Keturah Health llc
Medical and Mental Health Clinic
1420 Valwood Parkway Ste. 170a
Carrollton, Texas 75006

Patient History

Patient Name: _____

Chief Complaint: _____

Current Symptoms Please review the following and check any symptoms that you have been recently experiencing:

Depressed mood ☐ Inflated Self-esteem/Grandiosity ☐ Sleep problem ☐ Decrease Need for Sleep ☐ Change in Appetite ☐ Racing Thoughts ☐ Decrease Interest ☐ Pressure to Keep Talking ☐ Decrease Energy ☐ Spending Spree ☐ Difficulty in Concentration ☐ Distractibility ☐ Guilt ☐ Impulsive Behavior ☐ Irritability ☐ Trying to do Way Too Much ☐ Crying Spells ☐ See/Hear Things that May Not be real ☐ Excessive Worrying ☐ Suspect/Believe Things that May Not be Real ☐ Often Tense/Keyed Up ☐ Cannot Stop Repetitive Thoughts ☐ Panic Attack ☐ Cannot Stop Repetitive Behavior ☐ Intrusive/Recurrent Memory of Past Trauma ☐ Hyper Vigilant ☐

Stressors: _____

Past Psychiatric History

In-Patient Psychiatric Treatment: ☐ Yes ☐ No _____

Out-Patient Psychiatric Treatment: ☐ Yes ☐ No _____

Past Psychiatric Medication: ☐ Yes ☐ No _____

History of Suicide: ☐ Yes ☐ No _____

History of Violence: ☐ Yes ☐ No _____

Substance Abuse History

Average per Day/How long

Alcohol: ☐ Yes ☐ No _____

Tobacco: ☐ Yes ☐ No _____

Illicit Drugs: ☐ Yes ☐ No _____

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Medical History

Primary Care Physicians Name: _____

Do you have any of the following medical problems?

Hypertension ☐ Asthma ☐ Cancer ☐ Heart Disease ☐ Allergies ☐ Migraine Headaches ☐ CHF ☐ Chronic Lung Disease ☐ Seizures ☐ Diabetes ☐ Anemia ☐ Head Injury ☐ Liver Disease ☐ Bleeding Tendency ☐ Stroke ☐ Stomach Ulcers ☐ High Cholesterol ☐ Hypothyroidism ☐ Other Medical Problems ☐:

Past Surgical History: ☐ Yes ☐ No _____

Past Hospitalization: ☐ Yes ☐ No _____

Please list all current medications including over the counter and herbal medications:

_____

_____

_____

Allergies:

_____

Family History

Family Medical History: ☐ Yes ☐ No _____

Family Psychiatric History: ☐ Yes ☐ No _____

Social History

Developmental History/Issues:

_____

Marital Status/Relationship:

_____

Education:

_____

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Occupation:

_____

Religious Affiliation:

_____

Legal Issues:

_____

Living in: _____ with _____

Patient Signature: _____

INSURANCE INFORMATION/ RESPONSIBLE PARTY INFORMATION

Primary Insurance Company: _____

Name is Insured: _____ Relationship to Patient: _____

Policy #/ Member ID: _____ Group ID #: _____

Secondary Insurance Company: _____

Name is Insured: _____Relationship to Patient: _____

Policy #/ Member ID: _____Group ID #: _____

PHARMACY INFORMATION

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR E-PRESCRIBING TO YOUR PREFERRED PHARMACY

PREFERRED PHARMACY NAME: _____

PHARMACY ADDRESS:

_____

CITY: _____ STATE: _____ ZIP: _____

PHARMACY PHONE NUMBER: _____ PHARMACY FAX NUMBER: _____

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Consent for Evaluation and Treatment

Name of Patient: _____ Date: _____

Name of Guardian (if patient is a minor): _____

I acknowledge that I am seeking psychiatric evaluation/treatment by Keturah Health Medical and Mental Health Clinic. I understand that as part of that process, I may be recommended to receive diagnostic testing, psychological testing, and psychotherapy and or medication management. I understand that I have the ability to decline the aforementioned services at any time, but this may affect my treatment process and outcome.

