FREMOUW-SIGLEY
PSYCHOLOGICAL ASSOCIATES, PLLC
Independent Licensed Psychologists
1224 B Pineview Drive Telephone: (304) 598-2300 Morgantown, WV 26505 Fax: (304) 598-2307

New Patient Packet for One-Time Assessment (Testing)

Please ensure that you have read through the material contained on the website http://fspsych.com before you proceed.

After you have read the information on the website, please call me, if you have not already at (304) 598-2300 to schedule a brief phone interview. This will allow me to assess whether or not I would be an acceptable provider of assessment services for you. If so, I will:

1. Schedule the assessment session with you, and;

2. Ask that you print out and complete all the forms in this New Patient Packet to bring with you to the assessment session. (If you cannot print them out, we will arrange for you to come to the session 60 minutes early to complete them in the waiting room)

If I do not determine that there is a good match between your assessment needs and my services, I will suggest other providers in the area who may better serve you.

There are many forms in this packet and it may seem like quite a lot to complete. These forms are designed to give me the most information possible at the very beginning so I can better serve you. Your time spent providing this information will allow us to spend more time in our session completing your assessment. Providing this information and bringing it all with you to the session helps me focus on you during that session.

Thank you,

T. Anne Hawkins, PhD

Assessment Registration Sheet

Date: ______________Patient Name: ______________________________________

Date of Birth: ____ /____ /______ Age: _____ SSN: _______-_____-_______

Gender: [ ] Male [ ] Female Last School Grade Completed: ____________

How do you prefer to be addressed (Name/Nickname)?
____

Address:
____

City: _________________________________ State: ___________ Zip: __________

Home Phone: (___) ____-______ can a message be left: ___yes___no

Work Phone: (___) ____-______ Ext.: ___ can a message be left: ___yes___no

Cell Phone: (___) ____-______ can a message be left: ___yes___no

E-mail Address: ____________________ can a message be sent: ___yes___no

How do you prefer to be contacted? ____________________________________

Occupation: ___________________________ Employer: _____________________

Relationship Status:
- □ Single
- □ Married
- □ Partnered
- □ Separated
- □ Divorced
- □ Widowed

In Case of Emergency, Contact:
Name: _____________________ Relationship: _____________________________

Phone: ________________________________

Medical/Mental Health History Self Report

Patient's Name: ______________________________________ Date of Birth: ______________________

Allergies to Food, Medication, Other: ____

Current Family Physician: __________________________ Date of Last Physical Exam: ______________

Physician who referred you: ________________________ Date of Last Physical Exam: ______________

Height: ________________ Weight: _____________ Disabilities: ________________________________

Do you currently or have you previously experienced problems with any of the following?

	Currently	**Previously**
Skin problems	□Yes □ No	□Yes □ No
Eating	□Yes □ No	□Yes □ No
Wounds not healing/easy bruising	□Yes □ No	□Yes □ No
Alcohol	□Yes □ No	□Yes □ No
Glaucoma/Vision	□Yes □ No	□Yes □ No
Street drugs	□Yes □ No	□Yes □ No
Gum(s)/Teeth	□Yes □ No	□Yes □ No
High blood pressure	□Yes □ No	□Yes □ No
Hearing	□Yes □ No	□Yes □ No
Heart disease/Chest pain	□Yes □ No	□Yes □ No
Headaches	□Yes □ No	□Yes □ No
Rheumatic fever	□Yes □ No	□Yes □ No
Head injuries	□Yes □ No	□Yes □ No
Nausea/Vomiting	□Yes □ No	□Yes □ No
Black outs/Fainting	□Yes □ No	□Yes □ No
Ulcers	□Yes □ No	□Yes □ No
Numbness/Tingling	□Yes □ No	□Yes □ No
Liver disease or jaundice	□Yes □ No	□Yes □ No
Thyroid problems	□Yes □ No	□Yes □ No
Kidney/Bladder problems	□Yes □ No	□Yes □ No
Blood sugar	□Yes □ No	□Yes □ No
Pregnancy (if pregnant, due date ____/_____/____)	□Yes □ No	□Yes □ No
Sickle cell	□Yes □ No	□Yes □ No
Sexual function	□Yes □ No	□Yes □ No
HIV/AIDS	□Yes □ No	□Yes □ No
Difficulty walking/standing	□Yes □ No	□Yes □ No
Fatigue	□Yes □ No	□Yes □ No
Pain	□Yes □ No	□Yes □ No
Anemia/Low blood count	□Yes □ No	□Yes □ No
Sleeping too much	□Yes □ No	□Yes □ No
Breathing/shortness of breath	□Yes □ No	□Yes □ No
Sleeping too little	□Yes □ No	□Yes □ No
Sleeping too much	□Yes □ No	□Yes □ No
Fever	□Yes □ No	□Yes □ No
Lead/Chemical exposure	□Yes □ No	□Yes □ No
Gallstones	□Yes □ No	□Yes □ No
Seizures	□Yes □ No	□Yes □ No
Cancer	□Yes □ No	□Yes □ No
Change in weight	□Gain □ Loss	□Gain □ Loss
If change in weight: _______ lbs. In _______time		

Please describe:

____

____

____

Have any family members had any of the following?

Depression □Yes □ No Who: ____________________________________
Bipolar Disorder □Yes □ No Who: ____________________________________
Suicide or Suicide Attempt □Yes □ No Who: ____________________________________
Schizophrenia □Yes □ No Who: ____________________________________
Eating Disorder □Yes □ No Who: ____________________________________
Anxiety Disorder □Yes □ No Who: ____________________________________
Alcohol/Drug Problems □Yes □ No Who: ____________________________________
ADHD □Yes □ No Who: ____________________________________
Psychiatric Hospitalization □Yes □ No Who: ____________________________________
Learning Problems □Yes □ No Who: ____________________________________
Thyroid Problems □Yes □ No Who: ____________________________________
Asthma □Yes □ No Who: ____________________________________
Diabetes □Yes □ No Who: ____________________________________
Stroke □Yes □ No Who: ____________________________________
Dementia/Senility □Yes □ No Who: ____________________________________
Stomach Problems □Yes □ No Who: ____________________________________
Seizures (what kind) □Yes □ No What kind:________________________________
Heart Problems □Yes □ No Who: ____________________________________
Cancer (what kind) □Yes □ No What kind:________________________________
High blood pressure □Yes □ No Who: ____________________________________
Sudden cardiac death □Yes □ No Who: ____________________________________
Tics □Yes □ No Who: ____________________________________

Have you been hospitalized **for any medical reasons** such as illness, accidents, operations, or tests?

Reason for Hospitalization:	Date:	For How Long:

Continue on back of this sheet, if needed.

Please list any outpatient/same day surgeries which you have had:

Procedure/surgery	Date:	Outcome

Current Medications (including any *over the counter* or *herbal preparations*):

Name of Medication	**Dosage**	For what reason?	**For how long?**	Side effects(if any)

Continue on back of this sheet, if needed.

If you have pain related problems, please list the treatments you have attempted to manage your pain (i.e. physical therapy, medication, exercise, yoga, surgery, biofeedback etc):

Treatment:	Provider name (if relevant):	Approximate dates:	Describe outcome:

If you are requesting an evaluation for Bariatric Surgery, Please describe strategies you have utilized to manage your weight: ____

____
____
____
____
____
____
____
____
____

Please describe the Mental Health Care you have received: (such as psychiatrist, psychologist, social worker, nurse, counselor, or psychological testing)

By Whom?	**Dates**	**Diagnosis/Problem treated**	**Type of treatment****	Were you hospitalized?

Continue on back of this sheet, if needed.

*** Counseling, medication, IOP, Day Hospital, Biofeedback

Are you:
Currently using caffeine?
□ Yes
□ No
If yes, how much, how often__________________

Currently using cigarettes or other nicotine containing products?
□ Yes
□ No
If yes, how much, how often__________________ If no, past use? ___________

Currently using alcohol?
□ Yes
□ No

If yes, how much, how many alcoholic drinks in an average week? _______

Have you ever been arrested/charged with an alcohol related offense?
□ Yes
□ No
If yes, when _____________

Currently using any medication/drug that has not been prescribed for you or that you are using in a way other than its prescribed use:
□ Yes
□ No

If yes, please describe what you are using and include the frequency, amount and last use

Drug/Dosage	Frequency	Amount	Last Use

How often do you have the following problems?

Problem	Never	Rarely	Frequently	Always
Talking, thinking, and more active than normal; Can’t be still or quiet				
Talking, thinking, and less active than normal; Can’t do things				
Loss of interest in activities				
Feeling sad or depressed; Feeling like crying				
Wishing I was dead				
Planning ways to kill myself or attempting to kill or harm myself				
Low energy, fatigue				
Trouble making decisions or concentrating				
Feeling worthless or guilty				
Eating and appetite more than normal or gained weight				
Eating and appetite less than normal or lost weight				
Trouble falling/staying asleep or early morning wakening (circle which)				
Racing heart or chest pain (circle which)				
Lightheadedness, dizziness				
Nausea, vomiting, or diarrhea (circle which)				
Sweating or breathing fast and shallow (circle which)				
Tingling in hands, face or feet				
Hot or cold flashes (circle which)				
Trembling or shaking				
Racing thoughts				
Feeling “I’m going crazy” or losing control (circle which)				
Excessive worrying, fear, dread, feeling out of control				
Dream-like sensations or distortions in vision, hearing, etc.				
Frightening flashbacks to an earlier traumatic event				
Nightmares or frightening dreams (circle which)				
Having lots of aches/pains/physical complaints				
Having to do/say something to prevent bad things from happening				
Frequent, unwanted thoughts or images (circle which)				
Being afraid of certain things such as _______________ (fill in blank)				
Mood swings: really down for a time and then really up for a time				

