Guinn . . . dedicated to helping the people we serve have a better life
HEALTHCARE TECHNOLOGIES, LLC

Adult Patient Initial Visit Information Prt I & II

Patient Information Section

Last Name	First Name	MI	Date of Birth	Soc. Sec. #
			___/___/____	XXX-XX-__ __ __ __

Gender	Citizenship	Race (□ Mixed - check all that apply)		Ethnicity
□ Male □ Female	□ U.S. Citizen □ Permanent Residence □ Refugee □ Other	□ American Indian □ Alaskan Native □ Asian □ Asian - Indian	□ Black/African American □ Native Hawaiian □ Pacific Islander □ White	□ Non-Hispanic/Latino □ Hispanic/Latino

Current Address - Street/PO Box	Preferred Phone #	Alternate Phone #

City	State	Zip Code	Email Address
	TX		

Marital Status		Parenting Status	Number in Household	Medication Allergies
□ N/A(Child) □ Single □ Married □ Separated	□ Divorced □ Widowed □ Cohabitating	□ N/A (Not a parent) □ Parent in One-Parent Family □ Parent in Two Parent Family □ Non-custodial Parent (Children not living in home or children are adults)	____ Dependents (under 18) ____	□ No □ Yes (If yes, list)

Last grade completed in School?		Disability Status	Employment Status
□ No schooling □ Nursery to 4th □ 5th or 6th □ 7th or 8th □ 9th □ 10th □ 11th	□ 12th: no diploma □ High Sch Grad □ GED □ 1-2 year college/trade □ 3-4 year college □ Bachelors □ Masters	□ N/A or None □ Disabled - Mental □ Disabled - Physical □ Disabled - Mental & Physical □ Disabled - Veteran □ Disabled - Short Term Illness □ Disabled - Developmental	□ N/A □ Full Time □ Part Time □ Searching □ Not employed - student □ Not seeking employment □ Disabled

Primary Language	Military	Military Branch		VA Discharge Status	
□ English □ Spanish □ Other _____	□ Yes □ No	□ N/A □ Army □ Navy	□ Air Force □ Marines	□ N/A □ Honorable □ General □ Medical	□ Bad conduct □ Dishonorable □ Other

Behavioral Health Screening Section

Please complete the following screening questions; ask your counselor for help if needed.

Section I - Simple Screening Instrument for AOD Abuse (SSI)

Each "Yes" = 3 points, if you answer yes, place a 3 in the line provided.) **Pts.**

1. During the past six months, have you used alcohol or other drugs? ..... ☐ Yes ☐ No [___]
   (If "No", GO TO SECTION II; otherwise continue)
2. During the past six months, have you felt that you use too much alcohol or other drugs? ..... ☐ Yes ☐ No [___]
3. During the past six months, have you tried to cut down or quit drinking or using drugs? ..... ☐ Yes ☐ No [___]
4. Do you feel that you have a drinking or drug problem now? ..... ☐ Yes ☐ No [___]

(Further Assessment recommended for a score of 6 and higher) Total Points

Section II - Post Traumatic Stress Disorder Screening (PTSD)

1. Have you witnessed or had a terrible experience that most people never go through, such as a natural disaster, a serious accident, a violent crime, being sexually assaulted or raped, sexual or physical abuse, or being in a military war zone or combat?

☐ Yes
☐ No ***(If "No", SKIP to the next section, SECTION III; otherwise continue)***

(Question 2 – 7) Each "Yes" = 3 points, if you answer yes, place a 3 in the line provided.

Pts.

2. In the past month have you repeatedly remembered these experiences, even when you did not want to? ..... ☐ Yes ☐ No [___]

3. In the past month have you had repeated dreams or nightmares about these experiences? ..... ☐ Yes ☐ No [___]

4. In the past month have you thought about these experiences when you did not want to, or been bothered by repeated, disturbing memories, feelings, or dreams? ..... ☐ Yes ☐ No [___]

5. In the past month have you tried hard not to think about these experiences, or avoided situations, conversations, people, or feelings that reminded you? ..... ☐ Yes ☐ No [___]

6. In the past month have you often felt extremely unsafe, on-guard, watchful when you didn't need to be, or jumpy and easily startled? ..... ☐ Yes ☐ No [___]

7. In the past month have you felt emotionally numb (unable to feel most feelings) or detached from your relationships, activities, or surroundings? ..... ☐ Yes ☐ No [___]

(Further assessment recommended for a score of 6 and higher) Total Points

Section III - Mental Health Inventory – 5 (MHI-5)

Please check only one box, place the number next to the box you checked in the line provided.

Pts.

1. During the past month, how much of the time were you a happy person?

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*	
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	[___]

2. How much of the time during the past month have you felt calm and peaceful?

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*	
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	[___]

3. How much of the time during the past month have you been a very nervous person?

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*	
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	[___]

4. How much of the time during the past month have you felt downhearted and blue?

All of the time	*Most of the time*	*A good bit of the time*	*Some of the time*	*A little of the time*	*None of the time*	
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	[___]

5. How much of the time during the past month did you feel so down in the dumps that nothing could cheer you up?

Always	*Very often*	*Fairly often*	*Sometimes*	*Almost never*	*Never*	
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	[___]

(Further assessment recommended for a score of 18 and lower) Total Points

Section IV - Current Problem

Please describe the issue/reason for this visit:

_____

_____

_____

_____

_____

Section V - Treatment History

1. At **any time in your life, have you been treated** for a substance abuse, psychiatric, psychological, emotional or relationship problems? (For example: taking medications, counseling, hospital, outpatient program, etc)

   ☐ No, **I have never** been involved with treatment before.
   (★*If "No", skip questions 2, 3, 4 and go to the* ***Physical Health Screening Section)*

   ☐ Yes, **in the past** for:(check all that apply)
   ☐ substance abuse, ☐ psychiatric, ☐ psychological or emotional problem, ☐ relationship problems
   I was first treated at age (_____)

   ☐ Yes, **currently** receiving treatment for:(check all that apply)
   ☐ substance abuse, ☐ psychiatric, ☐ psychological or emotional problem, ☐ relationship problems

2. What substance abuse and/or psychiatric conditions were you/are you being treated for? (list diagnosis if known)

3. What type of psychiatric or substance abuse treatment program(s) have you participated in (either past or present; check all that apply):

☐ a hospital
☐ a "partial hospital" day program
☐ an intensive outpatient program
☐ a regular outpatient program
☐ weekly individual or group counseling
☐ periodic doctor's office visits for psychiatric medication
☐ treatment in a public agency program (such as MHMR)
☐ other_____

4. Have you ever attended 12 step meetings for a substance abuse problem? (check all that apply)
   ☐ No, I have never attended 12 step meetings
   ☐ Yes, currently attending
   ☐ Yes, in the past

Physical Health Screening Section

Do you have now, or have you ever had the following conditions...

1. **Neurological Problems**
Seizures, numbness in limbs, head injury, strokes, other neurological ☐ Yes ☐ No
Comment:

2. **Cardiovascular Problems**
Heart disease, hypertension, heart attack, congestive heart disease, blood clots, other cardiovascular ☐ Yes ☐ No
Comment:

3. **Respiratory Problems**
Pneumonia, chronic cough, positive tuberculosis test, chronic obstructive pulmonary disease, asthma, smoker/former smoker, cancer involving this system ☐ Yes ☐ No
Comment:

4. **Gastrointestinal/Digestive Problems**
Frequent nausea/vomiting, blood in stool/vomit, frequent diarrhea, recent weight loss/gain, liver disease, hepatitis, cirrhosis, alcohol use, cancer involving this system, other gastrointestinal/digestive ☐ Yes ☐ No
Comment:

5. **Kidneys/Urinary Problems**
Kidney disease, dialysis, urinary problems, kidney stones, cancer involving this system, other kidney/urinary ☐ Yes ☐ No

Comment:

6. **Endocrine/Reproductive Problems**
Diabetes, insulin dependent, thyroid problems, cancer involving this system, other endocrine/reproductive ☐ Yes ☐ No

