox"/>
Behavior Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Problems with Math	Yes <input type="checkbox"/> No <input type="checkbox"/>
Family Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Problems with Reading	Yes <input type="checkbox"/> No <input type="checkbox"/>
Legal Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Problems with Writing	Yes <input type="checkbox"/> No <input type="checkbox"/>
Running Away	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eating Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Shyness	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Doctor Comments:

FAMILY HISTORY

Current Marital Status:
 Never Married Married Divorced Domestic Partner

Gender Identity:
 Female Male Transgender/Other Prefer not to answer

Sexual Orientation:
 Heterosexual Homosexual Bisexual Prefer to Not Answer

Children (living and deceased)	Age	Live at Home?	Relationship		
			Good	Fair	Poor

Are there any specific problems with the children? If so, what?

Names of Parents/Step Parents	Living:		Relationship:		
	Yes	No	Good	Fair	Poor
Mother/Step Mother:					
Father/Step Father:					
Names of Siblings:					

FAMILY MENTAL HEALTH HISTORY

Has any blood relative had any of the following conditions:					
Depression	Yes <input type="checkbox"/> No <input type="checkbox"/>	Suicide	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Anxiety	Yes <input type="checkbox"/> No <input type="checkbox"/>	Alcohol/Drug Abuse	Yes <input type="checkbox"/> No <input type="checkbox"/>		
OCD	Yes <input type="checkbox"/> No <input type="checkbox"/>	Developmental			
Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>	Disabilities	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Schizophrenia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dementia	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Bipolar Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>				

Today's Date:

Patient Name:

DOB:

SOCIAL HISTORY

Who do you live with (Spouse, Children, Roommates, etc.)?	Doctor Comments:
Where were you raised?	
Were you adopted and if so, at what age?	
Parents: Still Married <input type="checkbox"/> Divorced <input type="checkbox"/> If parents divorced how old were you?	
Highest Level of Education Completed and/or Degree:	
Were you abused as a child? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how? Physically <input type="checkbox"/> Mentally <input type="checkbox"/> Verbally <input type="checkbox"/> Neglect <input type="checkbox"/> Other <input type="checkbox"/> At what age/s?:	
List any other significant traumatic events you have experienced and at what age:	
Occupation/Employment: Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> If employed, current employer: Position: For how long: Are you satisfied with current job? Yes <input type="checkbox"/> No <input type="checkbox"/> Stressful: Yes <input type="checkbox"/> No <input type="checkbox"/> Past Occupations:	
Sources of Income: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Disability <input type="checkbox"/> Alimony/Child Support <input type="checkbox"/> Other <input type="checkbox"/>	
Financial Status: Adequate <input type="checkbox"/> Significant Financial Stress <input type="checkbox"/> Bankruptcy <input type="checkbox"/>	
Current Religion: <input type="checkbox"/> Prefer not to answer <input type="checkbox"/>	
Religion of family when growing up: Is religion or spirituality important in your life? Yes <input type="checkbox"/> No <input type="checkbox"/>	
TALENTS AND STRENGTHS	
List three of your strengths: 1. 2. 3.	
How do you learn best? By doing <input type="checkbox"/> By watching <input type="checkbox"/> By reading <input type="checkbox"/> By listening <input type="checkbox"/>	
Hobbies or Leisure Activities: Are you participating in them now? Yes <input type="checkbox"/> No <input type="checkbox"/>	
LEGAL HISTORY	
I do not have any legal history <input type="checkbox"/>	
Arrests <input type="checkbox"/> Probations <input type="checkbox"/> Convictions <input type="checkbox"/> Parole <input type="checkbox"/> DUI <input type="checkbox"/> Assault <input type="checkbox"/> List any pending court dates:	

Today's Date:

Patient Name:

DOB:

MEDICAL HISTORYList of Allergies to Medications: No Known Drug Allergies

Doctor Comments:

Primary Care Physician:

Date of last Visit:

Do You Frequently Use:

Caffiene If so, daily amount: _____ Tobacco Daily packs per day: _____Herbs Diet Aids Laxatives Cough Syrup Other **Menstrual History (Females Only):**

Check all that apply:

- Regular Menstrual Cycle
 PMS
 Irregular Menstrual Cycle
 Sexually Active

- Menstrual Pain
 Use Birth Cotrol
 Menopausal
 Pregnant. How many weeks _____

Medical Conditions:

- Acid Reflux
 Anemia
 Asthma
 Bone Fractures
 Cancer
 Chronic Constipation
 Chronic Fatigue Syndrome
 Colitis/Irritable Bowel Syndrome
 Diabetes
 Enlarged Prostate
 Fibromyalgia
 Glaucoma
 Headaches
 Head Injury
 Heart Disease
 Heart Rhythm Problems
 Hepatitis

- High Blood Pressure
 High Cholesterol
 High Triglycerides
 Kidney Disease
 Kidney Stones
 Loss of Consciousness
 Lupus
 Nausea/Vomiting
 Seizures
 Serious Injuries
 Sexual Dysfunction
 Sinus Infections
 Thyroid Problems
 Ulcers
 Urinary Tract Infections
 Other Concerns about your Health

CHRONIC PAINDo you suffer from Chronic Pain? Yes No If yes, location:

Please rate your current pain: (Circle)

(none) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (worst ever)

Physician Treating Pain Condition:

URGICAL HISTORY

Check all that apply and list approx. dates:

- Appendix
 Back
 Bladder
 Gall Bladder
 Heart (list type) _____
 Hysterectomy

- Neck
 Stomach Bypass
 Thyroid
 Tonsils
 Other (describe)

Today's Date:

Patient Name:

DOB:

SYMPTOM CHECKLIST

Please indicate how much you have experienced the following symptoms in the last 30 days.

Symptom	Not at all	A little	A lot	All the time	Doctor Comments:
1. Sad or Depressed					
2. Irritable					
3. Crying					
4. Feeling unworthy or like a failure					
5. Feeling guilty					
6. Loss of interest in most things or that I used to enjoy					
7. Loss of pleasure in most things					
8. Lack of motivation					
9. Withdrawing or Isolating oneself					
10. Change in sexual desire					
11. Problems with memory					
12. Difficulty making decisions					
13. Difficulty concentrating					
14. Distracted					
15. Change in appetite					
16. Change in weight					
17. Tired or loss of energy					
18. Sleeping more than usual					
19. Difficulty falling asleep					
20. Difficulty staying asleep or waking too early					
21. Decreased need for sleep					
22. Feeling that there is no hope					
23. Thoughts of death or suicide					
24. Worrying or feeling anxious					
25. Feeling tense or stressed					
26. Panic attacks					
27. Restlessness					
28. Constant worries					
29. Headaches or other aches and pains					
30. Irrational fears or situations or objects					
31. Washing hands over and over					
32. Checking things repeatedly (stove, locks)					
33. Meaningless thoughts you cannot stop					
34. Feeling that you are unsafe					
35. Feeling that someone is monitoring you					
36. Feeling that someone is out to hurt you					
37. Unusual ideas or experiences which other people do not have					
38. Hearing voices that others do not hear					
39. Seeing things that others cannot see					
40. Feel that you have special powers					
41. Irresponsible risk-taking					
42. Period of very high energy					
43. Much better mood than usual					
44. Racing thoughts					

Today's Date:

Patient Name:

DOB: