Psychiatric History Record Page 1.

Date:_____

Name: _____DOB: _____

Address: _____ City: _____Zip:_____

Home Phone: _____ Business Phone: _____

Family Physician: _____ Referred By: _____

Employed Where: _____ How Long: ____ Job Title:_____

Marital Status: _____ SS#_____ DL# _____

Name of Spouse: _____ DOB: _____

Spouse Employment: _____ How Long:____ Job Title:_____

List Any Medicine You Take Regularly: _____

_____

List What You Consider Your Main Problem: _____

_____

_____

_____

_____

_____

Medical History

Height: _____ Weight_____ Any Weight Change In Past Year? _____

Allergic To Any Medications? _____

List any Current Medical Problems of Yours or Your Spouse_____

List All Hospitalizations In Past 10 Years For You, Spouse Or Children:

Year, Where, Reason and Doctor: _____

_____

Any Other Surgery or Major Illness or Injury in Your Past History? _____

_____

_____

Any Previous Counseling or Psychiatric Treatment for You or Your Spouse List When and Where

_____

_____

List Any Tranquilizers, Antidepressants or Nerve Medicines You Have Taken On a Regular Basis in the Past._____

_____

Have You Had any Bad Reaction To Any Of these Medicines? _____

_____

Have You Ever Taken Any Psychological Test Before? _____ Where? _____

_____

List Any Physicians Who Have Diagnosed or Treated You in Past 12 Months._____

_____

Date of Last Physical Exam._____

Have You Had any Unexplained Medical Symptoms?

_____

Alcohol and Drug History

At What Age Did You Take First Drink/First Use Drugs? _____

Do You Think You Have Any Alcohol Or Drug Problems? _____ Does Your Family Think So? _____

How Did You Fist Get Started With Drinking/Drugs regularly? (With Friends, Family, Alone, Other)

Do You Drink Do Drugs Regularly, How Many Years? _____

What Blood Relatives Have Suffered From Alcohol and/or Drug Problems? _____

_____

Do You Have Any Current Legal Problems/ Charges Pending As a Result Of Alcohol Or Drugs?

_____

Name _____ D.O.B. _____ Page 3.

Family History

	Age now	Health Now	Lives Where	Living or Deceased	Cause Of Death
Father					
Mother					
Brothers and sisters					
1					
2					
3					
4					

Do you have any blood relatives who have suffered from depression? _____

_____

Have had any emotional problems or mental problems? _____

_____

Been hospitalized from emotional or mental problems? _____

_____

Has had heart disease, cancer or diabetes? _____

Have there been any suicides in our family? _____

How did your parents get along when you grew up? _____

Briefly describe your father's personality during your childhood._____

Briefly describe your mother's personality during your childhood._____

Where you aware of any physical or sexual abuse in your family during your childhood? _____

_____

Military History

Which branch of service? _____ Date entered? _____

Date of discharge: _____ Highest Grade Held: _____

Type of discharge: _____

Past History

Birthplace and date of birth: _____

Age of parents when you were born: Father _____ Mother _____

Occupation of your parents during your childhood:

Father: _____ Mother: _____

List all cities lived in before age 18, include years:

_____

_____

_____

Did you live away from your parents any time during your childhood? _____

Explain: _____

_____

During you childhood:

Did you have any serious illnesses? _____

Was there any serious illnesses or death of parents or siblings? _____

Did you parents separate or divorce? _____

Do your parents live together now? _____ Separated or divorced,

List date: _____If remarried when: _____

Did you ever had to drop out of school or repeat a school year? _____

What school activities did you take part in during high school? _____

_____

Went to high school where? _____ Year graduated _____

College attendance: (Where, when, and what degree?)_____

_____

_____

Do you smoke? _____How much? _____How long have you smoked? _____

Do you attend church regularly? _____Which church? _____

Any past legal problems? _____ If so why? _____

Ever been in jail? _____ If so why? _____

How many arrest? _____DWI's _____ License suspended _____

What is the pattern for your drinking now? (With friends, family, alone, other)_____

_____

_____

Has your drinking or drug use increased/decreased recently? _____

How? _____

Do you have blackouts? _____Do you miss work from drinking/drugs?

_____

Have you ever been in an alcohol or drug rehab program _____

When? _____ Where? _____

Have you been violent when drinking/doing drugs? _____

How much do you estimate you spend a week on alcohol/drugs? _____

Have you ever gone to AA/NA Meetings? _____ When? _____

Have you ever felt you ought to cut down? _____

Have people annoyed you by criticizing your drinking/drugs? _____

Have you ever felt bad or guilty about you drinking/drugs? _____

Have you ever had a drink/drug first thing in the morning to steady nerves or stop a hangover? _____

R.O.S.S.-(CIRCLE ANY PROBLEMS YOU HAVE)

Heent-Headache, Dizzy Spells, Passing Out, Hearing, Vision)

CR-Shortness of Breath, Chest Pains, Coughing Blood, Ankle/Leg Swelling.

GI- Constant Indigestion, Black Stool, Vomiting Blood, Nausea.

GU- Burning With Urination, Blood in Urine, Hard To Stop/Start Urine.

NM- Weakness Of Arm Or Legs, Fainting Spells, Balance Problems, Twitching Muscles.

Marriage Name _____ D.O.B. _____ Page 6.

Year you were married? _____ Your age then? _____ Spouse's age then? _____

Years children were born: _____

If marriage ended, when? _____ Year you remarried? _____

Years children were born: _____

Your age then? _____ Spouse's age then? _____ If marriage ended, when? _____

Children and or stepchildren:

Name	Age	Health	Lives where
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

If any children deceased, cause of death _____ Year _____ Age _____

Any children with serious health problems now or in the past? _____

_____

Any separation during current marriage: _____

Employment

Employment changes in the last 5 years:

Employer	Type of work	Year changed	Reason

Employment of spouse in past 5 years:

_____

_____

List all cities lived in past 5 years: _____

_____

_____

Any other information you feel the Doctor should know?

_____

_____

_____

_____

_____

_____

_____

_____

Person completing the form: _____

Relationship to patient: _____ Date _____

Physician Reviewed: _____Date _____

Patient Name: _____

Address: _____

_____

DOB: _____

Emergency Contact/Relationship to Patient/Phone:

_____

_____

_____

As a courtesy to you, we may attempt to call you prior to your appointment as a reminder. However, it is your responsibility to keep up with your scheduled appointments.

Please list below what phone numbers that we may call to confirm your appointment time:

Home: _____

Work: _____

Cell: _____

Other: _____

Thank you for your assistance.

_____ _____

Signature Date

_____ _____

Witness Date

NAME: _____ DOB: _____

DATE _____

ADDITIONAL MEDICAL HISTORY:

HEIGHT _____

WEIGHT _____

ANY WEIGHT CHANGES IN PAST YEAR? Y / N

HOW MUCH? _____

Do you have a medical history of the following:

Diabetes	Y / N
Elevated blood sugar	Y / N
Elevated cholesterol	Y / N
Heart disease	Y / N
High blood pressure	Y / N
Stroke	Y / N
Obesity	Y / N

Does any family member (blood relative) have a history of the following:

Diabetes	Y / N
Elevated blood sugar	Y / N
Elevated cholesterol	Y / N
Heart disease	Y / N
High blood pressure	Y / N
Stroke	Y / N
Obesity	Y / N

PHYSICIANS USE ONLY

Diabetes Risk Factor

- BMI greater than 25
- 1st degree relative with diabetes mellitus
- Habitual physical inactivity
- Being a member of a high-risk ethnic population (e.g., African American Hispanic American, Native American, Asian American, Pacific Islander)
- Having delivered a baby heavier than 9 lbs or having had gestational diabetes
- Hypertension
- A high-density lipoprotei8n cholesterol level less than 35mg/dl and /or a Triglyceride level greater than 250 mg.dl
- History of abnormal findings on the Glucose Tolerance test or an abnormal Fasting Blood glucose
- History of vascular disease

PATIENT AUTHORIZATION

Patient Name_____**Date of Birth**_____

Please initial all applicable boxes. If a category does not apply to you, please write "N/A." Definitions. "I,", "me," and "my" means the patient named above. I am signing this agreement to obtain services.

COMMUNICATION RELATING TO DIAGNOSIS AND TREATMENT THROUGH USE OF E-MAIL

_____ Due to the nature of e-mail, third parties may have access to messages. When communicating from work, you should be aware that some companies consider e-mail corporate property and your messages may be monitored. I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control regarding e-mail messages.

FINANCIAL RESPONSBILITY

_____ I agree that I am ultimately responsible for payment for services rendered by Joseph P. Arisco, M.D. I will honor Dr. Arisco's payment policy.

