MEIER CLINICS PATIENT REGISTRATION

PATIENT INFORMATION

Name:____
(Last) (First) (Middle Initial) (Nickname)

Mailing Address:____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Home Phone:________________ Work Phone:________________Ext. #:_____ Cell:________________

Social Security #:____________________ Sex: ❒M ❒F Birth date:________________ Age:________

Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed ❒Other ________________________

Ethnicity: ❒American Indian/Alaskan Native ❒Asian ❒African/American ❒Hispanic ❒White ❒Hawaiian/Pacific Islander ❒Other____________

GUARANTOR INFORMATION
(Person who is financially responsible if different from patient above.)

Name:____ Birth date:________________
(Last) (First) (Middle Initial)

Mailing Address:____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Relationship to Patient: ❒Spouse ❒Mother ❒Father ❒Sibling ❒Other (relationship) ________________________

Home Phone:__________________ Cell Phone:__________________ Soc. Sec. #:__________________

INSURANCE INFORMATION

NOTE: Meier Clinics® ONLY files insurance if your provider is contracted with your insurance plan. Complete the following ONLY if we are filing claims for you.

Primary Insurance Co. Name:____________________________________ Phone:__________________

Subscriber's Name:____________________ Relationship to Pt: ❒Self ❒Spouse ❒Parent ❒Other__________________

Employer:______________________________________ Phone:__________________________

Birth date:____________ Member ID #:________________________ Group ID #:___________________

Secondary Insurance Co. Name:____________________________________ Phone:__________________

Subscriber's Name:____________________ Relationship to Pt: ❒Self ❒Spouse ❒Parent ❒Other__________________

Employer:______________________________________ Phone:__________________________

Birth date:____________ Member ID #:________________________ Group ID #:___________________

CONSENTS TO RELEASE INFORMATION

I hereby consent for Meier Clinics to contact my Primary Care Physician or other health care provider as noted below regarding my treatment, as deemed necessary. This consent shall remain in force during my treatment at Meier Clinics and for 90 days following my last visit unless expressly revoked by me in writing.

Physician Name: ______________________________________ Phone #: _________________________

Address: ____

- -

I hereby consent for Meier Clinics to contact the person(s) below as deemed necessary regarding the information indicated. This consent shall remain in force during my treatment at Meier Clinics and for 90 days following my last visit or after services have been paid in full unless expressly revoked by me in writing.

Name	Relationship	Daytime Phone #	Evening Phone #	OK to leave message	Financial Info.	Medical Info.	Other (Specify)
				❑	❑	❑	
				❑	❑	❑	
				❑	❑	❑	

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CONSENT FOR CONTACT VIA E-MAIL

By providing an e-mail below, I hereby consent to the following: Contact by Meier Clinics (MC) via e-mail communication at the personal address below. I am 18 years old or older, or the e-mail is that of a parent/legal guardian. E-mails may be viewed by unintended persons as e-mails are not sent by way of encryption. E-mail communication may be seen, received and/or responded to by any MC staff. E-mail is not intended for clinical purposes or as a replacement to therapy but may be used as a simple adjunct to therapy or for administrative purposes (i.e., billing, appointments, satisfaction surveys, donor opportunities, events, etc.). I release and hold harmless MC and MC staff for any claim(s) I may have, past, present and future, arising from the use of e-mail. This consent will remain in force until I provide written revocation to MC.

E-mail Address:

ACKNOWLEDGEMENTS

By signing below, I acknowledge the following:

- I have been offered the "Notice of Privacy Policies and Clients Rights."
- I have consented to treatment provided by Meier Clinics and its employees or designees (caregivers). I understand Meier Clinics serves as a training ground for mental health professionals and that I may be seen by an intern who will provide care to me under the supervision of a licensed professional. I authorize the services deemed necessary or advisable by my caregivers to address my needs.
- I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Meier Clinics. I authorize Meier Clinics to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Meier Clinics may release objective clinical information related to my diagnosis and treatment that may be requested by my insurance company (if applicable) or its designated agent.
- I authorize and request my insurance plan(if applicable) pay directly to Meier Clinics the amount due for services rendered to the patient, myself, or others covered by the above insurance plan(s). I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered. I understand this consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this consent will be null and void six months after the final payment has been received on this account. This consent is subject to state and federal confidentiality regulations.
- I agree to take full responsibility for the entire amount due for any and all services rendered. If the provider is contracted with my insurance company, I will be responsible only for the co-pay, co-insurance, deductible, and non-covered services as determined by the insurance plan. If I do not inform Meier Clinics in a timely manner of any changes to my insurance coverage, I understand that I may need to pay for services in full if payment is denied in part or in full by my insurance carrier. I further understand that I may not be able to schedule appointments if my account becomes delinquent and/or my account is turned over to collections.
- I understand that my patient records are the property of Meier Clinics and shall be treated as confidential; that Meier Clinics will conduct routine patient audits to insure quality record maintenance; that my records will not be released without my written consent or as provided by the laws of the State where I am receiving treatment. I understand that if I choose to have my records or treatment updates provided to a third party, I must request this in writing using Meier Clinics "Authorization for Use and Disclosure of Protected Health Information" form or another acceptable form, with the exception of information I have agreed to release per this Acknowledgement.
- I acknowledge that if I need to cancel or reschedule an appointment I will provide a minimum of one business day's notice. Otherwise, I understand that I am subject to the full charge for the missed appointment and am responsible for payment in full.
- I attest that I am coming strictly for counseling needs, not for any type of litigation purposes. If in the course of my care, I become involved in litigation and need Meier Clinics to provide any type of report, testimony or other litigation required services, I understand I am fully responsible for any fees for these services and that these fees are payable in full and in advance of services.
- I acknowledge that Meier Clinics is not a 24/7 care facility and that I am responsible for seeking care at my nearest emergency center or through another provider of choice when my Meier Clinics caregiver is not available.
- I certify that all the information I have provided above is true and correct.

Patient Signature: ____ Date: ____________________

Guarantor's Signature (if not patient): ______________________________ Date: ____________________

Patient/Guardian Name (please print if applicable): ____

PLEASE COMPLETE THIS SECTION ONLY IF APPLICABLE

CHILD AND ADOLESCENT CONSENT FOR TREATMENT

I certify that I am the ❒ father, ❒ mother, ❒ legal guardian and have legal custody of the above named patient. I, hereby, give my authorization and consent for the patient to receive outpatient assessment/treatment from ____.

I understand it is the policy of Meier Clinics that the parent/guardian bringing the patient for treatment is responsible for payment at the time services are rendered. I will be responsible for payment of the patient's treatment regardless of any financial arrangement for payment of the patient's medical care, either oral or written, with the patient's other parent or responsible party. I understand that Meier Clinics assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements for the patient's medical care.

Parent/Guardian Name (please print): ____

Parent/Guardian Signature: ____ Date: ____________________

PSYCHOSOCIAL ASSESSMENT

Age 16 and Above

Name: ________________________________ Acct. # ______________

Age: _____ DOB: ____________ Sex: _____ Clinician: ______________________________

DIRECTIONS: Please answer the following questions as fully as possible.

Problem Assessment

Present Problem/Stressors —*Please check all that apply:*

❑ Marital issues ❑ Health issues ❑ Job issues ❑ Financial issues
❑ Parent/child issues ❑ Issues of past (guilt, abuse, neglect, family of origin issues, etc.)
❑ Other ______________________________

Symptoms —*Please check all that apply:*

❑ Change in sleep pattern ❑ Depressed mood ❑ Mood swings
❑ Decreased energy ❑ Decreased interest or pleasure ❑ Anger problems
❑ Decreased concentration ❑ Change in appetite ❑ Thoughts of death
❑ Decreased motivation ❑ Anxiety/Worry/Panic
❑ Other ______________________________

Suicidal/Homicidal Ideation —*Please check all that apply:*

Have you attempted to commit suicide or homicide in the past? ❑ yes ❑ no
If yes, how? ______________________________

Is there a history of suicide in your nuclear and/or extended family? ❑ yes ❑ no

Have you ever inflicted burns or wounds on yourself? ❑ yes ❑ no

Are you presently suicidal or homicidal? ❑ yes ❑ no

Are there any other risk-taking behaviors that you engage in? ❑ yes ❑ no

If yes, please explain ______________________________

What event(s) in the recent past has prompted you to seek counseling? ______________________________

Describe additional problems you are experiencing. ______________________________

When did these problems develop? ______________________________

Check any recent losses you have experienced.

❑ Family ❑ Health ❑ Disruption of lifestyle ❑ Job ❑ Significant other
❑ Other ______________________________

List your strengths and weaknesses.

Strengths	Weaknesses

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If applicable, please list abilities/interests and preferences that you have.

Abilities/Interests	Preferences

Psychiatric History

Have you ever had any previous outpatient counseling? ❑ yes ❑ no If yes, please complete information below.

Place	Length of Time	Date(s)

Have you ever been admitted to the hospital for mental health or addiction issues? ❑ yes ❑ no

Place: ______________________________ Dates: ______________________________

Name of current doctor and/or therapist: ______________________________

Have you ever received a psychiatric diagnosis? ❑ yes ❑ no If yes, please explain. ______________

____

Do you feel medications you have been on, past or present, have been effective? ❑ yes ❑ no

Please explain: ______________________________

List all medications you have taken *in the past* for anxiety, depression, and/or sleep. ______________

____

Medical Information

How would you describe your current condition of health? ______________________________

Do you have any disabilities and/or disorders? ❑ yes ❑ no If yes, explain. ______________

____

Explain any special adjustments needed for the disability or disorder: ______________________

____

Are you currently on any medication? ❑ yes ❑ no If yes, please complete the information below.

Name of Medication	Dosage/Frequency	Prescribing Physician

Are you allergic to any medications or have you ever had an adverse reaction to medication? ❑ yes ❑ no

If yes, please list: ______________________________

Has it been more than a year since your last physical exam, including blood tests? ❑ yes ❑ no

Have you ever had an abortion? ❑ yes ❑ no Males: Has a child of yours ever been aborted? ❑ yes ❑ no

Do you have allergies? ❑ yes ❑ no If yes, explain. ______________________________

____

Are you pregnant? ❑ yes ❑ no

Could you become pregnant? ❑ yes ❑ no

List any prenatal care you are receiving:______________________________

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List any previous health problems, operative procedures, and medical hospitalizations.

Problem	Dates	Treatment

Use History

Describe your current usage, or usage within the past year of the following items.

Substance	Amount	Frequency	Age of 1st Use	Age regular use started	Last use
Caffeine					
Nicotine					
Marijuana					
Alcohol					
Other (please list)					

Have you experienced a recent increase in the use of alcohol and/or other substances? ❑ yes ❑ no

Do you, your family, or your friends see your current usage as a problem? ❑ yes ❑ no If yes, when did it become problematic? ____________________

Please describe any previous experience with drugs or alcohol. ____________________

Describe any significant family history of substance abuse. ____________________

____

____

Nutrition

Do you feel you have balanced, healthy eating patterns? ❑ yes ❑ no

Do you have a lot of concerns about your weight and shape? ❑ yes ❑ no

Do you often eat out of depression, boredom, anger? ❑ yes ❑ no

Do you ever binge eat or fear losing control of your eating? ❑ yes ❑ no

Do you ever self-induce vomiting? ❑ yes ❑ no

How do you feel about eating with others in a group? ____________________

Do you use laxatives, diuretics (water pills), or diet medications to control your weight? ❑ yes ❑ no

Do you or others believe you exercise excessively? ❑ yes ❑ no

Legal History — Please explain all that apply.

Charges as a minor: ____________________

Charges presently: ____________________

Arrests (How many): ____________________

Incarcerations (How many): ____________________

Parole: ____________________

Convictions (How many): ____________________

Probation: ____________________

Bankruptcy: ____________________

Civil Suits: ____________________

Child Custody Problems: ____________________

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Developmental History

List members of your family of origin and comment on how you got along with each one.

Name	Relationship	Comment

What was your birth order? I was the _____ of _____ children. Who primarily raised you? __________________

How would you describe your childhood? ❑ Traumatic ❑ Painful ❑ Uneventful ❑ Good ❑ Happy

What were you like as a child (include friends, school, hobbies, and personality)? ___________________________

____

____

____

Did you have any unusual or traumatic experiences as a child, either experienced or witnessed?

Date	Age	Event

Have you ever been the recipient of unwanted sexual acts? ❑ yes ❑ no

If yes, please explain: ____

Have you ever been the victim of abuse, neglect, or violence? ❑ yes ❑ no

If yes, please explain: ____

Have you ever been the perpetrator of abuse, neglect, or violence towards another person? ❑ yes ❑ no

If yes, please explain: ____

____

____

What is your sexual orientation? ❑ Heterosexual ❑ Homosexual ❑ Bisexual

What is your gender expression? ❑ Male ❑ Female ❑ Other ______________________

Living Arrangements

❑ Satisfactory? ❑ Unsatisfactory?

Where do you currently live? ______________________________ How long there? __________

With whom are you living? ____

Describe your current relationships with family members. _____________________________

____

____

____

____

____

____

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Social Relationships/Support System

Who can you count on for support? *Check as many as apply.*

❑Parents ❑Spouse ❑Siblings ❑Extended Family ❑Employer ❑Church ❑Pastor ❑Co-worker
❑Neighbor(s) ❑Close Friend ❑Self-help Group ❑Community Services ❑Therapist ❑Medical Doctor

List close friends, outside of family, if any. ______________________________

____

What are your hobbies or leisure activities? ______________________________

____

Marital History (if applicable)

When were you married? ____________ Name and age of spouse. ______________________

Previous marriage(s)? ❑ yes ❑ no If yes, date of divorce(s). ______________________

How many children from above marriage(s)? ______________________________

What is your perception of your current marriage (include communication patterns, problems, sexual relations).

____

____

____

List names and ages of children. How do you get along with each one?

Name	Age	Comment

Financial Situation

Describe briefly your financial situation. ______________________________

____

____

____

Religious/Cultural Factors

What is your religious background? ______________________________

Describe the religious atmosphere in your home (past or present). ______________________

____

____

____

____

Do you currently attend church, synagogue, mosque, or other religious services? ❑ yes ❑ no

What does God seem like to you? ______________________________

____

____

____

____

Describe your relationship with God. ______________________________

____

____

____

____

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What do you consider to be the role of God in your recovery? ______________________________

Please list any issues (positive or negative) which are important or may have affected you in regard to religion or ethnic/cultural background. ______________________________

Educational History

What was school like for you? ______________________________

Highest grade level achieved. __________ What type of grades did you make? ______________

Are you currently in school? ❑ yes ❑ no If yes, what grade level? ______________

How would you describe your current literacy level? ______________________________

Work Adjustment History

Describe your current job/career. ______________________________

Would you enjoy doing this job on a long-term basis? ______________________________

How do you deal with authority figures? ______________________________

Describe your relationship with co-workers. ______________________________

Describe your job performance. ______________________________

Have you ever been fired or laid-off? ❑ yes ❑ no If yes, explain. ______________________________

How many jobs have you held within the previous five years? ______________________________

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Military History

List branch, dates, and duties. ____

____

____

Family

Would it be beneficial for any member(s) of your family/legal guardian to be involved in your treatment? explain who and why. ____

____

____

____

May we contact any of the persons you have mentioned above for their input and involvement in your care?

❑ yes ❑ no If yes, Contact Information: ______________________________

What is your family/legal guardian's perception of your difficulties? ______________________

____

____

____

____

Miscellaneous

Are there any other things that would be helpful for us to know about you? ______________________

____

____

____

____

With your permission, is there anyone else that would be appropriate to contact in regard to your care?

❑ yes ❑ no Name and phone number. ______________________________

How were you referred to Meier Clinics®? ______________________________

Is there anyone that we are legally required to notify in regard to your care? ❑ yes ❑ no

If yes, please give us the necessary information to contact them. ______________________

____

Is there a need for assistive technology in your treatment? ❑ yes ❑ no If yes, what is that need? __________

____

____

What would you like to accomplish during your treatment with Meier Clinics®? ______________

____

____

____

____

____

____

Client Signature: ______________________________ Date: ______________

Read and Reviewed by ______________________________ Date: ______________

(Clinician)

Date:

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Tamella Trulson, MD
Telephone 972/437-4698 • Voice Mail Extension 109

PHYSICIAN - PATIENT AGREEMENT & TREATMENT CONSENT

GENERAL: I ask all new patients to carefully read this 4 page form prior to our first meeting. Please print two copies, one to keep for your future reference and one to bring to your first appointment, noting any questions you may have about any of its terms. After I have answered your questions, a signed copy of this agreement will become a part of your clinic record.

All Meier Clinics® doctors and counselors are Christians. Addressing any spiritual concerns you have can be an important part of your care, or if you prefer, we can focus only on the medical and psychological aspects of your treatment. I do not supervise the work of any of the clinic counselors, but all chart documentation is accessible to me and to your Meier Clinic counselor, and we will communicate with each other as needed. If you are seeing an independent counselor, I will need a release of information so that we can work together for your benefit. Please direct all phone calls to your counselor except as your questions relate to medication issues.

In accordance with Meier Clinics policy, I am not involved in worker s compensation cases, disability evaluations, child custody, or other legal matters. Therefore, you will be referred to another psychiatrist if the need for testimony and/or reports arises.

APPOINTMENTS AND FEES: After your first visit, I will need to see you within 1-4 weeks to review your progress. Thereafter, follow-up appointment frequency will be individualized. Office visits are required for my ongoing assessment of your clinical status and treatment needs. I ask that you make every effort to arrange for childcare during appointments. Cell phones should be turned off or adjusted to silent mode prior to appointments to prevent interruptions. My office hours are on Tuesdays, Thursdays, and Saturdays.

Follow-up appointments are 20 minutes in length and cost $100 for private pay patients and for those for whom I am not an in-network insurance provider. In-network copays/co-insurance vary, so confirm this with your insurance company in advance. It is your responsibility to make alternate payment arrangements with me in advance if you are unable to pay the full fee or your in-network copay/co- insurance at the time of each appointment.

Please be careful to keep track of all your appointments. The clinic generally provides courtesy reminder calls, but do not depend upon receiving such a call. In accordance with clinic policy, you will be charged $25 for appointments cancelled without 24 hours notice and $50 for missed appointments. These fees apply whether you have or have not received an appointment reminder call. You will be fully responsible for these fees, as insurance companies will not pay them. To make, change, or cancel an appointment, call the clinic and dial 0 during regular business hours. The clinic does not have a receptionist on Saturdays; so to cancel a Saturday appointment after 5pm the day before, leave a message on my voicemail. I appreciate as much notice of appointment changes as possible, as I do not schedule more than one person per appointment time. Multiple missed appointments may result in the need to terminate our doctor- patient relationship. To be fair to patients who arrive on time, I may not be able to meet with you if you are late for your appointment.

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***PHONE CALLS & EMERGENCIES*:**

If needs arise that cannot wait until your next appointment, leave a detailed message on my voice mail. I retrieve messages at 2pm on Tuesdays through Saturdays. Messages left after 2pm on Saturdays will be responded to on the following Tuesday.

If you do not get a response in a timely manner, I have not received your message, so please call again. If another doctor is on call for me, my voice mail will tell you how to contact him or her. You will be charged $31-93 for the time required if frequent phone calls and/or calls of greater than 5 minutes duration are necessary between appointments. Insurance companies do not pay for phone consultations, so these fees will be your responsibility.

If you need to speak with me emergently, you can reach me during business hours by asking the clinic staff to page me, or by calling the answering service at 972-216-6102 after business hours. Emergency pages are to be restricted to needs that cannot wait until the next business day. If you do not get a call back from me in a timely manner; if you cannot wait up to an hour for me to respond; or if you are in danger of harming yourself, harming someone else, or being harmed by someone, go to the nearest hospital emergency room or call 911.

Successful treatment requires that you attend all scheduled sessions and express your ideas and emotions honestly and openly using verbal communication only. Threats or acts of physical harm to me, others, or clinic property will result in immediate termination of treatment and notification of the proper authorities.

It is important that I always have your current address, home and cell phone numbers. I also need you to designate an emergency contact person:

Name: ____

Phone:____(cell phone preferable)

Relationship to you: ____

***MEDICATION TREATMENT**:* In order to provide the best quality care, treatment is not conducted over the phone. Medication changes and dosage adjustments require an office visit. I will always prescribe enough medication to last until you are to come for a follow-up appointment. If for any reason you run out of medicine, do not have your pharmacy call for a refill. Rather, leave me a message with your name and phone number, your pharmacy phone number, needed medication and current dosage, and the date of your next appointment. Refill requests are processed only on Tuesday, Thursday and Saturday mornings. A $20 fee will be charged for refill calls to your pharmacy, so please make every effort to schedule appointments before you will run out of medicine. Insurance companies do not pay refill fees, so this cost will be your responsibility. Lost or stolen prescriptions for a controlled medication cannot be replaced or refilled early.

CONFIDENTIALITY: Doctor-patient confidentiality is limited under the following circumstances:

1. Insurance companies require dates of service and diagnosis code information to pay for services rendered, and they frequently request additional patient information to satisfy their prior authorization requirements for services and for certain medications to which they limit access.

2. If a legal action is filed in which your mental health is at issue and I am asked or ordered to testify.

3. If I become aware of abuse or neglect of a child, elder, or disabled person, I am obligated to report it to the appropriate authorities.

4. If I determine you are an imminent danger to yourself or others, I must contact a family member and/or the police in an effort to provide for your/others safety.

5. I cannot respond to any phone calls or correspondence from family members or friends unless I have a signed consent from you.

MEDICAL CARE: I advise all patients to have a complete physical examination with appropriate laboratory tests to rule out medical causes and/or contributors to psychological symptoms. Provide me with a copy of the results from your doctor to ensure coordination of care. If you do not follow this recommendation, you accept the liability for any disability or deterioration in physical or mental health incurred as a result. In order to provide appropriate treatment, I must be the only physician prescribing your psychiatric medications, including sleep aids. I may request a release of information to communicate with your other doctor(s) to optimize your care.

MEDICATION USE PRECAUTIONS: I may recommend psychiatric medication for you in an effort to improve your mental health. You always have the option of deciding not to take or continue prescribed medications, but it is always prudent to talk with the prescriber before discontinuing medication to ensure a medication is stopped in a safe manner.

All medications have the potential to cause good effects and side effects, some of which can be very serious, therefore, regular follow-up and monitoring is necessary. Always read all of the medication precaution information you receive from your pharmacy and contact me with any questions or concerns. Any medication can impair thinking or reaction time until your body gets accustomed to it. Therefore, do not operate hazardous machinery, including automobiles, or do anything potentially dangerous until you are certain any newly prescribed medication(s) does not affect your abilities.

Notify me and all your other doctors of any and all changes in prescribed and over-the-counter medicines or supplements. Keep in mind that herbal or natural does not always mean safe or good. Some over-the-counter products and prescription medications should not be taken with mental health medications due to the possibility of dangerous interactions. Two examples are St. John s Wort, which is dangerous to take along with antidepressant medication, and Kava, which has been associated with liver failure. For your safety, it is your responsibility to tell me about any a n d a l l prescription or over-the-counter substances you are considering adding to the medications I prescribe for you. I advise you to never obtain medication from a Canadian pharmacy, other foreign supplier, or via the internet. Even though the pills and packaging may look identical to medication obtained from within the USA, the Food and Drug Administration has discovered these pills are often counterfeit and potentially dangerous.

It is important to make sure the medication you receive from your local or mail order pharmacy is the correct type and dosage. Therefore, when you fill a prescription for the first time, and any time the appearance of a refilled prescription is different from what you have received in the past, you should verify it. You can do this by going to the pill identifier page on www.webmd.com or www.drugs.com. Your pills could look different than they have in the past because your pharmacy has changed generic medication suppliers, or because a mistake has been made in filling your prescription. If you have any concerns about the authenticity of your medication, please contact me and your pharmacist.

Store all medications at room temperature and away from heat and light. Contact me if you experience any unanticipated medication effects including a skin rash as that indicates a medication allergy. I advise you not to consume alcohol, including beer, or take illicit drugs while taking medication as this will prevent optimal benefit and the combination can be physically dangerous.

If you or someone else takes more than the recommended dose of a medicine, contact poison control, call 911, or go to an emergency room. Do not allow others to take your medicine and do not take medications prescribed for someone else. Keep all medications out of the reach of children and impaired adults. If you miss a dose, do not take two doses at the same time; instead resume your regular medication schedule. I recommend the use of a weekly pillbox to avoid accidentally taking more or less than prescribed.

