



## **Algos Behavioral Health Services, Inc.**

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Sandy Zamora, LPC-S

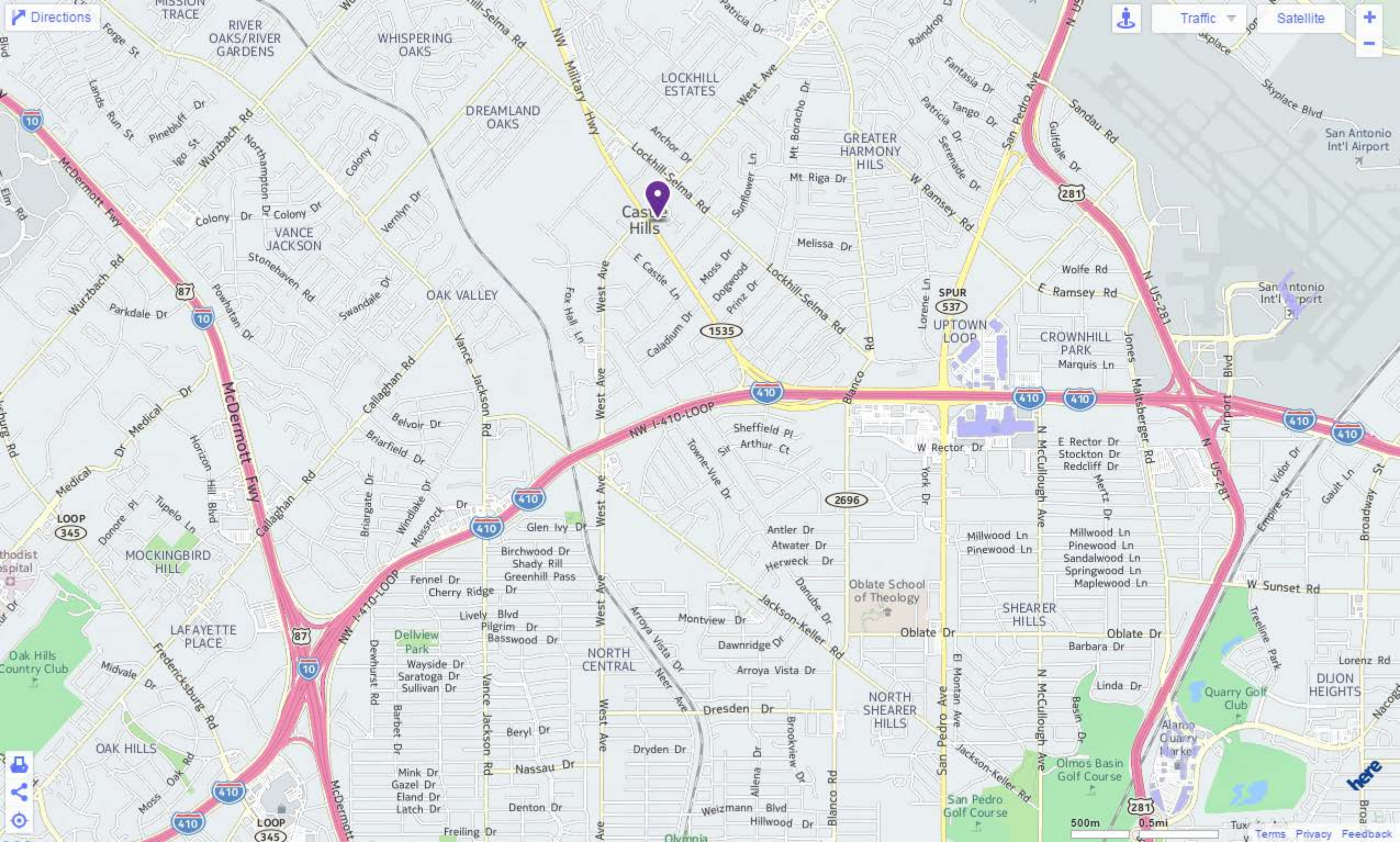
### **Behavioral Health Evaluation for Spinal Surgery Candidates**

You have been referred by your pain management physician for a Behavioral Health Assessment (BHA) as part of evaluating your candidacy for a dorsal column stimulator, spinal cord stimulator, intrathecal pump, or spinal surgery.

This is a routine step for individuals having these procedures. Such treatment options are invasive medical procedures and frequently require a Behavioral Health Assessment. This step will assist your physician in selecting the preferred treatment procedure, maximizing recovery, and predicting potential surgical outcomes. Insurance companies require such a BHA to assist the physician in determining that this is an appropriate procedure for your pain treatment. The purpose of this assessment is to identify and evaluate possible risk factors that may predict a successful or unsuccessful outcome to this procedure. Since your physician is considering a major procedure for the treatment of your chronic pain, every effort is made to make the best clinical judgment for its effectiveness. Research has shown that there are some medical, psychosocial and emotional risk factors that may predict an unsuccessful outcome. This BHA will help to determine the presence of any of these risk factors so appropriate treatments can be identified and implemented before and after you undergo the proposed surgery. Thus, it will help your physician make a more informed clinical decision about this step in the treatment of your chronic pain.

The BHA will consist of a clinical interview including a review of medical history and past life experiences, completion of some informational checklists and psychological testing instruments. You will have the opportunity to discuss with the psychologist/clinical associate any concerns you may have, and medical questions will be conveyed to the physician and his/her medical team. This BHA may take 3-4 hours to complete. Some of the paperwork can be completed at home prior to the appointment in order to facilitate the process. The extent of the assessment and what instruments will be administered depends on what the insurance company has requested and/or approved. The psychologist/clinical associate will utilize standard professional guidelines to assist with the clinical judgment and determination of your candidacy for this surgery. Every effort will be made to complete the assessment as efficiently as possible. Feel free to ask the clinician any questions you have about these psychological procedures.





Cast Hills

NW I-410-LOOP

McDermott Fwy

281

DREAMLAND OAKS

RIVER OAKS/RIVER GARDENS

LOCKHILL ESTATES

GREATER HARMONY HILLS

VANCE JACKSON

OAK VALLEY

CROWN HILL PARK

MOCKINGBIRD HILL

LAFAYETTE PLACE

NORTH CENTRAL

SHEARER HILLS

NORTH SHEARER HILLS

DIJON HEIGHTS

OAK HILLS

LOOP 345

500m 0.5mi

here

Terms Privacy Feedback



**ALGOS BEHAVIORAL HEALTH SERVICES, INC.**  
**NEW PATIENT INFORMATION RECORD**

Today's Date:		Referred By:	
Patient Full Legal Name:			
Date of Birth: / /	Age:	Male / Female (circle one please)	
SSN: / /	Marital Status: Single / Married / Divorced / Separated / Widowed		
Address (physical):		Drivers License#:	
City:	State:	Zip Code(9 digits):	
Home Phone: ( )	Cell Phone: ( )	Work: ( )	EXT#
<b>Can confidential messages (i.e., appointment reminders) be left on your answering machine or voicemail?</b>			
<input type="checkbox"/> YES <input type="checkbox"/> NO    If yes, which is best: cell / home / work			
Email Address:			
Employer's Name:		Occupation:	
Address:	City:	State:	Zip:

**PRIMARY INSURANCE**

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Primary Insurance:	Phone # <i>(Located on the back of card)</i>
Subscriber ID#:	Group # :
Name of Policy Holder:	DOB:
Insured's Address:	<input type="checkbox"/> same as patient
City:	State:                      Zip Code(9 digits):
Policy Holder's Employer:	
Patient Relationship to Policy Holder: SELF / SPOUSE / CHILD / PARTNER	

**SECONDARY INSURANCE**

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Secondary Insurance:	Phone # <i>(Located on the back of your card):</i>
Subscriber ID#:	Group # :
Name of Policy Holder:	DOB:
Insured's Address:	<input type="checkbox"/> same as patient
City:	State:                      Zip Code(9 digits):
Policy Holder's Employer:	
Patient Relationship To Insured: SELF / SPOUSE / CHILD / PARTNER	

**EMERGENCY CONTACT PERSON**

Name:	Relationship: Spouse / Brother / Sister / Mother / Father / Other:		
Home Phone: ( )	Work Phone: ( )	EXT:	

# ALGOS BEHAVIORAL HEALTH SERVICES, INC.

## Financial Policy

Thank you for choosing Algos Behavioral Health Services, Inc as your health care provider. The following is a summary of our financial policies. Please read the information carefully and sign or initial where noted below. We must obtain a copy of your driver's license and a current, valid insurance card. Failure to provide a current, valid insurance card and/ or information prior to your visit will result in payment due in full at the time of visit.

### Initial below please:

- 1. **PAYMENTS. All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment.**  
**Initial** We accept cash or credit card (Visa, MasterCard, or Discover). Unpaid accounts may be referred to an outside collection agency.
- 2. **CANCELLATIONS.** To reserve the hour of the clinician's time, we request a credit card to assure you of the availability of the doctor. There is a fee of **\$50.00** for a missed appointment or late cancellation. You can avoid this charge if you cancel 24 or more hours prior to the appointment. Your insurance carrier will not cover this fee.  
       \*\* When applicable, for individuals scheduled for a testing appointment – you will be charged **\$50.00** for every hour of testing that is missed or not cancelled within 24 hours. For example, if you are scheduled for 3 hours of testing, and you cancel or do not show for that appointment time, you will be charged \$150.
- 3. **CHANGE OF INFORMATION.** You are responsible to provide us with any change regarding your address, phone number or insurance information as soon as possible.  
**Initial**
- 4. **PRIVATE INSURANCE AUTHORIZATION AND INFORMATION RELEASE.**  
**Initial** I, the undersigned, authorize payment of mental health benefits to Algos Behavioral Health Services, Inc for any services rendered. **I understand that I am financially responsible for any amount not covered by my insurance policy including but not limited to co-payments, co-insurance and deductibles.** Any payments denied by the insurance company will be forwarded to the undersigned, and the undersigned will be held responsible for payment. I also authorize Algos Behavioral Health Services, Inc to release to my insurance company any information concerning health care, diagnosis or treatment provided to me. This information will be used only for the purpose of evaluating and administering claims of benefits.
- 5. **POTENTIAL NON COVERAGE**  
**Initial** Although other medical services may be covered by your insurance, this psychological service may not be covered and, in that case, you will be fully responsible for the entire amount. If the clinician is *out-of-network* with your insurance policy, you will be required to pay the full amount of the service rendered. We will NOT file claims for out-of-network services.
- 6. **NON-COMPLIANCE.** We reserve the right to discontinue care with you for non-compliance with any of the above policies.  
**Initial**
- 7. The undersigned agrees that in the event of **default in payment** or if the account is placed with a collection agency for collection, he/she is responsible for reasonable attorney's fees, miscellaneous costs of collection, collection agency fees, and court costs, at the interest rate of 18% per annum.  
**Initial**

*\*For all services rendered to minor patients, the adult accompanying the patient, or the policy holder, is responsible for payment.*

*I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.*

**X** \_\_\_\_\_  
**Signature of Patient OR Responsible Party if a Minor**

**Date:** \_\_\_\_\_

Printed Patient Name

**I WILL NOT BE USING INSURANCE FOR THIS SERVICE AND WILL PROVIDE ANOTHER FORM OF PAYMENT.**

**SIGNED:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Algos Behavioral Health Services, Inc.**

**Karri (Zumwalt) Lusk, Psy.D., Seán G. Connolly, Ph.D.,  
Geetanjali Sharma, Psy.D., Sandy Zamora, LPC-S**

***Health Insurance Portability and Accountability Act (HIPAA) Consent***

**General Notice**

When seeking psychological consultation and/or treatment in this practice, **Protected Health Information (PHI)** will be gathered about you. This information may include a clinical history, medical history, personal information, and possibly performance/responses on psychological testing instruments.

**Notice to Protect the Privacy of Your Health Information**

A complete description of how your **PHI** may be used and disclosed is available for your review in the **“HIPAA Notice of Privacy Practices.”** A copy of this document is available at the reception desk. You may request a copy for your records.

**Individual Rights**

You have the right to restrict the uses and disclosures of your **Protected Health Information (PHI)** for the purpose of treatment and health care. A signed consent form is usually required. This practice is not required to agree to requested restrictions, but is bound by any restrictions to which it agrees.

You have the right to revoke this consent in writing, except to the extent that our practice has taken action on the reliance on this consent. You have the right to refuse to sign this consent. This practice has the right to refuse to provide the clinical services requested, if you refuse to sign the consent or if you revoke this consent at any time.

**Your signature below acknowledges:**

- You have read and understand this consent;
- You have agreed to have your **Protected Health Information (PHI)** used by this practice for the purposes of your consultation and treatment, to secure payment for your treatment, and for this practice’s psychological care operations;
- Prior to signing this consent, you were given the opportunity to review the practice’s **“HIPAA Notice of Privacy Practices;”**
- You are aware that you may now, or at any time in the future, request restrictions to the use and disclosure of your **Protected Health Information (PHI)**;
- This consent may be terminated at any time, with written request, except to the extent that this practice has taken action in reliance of the consent.

**X** \_\_\_\_\_  
Signature of Client/Patient or Representative

\_\_\_\_\_  
Date

### Authorization Form to Release Protected Health Information (PHI)

This form when completed and signed by you authorizes this psychological clinic to release Protected Health Information (PHI) from your clinical record to the person(s) you designate.

I hereby authorize my psychologist and/or clinical associate, Karri (Zumwalt) Lusk, Psy.D., Seán G. Connolly, Ph.D., Geetanjali Sharma, Psy.D. or Sandy Zamora, LPC-S and their practice management company, Algos Behavioral Health Services, Inc. and/or their administrative and clinical staff to release *the following specific clinical record and/or administrative/payment information:* (please list which information you want released)

\_\_\_\_\_ results of the psychological evaluation \_\_\_\_\_

\*\*This information should be released to only the person(s) below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am requesting the release of this information for the following reasons:

at the request of the individual       for continuing care       for public agency use  
 legal purposes       other: \_\_\_\_\_

This authorization shall remain in effect until \_\_\_\_\_ (date),  
or until \_\_\_\_\_  
(specific purpose).

You have the right to revoke this authorization in writing at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist or clinical associate generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

X \_\_\_\_\_

Signature of Patient

\_\_\_\_\_

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

**Algos Behavioral Health Services, Inc.**

**Karri (Zumwalt) Lusk, Psy.D., Seán G. Connolly, Ph.D.,  
Geetanjali Sharma, Psy.D., Sandy Zamora, LPC-S**

**CONSENT TO TREATMENT AND CLINICAL ASSESSMENT SERVICES**

This is to certify that I give permission to Karri (Zumwalt) Lusk, Psy.D., Seán G. Connolly, Ph.D., Geetanjali Sharma, Psy.D. or Sandy Zamora, LPC-S at Algos Behavioral Health Services, Inc. to provide psychological and behavioral health services for myself and/or child(ren), or for an adult child for whom I am the legal guardian.

I have reviewed the **Statement of Office Policies for Clinical Practice** and the specific assessment and/or treatment procedures have been explained to me.

**Service:**

<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Couple Psychotherapy
<input type="checkbox"/> Psychoeducational Evaluation	<input type="checkbox"/> Group Psychotherapy
<input type="checkbox"/> Neuropsychological Evaluation	<input type="checkbox"/> Family Psychotherapy
<input type="checkbox"/> Behavioral Health Assessment	<input type="checkbox"/> Individual Psychotherapy
<input type="checkbox"/> Biofeedback Therapy	<input type="checkbox"/> Group Behavior and Health Intervention
<input type="checkbox"/> Other: _____	

The specific treatment has been described in the written **Statement of Office Policies for Clinical Practice** and/or explained by the clinician. If applicable, alternatives to treatment have been explained to me. Due to the complex nature of psychotherapy and other behavioral health services, including discussing past and present emotional pain and the stresses in life, it is quite common for persons entering this type of treatment to have periods of time when they experience their feelings as more intense, and perceive their condition as possibly worse. This should be discussed as part of the treatment, and is usually temporary. Please note that it is impossible to guarantee any specific results regarding psychological treatment. However, every effort will be made to achieve the best possible results for you. Maximum benefits occur with regular attendance and your active emotional investment in the process.

The issues of confidentiality have been reviewed, and I have been assured that all communications between a professional and a client are held in strict confidence. However, I also understand that there are exceptions to those laws and regulations. I understand it is the clinician's legal responsibility to disclose certain issues for my protection and that of others, and these situations have been clarified to me. Every reasonable effort will be made to resolve issues through discussion and planning within the clinical setting, and I will be notified of any anticipated compromise of the client-therapist relationship.

I have the right to terminate the therapeutic relationship at any time that I desire, without fault, and I have the right to seek and obtain a second opinion on the procedures and/or treatment process.

I understand that I am fully financially responsible for my treatment provided by the clinician, and for any balance that is not covered by my insurance company. A billing service may be used for the

collection of insurance reimbursement and co-pay fees. Psychologists have the right to seek the services of a collection agency to obtain payment of past due balances.

My signature certifies that I have read and understand all the information provided by Algos Behavioral Health Services Inc., about the clinicians, the treatment to be provided, and the expense to be incurred. I hereby voluntarily give my informed consent for treatment. A copy of this authorization shall be considered valid. I understand that I will be informed of any changes concerning what is in this document and my consent will be obtained regarding these changes.

You are assured that the services will be provided in a professional manner, consistent with the rules and regulations of the Texas State Board of Examiners of Psychologists and the ethical principles of the American Psychological Association. Every effort will be made to provide services in a caring, supportive and trustworthy environment.

In addition to the specified procedure checked above, the initial goals of treatment will be established after the first or second session.

My signature certifies that I have been provided the opportunity to read/review the following relevant documents:

- **Notice of Privacy Practices**
- **Statement of Office Policies for Clinical Practice: Psychotherapy, Psychological or Neuropsychological Testing and Behavioral Health Assessments**

My signature certifies that I voluntarily give my informed consent to the clinical services offered by this psychological practice.

X \_\_\_\_\_

Signature of Client/Patient

\_\_\_\_\_

Date

\_\_\_\_\_  
Signature of Responsible Party (if client is a minor)

\_\_\_\_\_  
Date



**Behavioral Health Assessment**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
SS# \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Today's Date: \_\_\_\_\_  
Education: \_\_\_\_\_

**Reason for Referral?**  Stimulator Implant  Intrathecal Pump  Spinal Surgery  
 Depression/mood concerns  Pain Management  other \_\_\_\_\_

Referring physician: \_\_\_\_\_

**History of Pain**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was pain caused by injury? If so, when and how were you injured? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Treatment for Pain**

Surgery related to pain? \_\_\_\_\_ When & what type? \_\_\_\_\_  
Outcome? \_\_\_\_\_

Steroid injections \_\_\_\_\_; Trigger point injections \_\_\_\_\_; Physical therapy \_\_\_\_\_;  
Chiropractor \_\_\_\_\_; Acupuncture \_\_\_\_\_; Massage therapy \_\_\_\_\_; Water therapy \_\_\_\_\_;  
Nerve Blocks \_\_\_\_\_; Radio frequency \_\_\_\_\_; Medications \_\_\_\_\_; TENS unit \_\_\_\_\_;  
Other procedures? \_\_\_\_\_

Current pain medications: \_\_\_\_\_  
Outcome: \_\_\_\_\_  
Level of relief: poor (0%) \_\_\_\_\_ fair \_\_\_\_\_ moderate \_\_\_\_\_ good \_\_\_\_\_ very good (100%) \_\_\_\_\_

**Other Medical Problems**

High blood pressure \_\_\_\_\_ High Cholesterol \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart problems \_\_\_\_\_  
Migraine headaches \_\_\_\_\_ CRPS/RSD \_\_\_\_\_ Fibromyalgia \_\_\_\_\_ Arthritis \_\_\_\_\_  
Other problems \_\_\_\_\_

Other injuries, surgeries, accidents: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other treating physicians/medications: \_\_\_\_\_

Have you ever had a head injury or concussion? \_\_\_\_\_ Details - \_\_\_\_\_  
\_\_\_\_\_

**Pain Location/Intensity**

Where is most of your pain localized? Lower back \_\_\_ upper back/neck \_\_\_ mid-back \_\_\_  
right leg \_\_\_ left leg \_\_\_ right foot \_\_\_ both legs and feet \_\_\_ left arm \_\_\_ right arm \_\_\_  
right shoulder \_\_\_ left shoulder \_\_\_ head \_\_\_ tailbone \_\_\_ headaches \_\_\_

Other: \_\_\_\_\_

On a scale of 0 to 10, (0 being no pain, 10 being the worst pain imaginable) what level is your pain: Most of the time? \_\_\_ On a good day? \_\_\_ On the worst day? \_\_\_ Today? \_\_\_  
The pain is most intense – When you get up in the morning? \_\_\_ As the day progresses? \_\_\_  
Afternoon/Evening? \_\_\_ No change during the day? \_\_\_ Other? \_\_\_\_\_

**Factors Influencing Pain**

What *aggravates* your pain? movement \_\_\_ activity \_\_\_ standing \_\_\_ sitting \_\_\_  
walking \_\_\_ lying down \_\_\_ weather changes \_\_\_ stress \_\_\_ conflict \_\_\_

Other \_\_\_\_\_

What *alleviates* your pain? inactivity \_\_\_ resting \_\_\_ lying down \_\_\_ walking \_\_\_  
massage \_\_\_ medication \_\_\_ stretching \_\_\_ exercise \_\_\_ relaxation \_\_\_ sleeping \_\_\_  
changing posture/position \_\_\_ ice \_\_\_ heat \_\_\_ other \_\_\_\_\_

**Level of Activity**

Currently employed? \_\_\_\_\_ **OR** When were you last employed? \_\_\_\_\_

Daily activity? \_\_\_\_\_

Are you awake most of the day? \_\_\_\_\_ Time spent in bed during the day? \_\_\_\_\_

Do you do household chores? \_\_\_\_\_

cook meals \_\_\_ dishwashing \_\_\_ laundry \_\_\_ fold clothes \_\_\_ yard work \_\_\_ dust \_\_\_  
vacuum \_\_\_ dust \_\_\_ sweep \_\_\_ repairs \_\_\_ care for children \_\_\_\_\_

Other: \_\_\_\_\_

Current level of functioning as compared to before injury/onset of pain?

60% \_\_\_ 50% \_\_\_ 40% \_\_\_ 30% \_\_\_ 20% \_\_\_ 10% \_\_\_ 5% \_\_\_

How do you spend most of your time? \_\_\_\_\_

TV \_\_\_ Reading \_\_\_ Playing games/puzzles \_\_\_ Computer \_\_\_ School \_\_\_

Volunteer \_\_\_ Hobbies \_\_\_ Distractions \_\_\_ Other \_\_\_\_\_

*Sleep Patterns:* Limited sleep (3/4 hrs) \_\_\_\_\_ Normal sleep \_\_\_\_\_  
Excessive sleep \_\_\_\_\_ Sleep during the day \_\_\_\_\_  
No sleep \_\_\_\_\_ Interrupted sleep \_\_\_\_\_  
Use of sleep meds. \_\_\_\_\_

Comments: \_\_\_\_\_

How does sleep deprivation affect you? \_\_\_\_\_

**Personal and Social History**

With whom are you living? \_\_\_\_\_ How long have you been married? \_\_\_\_\_

Do you have children? \_\_\_\_\_ How many? \_\_\_\_\_ Contact with the children? \_\_\_\_\_

Any other info. on family life? \_\_\_\_\_

Birthplace: \_\_\_\_\_ Where have you lived most of your life? \_\_\_\_\_

*Family of origin* - How many **total children** in your family growing up? \_\_\_\_\_

Where did you fit in the birth order? # \_\_\_\_\_ How was family life? \_\_\_\_\_

Abuse or trauma? \_\_\_\_\_

### Education and Work History

How far did you go in formal school? \_\_\_\_\_ City/State? \_\_\_\_\_

How did you do in school? \_\_\_\_\_

College Experience? \_\_\_\_\_

Vocational Training? \_\_\_\_\_

What kind of work have you done? \_\_\_\_\_

How long have you been out of work? \_\_\_\_\_

Have you been able to return to work? \_\_\_\_\_

Work/Career concerns? \_\_\_\_\_

### Psychological Functioning

How are you doing emotionally? \_\_\_\_\_

Depression \_\_\_\_\_; Anxiety or stress \_\_\_\_\_; Panic Attacks \_\_\_\_\_; Excessive anger \_\_\_\_\_

*Current symptoms?*

- |   |  |
|---|--|
| <input type="checkbox"/> loss of sleep                            | <input type="checkbox"/> low self-esteem/self-confidence                   |
| <input type="checkbox"/> excessive sleep                          | <input type="checkbox"/> irritability/getting upset with people easily     |
| <input type="checkbox"/> insomnia                                 | <input type="checkbox"/> loss of enjoyment in life (anhedonia)             |
| <input type="checkbox"/> loss of appetite                         | <input type="checkbox"/> fatigue/always tired                              |
| <input type="checkbox"/> excessive appetite                       | <input type="checkbox"/> loss of sexual interest/desire (decreased libido) |
| <input type="checkbox"/> crying episodes                          | <input type="checkbox"/> concentration problems                            |
| <input type="checkbox"/> social withdrawal/wanting to be alone    | <input type="checkbox"/> forgetfulness/memory problems                     |
| <input type="checkbox"/> loss of energy/motivation to do things   | <input type="checkbox"/> manic behavior                                    |
| <input type="checkbox"/> loss of interest in enjoyable activities | <input type="checkbox"/> sad feelings                                      |
| <input type="checkbox"/> mood swings/rapid mood changes           | <input type="checkbox"/> excessive feelings of guilt                       |
| <input type="checkbox"/> agitation/restlessness                   | <input type="checkbox"/> weight loss/gain _____                            |
| <input type="checkbox"/> negative/pessimistic thoughts            | <input type="checkbox"/> indecisiveness/unable to make decisions           |
| <input type="checkbox"/> sense of worthlessness                   | <input type="checkbox"/> inability/difficulty in thinking clearly          |
| <input type="checkbox"/> sense of hopelessness                    | <input type="checkbox"/> thoughts of dying                                 |
| <input type="checkbox"/> other mood problems _____                |  |

thoughts of suicide; if so, how frequently \_\_\_\_\_

passive death wishes; if so, how frequently \_\_\_\_\_

any suicide attempts in your lifetime? \_\_\_\_\_ If so, how many? \_\_\_\_\_

What did you do? \_\_\_\_\_

What happened? \_\_\_\_\_

hospitalized  ER visit  stomach pumped  charcoal  sutures

How recently was the last suicide attempt? \_\_\_\_\_ Details \_\_\_\_\_

Any serious consideration of suicide at this time? \_\_\_\_\_

\*Anxiety/panic attacks? \_\_\_\_\_ How often? \_\_\_\_\_

*Symptoms of panic attacks:*

___ racing heart	___ sweating	___ trembling/shaking
___ shortness of breath	___ sense of choking	___ fear of dying
___ sense of terror	___ chest pain/discomfort	___ agitation
___ nausea	___ dizziness/lightheadedness	___ chills
___ fear of losing control	___ hot flashes	___ avoid people