AUTHORIZATION FOR CARE

_____ I grant permission for Joseph P. Arisco, M.D., to render care such that he deems necessary in my diagnosis and treatment.

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ I hereby authorize Joseph P. Arisco, M.D., to release necessary information to other physicians for continuing professional care or otherwise as allowed by law. I release Joseph P. Arisco, M.D., from any liability from the release of this information, and I understand this release specifically includes any and all blood and related tests, including HIV, HIB and other diseases. This authorization is irrevocable and is not limited in time.

HIPAA NOTICE OF PRIVACY PRACTICES

_____ I understand that my initials on this form indicate that I have received or have been offered the full Notice of Privacy Practices.

_____	_____	_____
Signature of Patient or Representative	Relationship to Patient	Date
_____		_____
Witness		Date

Joseph P. Arisco, M.D., D.F.A.P.A.
Psychiatrist
10760 FM 2813, Suite 500
Flint, Texas 75762

NPI: 1902876378

PRIVATE CONTRACT

RE: _____

I, Joseph P. Arisco, M.D., as your provider have opted out of the Medicare program. You, as the beneficiary or your legal representative, accept full responsibility for payment of my physician charges for services provided to you by me. Medicare limits do not apply to any items or services furnished to you by me.

You agree not to submit a claim to Medicare or to ask me to submit a claim to Medicare. Medicare will not pay for any items or services provided by me that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

You enter into this contract with the knowledge that you have the right to obtain Medicare covered items or services from physicians or practitioners who have not opted out of Medicare, and that you are not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.

The effective date of the opt-out period is 7-1-18 and expires 6-30-22.

You understand that Medigap plans do not and that other supplemental plans may elect not to make payments for items or services for which Medicare does not pay.

_____ _____
Beneficiary/Legal Representative Date

_____ _____
Joseph P. Arisco, M.D. Date

_____ _____
Witness Date

FINANCIAL POLICY

Name_____**Date of Birth**_____

I am committed to providing you with the best possible care.

I do not accept any insurance. All visits are on a cash basis only and payment is due prior your scheduled appointment. I do accept cash, check, American Express, Discover, Mastercard, and Visa.

I do not accept any third party insurance, letters of protection from attorneys or Workers Compensation.

There will be a $30.00 charge for all returned checks. I do not accept post-dated checks.

I HAVE READ AND COMPLETELY UNDERSTAND THE FINANCIAL POLICY.

_____ _____

Signature of Patient and/or Responsible Party Date

Patient Consent for Use of Email Communications

Name_____ **Date of Birth**_____

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at info@josepharisco.com . Please remember: this form of communication in not appropriate for us in an emergency. The turnaround time for routine communication is 24 hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

Please put the subject of your message in the subject line so we can process it more efficiently. Be sure to put your name, message, and return telephone # in the body of text. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications related to diagnosis, questions, and/or treatment will be filed in your medical records.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of emails, third parties may have access to such messages. When communicating from work, you should be aware that some companies consider email "corporate property" and your messages may be monitored. Even when emailing from home, you may feel that access to your email in not controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff may have access to this information.

I understand that this office will not be responsible for information, loss, delay, or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

_____ _____

Patient Signature **Witness**

_____ _____

Date **Date**

Email

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

SUMMARY:

This information is a summary of the most important aspects of how Joseph P. Arisco, M.D., will be using your personal health information. We call this information "PROTECTED HEALTH INFORMATION" or "PHI." This notice describes the types of uses and disclosures that we make with your PHI.

A. You have several rights regarding your PHI. You may:

*Request restriction on uses and disclosures of your PHI.
*Request that we use different methods to communicate with you.
*View and have copies made of your PHI.
*Request amendments of your PHI.
*Obtain a listing of disclosures we have made.
*Obtain a copy of this notice.

B. You may file a complaint about our privacy practices.

C. We may use and disclose your PHI without authorization from you in the following circumstances:

*To provide health care treatment to you.
*To obtain payment for services.
*For health care operations.
*For other required circumstances.

D. You can object to certain uses and disclosures.

E. We may contact you in certain circumstances such as:

*To provide appointment reminders.
*To provide information about treatment, services, products or health care providers.
*For fundraising activities.

FOR MORE DETAILED INFORMATION, PLEASE ASK FOR A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM THE RECEPTIONIST.