Comment:

7. **Musculoskeletal Problems**
Serious accident, amputations, arthritis, difficulty walking, back injury, other musculoskeletal ☐ Yes ☐ No

Comment:

8. **Skin Problems**
Chronic skin condition, current skin problems, lice - scabies - rash, wounds, other skin problems ☐ Yes ☐ No

Comment:

9. **Vision Problems**
Vision problems that cannot be corrected by glasses or contacts (please describe in comments) ☐ Yes ☐ No

Comment:

10. **Hearing Problems**
Hearing problems (please describe in comments) ☐ Yes ☐ No

Comment:

11. **Dental Problems**
Current dental problems, infections, abscess, chronic pain, needs dentures, other dental problems ☐ Yes ☐ No

Comment:

12. **Allergies**
History of allergies, reactions to medications, other allergic reactions ☐ Yes ☐ No

Comment:

13. **Use of Tobacco Products**

Do you use any tobacco products? ☐ Yes ☐ No ☐ No; I used to, but quit _____ ☐ years *or* ☐ months ago

If "Yes" > > ☐ I smoke tobacco ☐ I "dip" or "chew" tobacco

Use Pattern > > ☐ Several times per day ☐ Almost every day ☐ Several times per month ☐ Occasionally

Other

Within the past 5 years...

History of a disability; short tem or long term ☐ Yes ☐ No

Comment:

Treatment of a chronic (long term) medical condition ☐ Yes ☐ No

Comment:

Overall health rating…

How would you rate your overall health? ☐ Poor ☐ Fair ☐ Average ☐ Above Average ☐ Excellent

Comment:

Medication

	List health/mental health disorders that you take medication for:	Medication name (if known)	Describe any side effects of the medication (if any)
A.			

B. Any medications prescribed, but not taken and reason (List)?

Patient/Guardian Signature:		Date:		

Insurance Section or Other Funding Source

Insurance or other Payment Source:

☐ Medicaid ☐ Regular Commercial Insurance ☐ Employee Assistance Program
☐ Self pay ☐ Contract ☐ Other ☐ Learning Lab

Insurance or Medicaid HMO company name:		Medicaid # (if applicable):	

If Medicaid; Specify Type: ☐ Traditional ☐ STAR Health (Foster Care) ☐ STAR Plus ☐ CHIP

Group/Policy # (if applicable):		Member ID #:	
If EAP, number of visits authorized:		Authorization #:	
Name of Primary Insured (if Different than Patient):			
Name of Primary Insured's Employer (if applicable):			

Copayment Required?	☐ Yes ☐ No	If required, CoPay amount per Visit:	$
Prior Authorization Required?	☐ Yes ☐ No	If "Yes", Authorization Number?	

Billing Authorization Statements

- I request that payment of authorized insurance benefits, including Medicare and/or Medicaid be made to the organization listed below for any services provided to me by that organization.
- I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for services to the organization, the Health Care Financing Administration, my Insurance Carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my Insurance Company or other entity, if requested. The original authorization will be kept on file by the organization.
- I understand that I am financially responsible to the organization for any charges not covered by my health plan benefits. It is my responsibility to notify the organization of any changes in my health care coverage.
- In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

Acknowledgement of Patient Notices

Initials _____ Section A: I acknowledge receipt of the Notice of Privacy Practices of GHT, LLC.

Initials _____ Section B: I acknowledge providing voluntary general consent to behavioral health treatment and procedures.

Initials _____ Section C: I acknowledge participation in treatment planning.

Initials _____ *Section D:* I acknowledge being informed regarding advance directives for mental health in the event that I become incapacitated (applies to adults only).

☐ I do not want to complete an advance directive at this time

☐ I want to complete an advance directive

_____ ____/____/_____
PATIENT SIGNATURE (or parent/guardian for minor) DATE

PATIENT SSN Last Four # (or parent/guardian for minor): XXX-XX- __ __ __ __

_____ ____/____/_____
STAFF SIGNATURE DATE