For your safety, if I prescribe a medication that has any known potential for abuse or dependence, I may at my discretion check the State of Texas internet registry of all controlled substance prescriptions filled for you to document you are not receiving medications with abuse potential from other doctors without my knowledge.

WOMEN: Notify me of any intent to become pregnant as some medications should be discontinued prior to conception. Waiting to stop medication until you discover you are pregnant exposes your baby to medication during the critical first few weeks of organ development and can lead to birth defects. Whenever possible, psychiatric medications should not be used at any time during pregnancy or while breastfeeding. Contact me within 24 hours if you discover you have become pregnant while taking medication. The effectiveness of birth control pills can be altered by certain medications, so be sure to discuss with me any intent to start, stop, or change birth control

REFERRALS: I do not provide inpatient or day hospital care. If at any time you should need that form of treatment, you would be transferred to the care of another psychiatrist for the duration of your hospital stay, and I may not be able to resume your care upon discharge. As your treating psychiatrist, it is my duty to seek your best interest; therefore, I cannot also serve as a consultant or witness in any legal matters. I will refer you to another psychiatrist for an objective evaluation if at any time legal reports or testimony is needed. If there is some aspect of your care we are unable to agree upon, I will need to refer you to another psychiatrist to continue your care. Please do not refer any of your family members or friends to me without discussing this directly with me in advance.

AGREEMENT: Your signature below indicates that you have carefully read, understand, and accept all the terms of this treatment consent and agreement. You are hereby giving your consent for appropriate medical treatment by Dr. Trulson following ongoing discussions of the risks and benefits of all prescribe medications and other treatments. Keep a copy of this agreement for future reference. *This agreement is in addition to the general Meier Clinics Patient Information and Consent to Treatment which is signed by all new clients.*

____
Print your name

____ ________________
Signature Date

MEIER CLINICS

One of the most trusted names in Christian Counseling

Name ______________________________ Date _________________________ ID # _______________

P S Y C H I A T R I C   M E D I C I N E S

Anti-Depressants	Mood Stabilizers	Anti-Anxiety	Major Tranquilizers	ADHD	Sleep	Pain
Anafranil	Carbatrol	Ativan (Lorazepam)	Abilify	Adderall	Ambien	Amerge
Aplenzin	Celontin	Buspar	Clozaril	Clonidine	Ambien CR	Anaprox
Brintellix	Depakote	Klonopin (Clonazepam)	Fanapt	Concerta	Dalmane	Axert
Celexa	Dilantin	Librium	Geodon	Cylert	Doxepin	Butalbital
Cymbalta	Felbatol	Moban	Haldol	Daytrana	Lunesta	Codeine
Desyrel	Gabitril	Neurontin	Invega	Dexadrine	Restoril	Darvocet
Effexor	Keppra	Restoril	Latuda	Focalin	Rozerem	Esgic
Elavil	Lamictal	Serax	Loxitane	Intuniv	Silenor	Fiorcet
Emsam	Lithium	Tranxene	Mellaril	Metadate	Sonata	Frova
Fetzima	Lyrica	Valium (Diazepam)	Navane	Methylin	Trazadone	Hydrocodone
Lexapro	Myosline	Vistaril	Prolixin	Nuvigil		Imitrex
Luvox	Phenobarbital	Xanax	Risperdal	Provigil		Lorcet
Nardil	Tegretol		Saphris	Ritalin		Lortab
Norpramin	Topamax		Seroquel	Strattera		Midrin
Pamelor	Trileptal		Stelazine	Tenex		Norco
Parnate	Zarontin		Thorazine	Vyvanse		Percocet
Paxil	Zonegran		Trilafon			Phrenilin
Pristiq			Zyprexa			Stadol
Prozac						Ultracet
Remeron				**ALCOHOL/DRUG CRAVINGS**		Ultram
Serzone						Vicodin
Sinequan				Campral		Zomig
Viibyrd				Naltrexone		Zydone
Vivacti		**PSUEDOBULBAR AFFECT(PBA)**		Neurontin		
Wellbutrin		Nuedexta		Suboxone		
Zoloft						

Place a check mark next to any medications you think you may have taken in the past even if it was for a very short time. Then, off to the side please write a one to two word description or phrase describing your experience with the medicine (e.g. “good” “bad” “great” “made me dizzy” “made me sleepy” etc.). Knowing how you responded on certain medication in the past will help us in your treatment.