Problem	Never	Rarely	Frequently	Always
Decreased need for sleep or can't sleep—too wound up				
People telling me "slow down, you are talking too fast"				
Feeling overjoyed with life/ on top of the world/like I can do anything				
Spending or giving away too much money for my financial situation				
Hearing things or voices other people don't hear (circle which)				
Seeing things other people don't see				
Smelling/tasting/experiencing odd things others don't				
Feeling that other people are controlling my thoughts				
Being physically or sexually abused (circle which)				
Getting into verbal and/or physical fights (circle which)				
Thinking about harming others				
Drinking alcohol to relax, for pleasure, recreation				
Using drugs to relax, for pleasure, recreation				
Binging on large amounts of food				
Restricting food intake for the purpose of losing weight				
Experiencing relationship or marital difficulties				
Taking more pain medication than prescribed				
Experiencing work or school related performance difficulties				
Experiencing legal difficulties (criminal)				
Experiencing legal difficulties (civil)				
Experiencing difficulties related to military deployment				

What is the reason you are seeking a psychological assessment/evaluation at this time?

____

____

____

____

How long have you had these problems or symptoms?

____

____

____

____

Who lives with you at home?

Name of person	Relationship to you	Age	Occupation/School
______________________	______________________	_____	_____________________
______________________	______________________	_____	_____________________
______________________	______________________	_____	_____________________
______________________	______________________	_____	_____________________
______________________	______________________	_____	_____________________
______________________	______________________	_____	_____________________

Are you currently experiencing difficulties at work or school that are related to your difficulties? Yes □ No

If yes, please describe: ____

____

____

____

____

____

Are you currently?

□ Considering an elective cosmetic surgical procedure (please describe________________________)

□ Considering Pre-Spinal Cord Stimulator or Intrathecal Pump Implant)

□ Considering Bariatric surgery

□ Considering another surgical procedure or treatment/intervention which requires an evaluation please describe________________________)

□ Receiving SSI/Disability or similar benefits (please describe________________________)

□ Applying for SSI/Disability or similar benefits (please describe________________________)

□ Involved in a legal/civil suit related to your difficulties (please describe________________________)

My signature below indicates that I have read and answered the questions honestly and to the best of my ability:

____ ________________________

Signature **Date**

PAYMENT AGREEMENT

Please initial

_______If Dr. Hawkins **does not** accept my insurance (or I prefer that it not be billed), I understand that fees are due as stated and are payable prior to the report being released to my physician. If Dr. Hawkins **does** accept my insurance, I understand that I am responsible for paying my **co-pay** amount at the time the service is rendered and that, if I cannot pay the correct amount at the time of service, my credit or debit card will be charged that amount at that time to ensure that payment has been received. If, after being billed for the services I receive, my insurance company refuses to pay Dr. Hawkins *the amount allowed by them*(because, for example, I have not yet met my insurance deductible or *for any other reason*) I agree that I am responsible for payment of any difference to make up that allowed amount.

_______I agree to neither accept financial responsibility for any missed appointment /"no show" and my insurance company will not be billed for nor reimburse me for missed appointments. **To avoid paying the full fee for the assessment (as quoted to me by Dr. Hawkins), 48 hours advance notice is required to cancel or reschedule an appointment without incurring this full fee charge to my credit/debit card.**

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***Payment in the form of cash, personal check, debit card, *Visa*, or *MasterCard*, is expected at the time services are rendered unless I accept your insurance in which case you will need to pay your co-pay portion at the time of service. If I accept your insurance I will file the claim for the portion beyond your co-pay. If I do not accept your insurance, I will provide you with the documentation you need to file your own insurance claim. *At this time I am a participant in some but not all insurance plans* and, if I am not a participant in yours at the time I see you, your insurance plan will consider me "out-of-network

I have carefully read all the terms of the above guidelines and have had an opportunity to discuss any questions.

_______________________________________ _____________________________

Signature of Patient **Date**