Other symptoms \_\_\_\_\_

How do you manage these episodes/attacks? \_\_\_\_\_

### ***Diagnosis***

What mental health diagnosis have you had? \_\_\_\_\_

### ***Treatment***

Have you ever seen a Psychiatrist? \_\_\_\_\_

Details - \_\_\_\_\_

Medications taken in the **past** for depression/anxiety \_\_\_\_\_

**Current** medications for emotional difficulties \_\_\_\_\_

Are the medications helping? \_\_\_\_\_ Are medications needed? \_\_\_\_\_

Have you ever been hospitalized for emotional issues? \_\_\_\_\_

Where? \_\_\_\_\_ When? \_\_\_\_\_

For how long? \_\_\_\_\_ Outcome \_\_\_\_\_

Follow-up treatment? \_\_\_\_\_

Have you ever seen a therapist/counselor/psychologist? \_\_\_\_\_

For how long? \_\_\_\_\_ Are you seeing anyone now? \_\_\_\_\_ Who? \_\_\_\_\_

### ***Psychosocial Stressors***

What contributes to your depression and stress? \_\_\_\_\_

___ chronic/constant pain	___ physical restrictions	___ slow/no medical progress
___ change in the quality of life	___ inactivity	___ loss of health
___ loss of employment	___ loss of independence	___ loss of career
___ financial problems	___ being unproductive	___ dependence on others
___ hassles with insurance co.	___ denial of treatment	___ employer termination
___ no income	___ denial of Social Security	___ bankruptcy
___ dependence on spouse	___ uncertainty about future	___ changes in the family
___ limited mobility	___ inability to drive	___ restricted social life
___ disappointment with surgical outcome	___ dependence on medication for relief	
___ marital problems	___ changes in parenting	___ disabling condition
___ social isolation	___ people's reactions to pain	___ loss of friends/support
___ trauma of injury	___ changes in intimacy	___ death of a loved one
___ unable to play with kids	___ change of roles in family	

Others \_\_\_\_\_



**Psychological Pain Management Strategies**

Have you used relaxation techniques? \_\_\_\_\_ Biofeedback Therapy \_\_\_\_\_  
Clinical Hypnosis \_\_\_\_\_ Pain Management Psychotherapy \_\_\_\_\_ Pain Groups \_\_\_\_\_  
Yoga \_\_\_\_\_ Other \_\_\_\_\_  
Were these strategies helpful? \_\_\_\_\_

**Addiction/Dependence Issues**

Current use of tobacco products? \_\_\_\_\_ How many, how often? \_\_\_\_\_  
For how long? \_\_\_\_\_ History of use? \_\_\_\_\_

Current use of alcohol? \_\_\_\_\_  
Any history of abuse of alcohol? \_\_\_\_\_ Have you ever been an alcoholic? \_\_\_\_\_  
Treatment \_\_\_\_\_ Outcome \_\_\_\_\_

Current use of street drugs? \_\_\_\_\_ Which drugs? \_\_\_\_\_  
How much, how often? \_\_\_\_\_  
Treatment \_\_\_\_\_ Outcome \_\_\_\_\_

History of overuse or abuse of (pain) medications? \_\_\_\_\_  
Details \_\_\_\_\_

Ever been arrested? \_\_\_\_\_ For what? \_\_\_\_\_  
Details \_\_\_\_\_  
Current status \_\_\_\_\_

Any current involvement in lawsuit/legal dispute? \_\_\_\_\_

<b>OFFICE USE ONLY</b>
<b>CPT:</b> ___ 90791    ___ 96101
<b>DX:</b> ___ F45.1    ___ <b>Other:</b> _____