MEDICATIONS: *Please list medications you are currently taking (psychiatric or other)*

____

____

List any Medications you are allergic to:

____

Name: ________________________________ Date: __________________
Age: ________ Marital Status: ___________ Employment Status: _____________________
Date Symptoms Began: _________________ Date Symptoms Worsened: ________________
What is your goal for seeking Counseling at this time in your life? ________________________
____
____

SYMPTOM CHECKLIST

☐ Depressed or Sad Mood
☐ Irritability/Short tempered
☐ Lack of Motivation/Drive
☐ Poor Concentration
☐ Can't sleep well
☐ Appetite/weight changes
☐ Loss of pleasure in activities
☐ Diminished self-esteem
☐ Hopeless/Helpless
☐ Decreased Energy/fatigue
☐ Excessive guilt or worry
☐ Crying Spells
☐ Decreased sex drive
☐ Intense fear of being fat

☐ Spending sprees
☐ Special Abilities
☐ Increased self-esteem
☐ Decreased need for sleep
☐ Lots of great ideas to get out
☐ Racing thoughts/can't keep up
☐ Increased energy/hyperactive
☐ Increased Sex Drive
☐ Making lots of plans/schemes
☐ Rapid speech
☐ Nonstop talking/can't interrupt
☐ Day-to-Day mood swings

☐ Suspiciousness/Paranoia
☐ Hallucinations (see/hear things)
☐ Unusual facial expressions
☐ Strange posture/gestures
☐ Disorganized thoughts
☐ Confusion
☐ Bizarre Behaviors
☐ Unusual or unwanted thoughts
☐ Constantly washes hands

☐ Anxiety about everything
☐ Intense episodes of fear
☐ Fear of Going crazy/losing control
☐ Chills/Hot flashes
☐ Abdominal distress/nausea
☐ Chest discomfort/choking
☐ Dizziness
☐ Numbness/tingling
☐ Feeling jumpy/on edge/easily startled
☐ Constantly Alert/Vigilant
☐ Nightmares/reliving trauma
☐ Avoiding of stressors/stimulus
☐ Heart racing/palpitations
☐ Sweating
☐ Trembling
☐ Shortness of Breath
☐ "Lump in Throat"/can't swallow
☐ Intense anxiety, fear, or panic
☐ Unable to leave home

☐ Counts things constantly
☐ Impaired intellect/thinking
☐ Language/speech difficulties
☐ Impulsive/poor judgment
☐ Unusual sleep pattern
☐ Disorganized/Confused
☐ Poor Memory

SUBSTANCE ABUSE
☐ Amphetamines/Stimulants
☐ Cocaine/Crack
☐ Marijuana/Cannabis
☐ Alcohol
☐ Sedative/Hypnotics
☐ Opiates/Narcotic pain pills/Heroin

Suicidal thoughts? ☐ Yes ☐ No
☐ passing thoughts/no intent
☐ persistent thoughts
☐ current plans/definite intent
☐ recent attempt
☐ past attempts

☐ Pulling hair out
☐ Anger/Emotional outburst
☐ Binge Eating/Purging
☐ Uncontrolled Gambling
☐ Stealing or Lying
☐ Ritualized behaviors/obsessions

☐ Attention/concentration issues
☐ Impulsive/can't wait turn
☐ Hyperactive/restless
☐ Can't perform at work/school
☐ Aggressive/Assaultive
☐ Self-mutilation/Self-harm
☐ Sleeping all the time
☐ Staring spells
☐ Chronic Pain
☐ Self induced vomiting
☐ Constant agitation
☐ Intense fear of rejection
☐ Legal Troubles
☐ Unexplained body complaints

Personal Past Psychiatric History: ☐ Counseling ☐ Psychiatrist ☐ Hospitalization ☐ Suicidal Attempts

Past or Current Medical Issues (thyroid/high blood pressure/etc): ___________________________
____

Please List your top 3 symptoms: ________________ ________________ ________________

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