The following types of medications are commonly prescribed to treat psychiatric conditions:

- Antidepressants
- Antipsychotics
- Anxiolytics
- Stimulants
- Mood Stabilizers

I understand that refusal to comply with Keturah Health recommendation could result in grounds for termination of the patient-physician relationship. I also understand that I have the right to terminate my relationship at any time.

_____ _____

Patient Signature Date

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Control Substance Policy

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe to you. Please be advised that it is extremely hazardous to obtain prescription medication for controlled substances from numerous providers. Be aware that if you are prescribed a controlled substance the doctor may utilize the following resources to obtain a history of prescribed medications:

• Requesting information from our past/current treating physician,

• Requesting information from your current/previous pharmacy

• Conducting a DPS report.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is pro-longed. For this reason the following policies have become effective and are agreed to by you.

• You acknowledge and agree to notify our clinic of any new medications as well as any medical conditions and/or adverse effects you experience from any of the medications that you consume. You shall utilize the prescribed dosage for the prescribed controlled substance. You will not share, sell, trade, exchange, your prescription(s) for revenue, products, services, or in any other manner enable other individual to possess use of this (these) prescription(s). You consent to keep and/or maintain this (these) prescription(s) in a secure and safe location.

• Refills are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

• Absolutely no premature refills will be provided regardless of the circumstances (i.e. stolen, misplaced, mislaid, exceeding prescribed dosage, etcetera). If your medication has been stolen and you complete a police officer report regarding the theft, an exception may be made once.

• Prescriptions may be issued early if the provider or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they are not filled until the appropriate date.

• Please note there will be a $10.00 (ten-dollar) charge for controlled substance refills picked up at the office that are approved by the treating physician.

• Schedule II Controlled Substance prescriptions pertaining to stimulant drugs (Adderall, Ritalin, Concerta, Focalin,

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Quillivant, ProCentra, etcetera) cannot be telephoned or faxed to the clinic and MUST be filled within 21 days (twenty-one days). In circumstance where a prescription for any stimulant medication is not filled within 21 days (twenty-one days), the expired prescription must be returned before a new prescription can be reissued. Please note there will be a $20.00 (twenty-dollar) charge to rewrite expired prescriptions.

• All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.

The pharmacy that you have selected is: _____

Phone: _____.

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Tel: 469-626-8195

• Changes and/or alterations in prescriptions shall only be made during clinic visits and never via telephone and/or nonclinical hours.

• Urine drug screenings may be requested to track your consumption of prescribed controlled substances and to screen for the use of illegal substances. Refusal to consent to such testing shall subject you to a medication taper schedule and may result in the discontinuance of your prescription.

• Altering the date, quantity, and/or strength of medications or altering a prescription by any means, shape, or form is prohibited. Forging prescriptions and/or your physician's signature is prohibited and violates state and federal law. Our office fully cooperates with the local, state, and federal law enforcement agencies as well as the Drug Enforcement Agency (DEA) and Department of Public Safety (DPS) regarding infractions involving prescription medications. The patient's pharmacy, local authorities, and DEA will be notified if the treating physician believes the law has been violated in any manner by the patient. If it is determined that any of the above policies have been violated, all orders for these prescriptions will cease and the patient will be dismissed from the care of this office.

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Acknowledgement of Controlled Substance Policy

I have read and understand the policies regarding controlled substance prescriptions. I agree to the terms involved in the Controlled Substance Policy and have received a copy of this policy. I understand that if any of the above policies are violated or I choose not to adhere to these policies; I will be dismissed from the clinic and will not receive any refills from the treating physician.

_____

Patient Name (Printed)

_____ _____

Patient Signature Date