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Behavioral Health Services
Adult Intake Questionnaire

Stephan F. Baum, MD, DLFAPA (young adults/children)
April E. Welborn, MD, PhD (adults)
102 Professional Park Dr, Ste A, Oxford, NC 27565

The following questionnaire is to be **completed** by the patient or legal power of attorney. This form has been designed to provide necessary information to our staff BEFORE your initial meeting in order to make the most productive and efficient use of our actual time together. As you complete this form, please feel free to add any additional information which you think may be helpful to us in understanding you. All information provided by you is strictly confidential and will **not** be released to anyone without your written request.

GENERAL INFORMATION			
Today's Date:	Person Completing Form:		
Patient's Name:	**Date of Birth:**	**Gender at birth:**	**Age:**
Home Street Address:			
City State Zip:			
Home Ph#	**Cell Ph #**	**Work Ph#**	
Marital Status:	**Religion:**	**Race:**	
Pharmacy:	**SSN:**		
E-Mail:	**Preferred Language:**		
Is there a Guardian or Legal Medical Power of Attorney? Yes or No **If yes, GUARDIAN/POA's Name:** ****GUARDIAN/POA must** attend all appointments with patient**.**			
Patient Occupation: _____ **Employer:** _____			
Emergency Contact: _____ **Relationship:** _____ **Phone#** _____ **Address:** _____			
Insurance (please attached copy of insurance card(s): **Primary Insurance**: _____ **Secondary Insurance:** _____ Member/Subscriber#: _____ _____ Policy Holder: _____ _____ Policy Holder's DOB/SSN_____ DOB/SSN_____			

Please fill out this packet completely. If a question does not apply to you, please put N/A.
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Previous mental health/substance abuse treatment: ___ **yes** ___ no

If YES, when, where and by whom: _____

_____

Previous use of psychiatric medications: ___ **yes** ___ no

If YES, please list previous psychiatric medications:

_____

_____

****REASON FOR REFERRAL**: Please **describe** the problems/symptoms you are having now and the **type** of services you are seeking:

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Granville HEALTH SYSTEM

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Symptoms/Stressors

Reference each applicable symptom noting current condition as (√) and historical condition (hx), include descriptions, approximate date of onset, duration, frequency, severity.

Behavior	Yes	Mood	Yes	Stressors	Yes	Thought	Yes
Appetite changes		Anxiety		Work problems		Attention problems	
Weight changes		Depression		School problems		Concentration problems	
Change in energy level		Elation/Mania		Absenteeism		Delusions	
Impaired impulse control		Hyperactivity		Financial issues		Flashbacks	
Impaired relationships		Feeling hopeless		Legal problems		Grandiosity	
Irritability		Grief or loss		Loss of job		Hallucinations	
Lack of motivation		Panic attacks		Separation		Impaired or difficulty thinking	
Obsessive compulsive behavior		Withdrawn		Divorce		Memory impairment	
Pain/Discomfort		Worrying		Custody issues		Self-depreciation	
Poor self-care		Paranoia		Other:		Racing thoughts	
Property destruction		Guilt				Flight of ideas	
Reckless behavior		Mood swings		**Lethality**	**Yes**	Fears/Phobias	
Self-mutilation		Feeling helpless		Access to firearms		Other:	
Sexually aggressive behavior		Crying spells					
Threats or acts of violence		Other:		Threats of self-harm			
Sleep disturbance		**STRENGTHS:** Please list below		Suicidal ideation			
Nightmares							
Psychomotor agitation				Suicide attempts			
Psychomotor retardation				Homicidal ideation			
Other Addictive Behaviors (such as gambling, overspending, etc):				Homicide attempts			
Other:							

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Current Medical Problems: ___ yes ___ no

History of significant head injury? ___ yes ___ no

History of seizures (epilepsy)? ___ yes ___ no

Allergic to Medications? ____ yes ____ no

If yes, list: _____

_____

Have you had COVID-19 Vaccination? ___ Yes ___ No If yes, ____ Pfizer _____ Moderna Boosters? __

Patient Habits

Cigarettes: ___ yes ___ no ___ in the past

How many cigarettes do you smoke in a day? _____

E-Cigarette: ___ yes ___ no ___ in the past

Chewing Tobacco: ___ yes ___ no ___ in the past

Caffeine: ___ yes ___ no ___ in the past

How much caffeine do you consume daily? _____

Eating Habits: ___ poor ___ good ___ excellent

Exercise Habits: ___ poor ___ good ___ excellent

Please circle your answers: During the past 6 months…(if yes, please explain)…

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, or inhalants.) (yes/no)
   _____
2. Have you felt that you use too much alcohol or other drugs? (yes/no)
   _____
3. Have you tried to cut down or quit drinking or using drugs? (yes/no)
   _____

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Granville HEALTH SYSTEM

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4. Have you had any of the following?
   Blackouts or other periods of memory loss (yes/no)
   Injury to your head after drinking or using drugs (yes/no)
   Convulsions, or delirium tremens ("DTs") (yes/no)
   Hepatitis or other liver problems (yes/no)
   Feeling sick, shaky, or depressed when you stopped drinking or using drugs (yes/no)
   Feeling "coke bugs," or a crawling feeling under the skin, after you stopped using drugs (yes/no)
   Injury after drinking or using drugs (yes/no)
   Using needles to shoot drugs
   (yes/no) _____
   _____
5. Has drinking or other drug use caused problems between you and your family or friends?
   (yes/no) _____
6. Has your drinking or other drug use caused problems at school or at work?
   (yes/no) _____
7. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)
   (yes/no) _____
8. Have you lost your temper or gotten into arguments or fights while drinking or using drugs?
   (yes/no) _____
9. Are you needing to drink or use drugs more and more to get the effect you want?
   (yes/no) _____
10. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes/no)
    _____
11. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes/no)
    _____
12. Do you feel bad or guilty about your drinking or drug use? (yes/no)
    _____

During your life: (not limited to the past 6 months):

1. Have you ever had a drinking or other drug problem? (yes/no)
2. Have any of your family members ever had a drinking or drug problem? (yes/no)
3. Do you feel that you have a drinking or drug problem now? (yes/no)

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4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) (yes/no)
   If yes, where/when:

_____
_____
_____
_____
_____
_____

Patient Birthplace (city/state/country): _____

Where patient raised? _____

Sexual Abuse history: ___ yes ___ no

Physical Abuse History: ___ yes ___ no

Emotional Support System: ___ poor ___ good ___ excellent

Please list: Name, Age, Relationship of those currently living with patient (including pets):

Name	Age	Relationship to Patient

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EDUCATIONAL HISTORY:

Last School Attended: _____

Education Level Completed:

Grade school ___ High School ____ Some College ____ College Degree ____ Graduate School ____

WORK HISTORY:

MILITARY HISTORY: _____Yes _____No

Date of Service: Branch: ___ Discharged ___Retired ___Active

BIOLOGICAL FAMILY HISTORY

Mother's Name: _____

Father's Name: _____

Sibling's Names(s): (List in order of birth including patient)

MARITAL & RELATIONSHIP HISTORY AND CURRENT LIVING SITUATION:

Marital Status (circle one):

Married Remarried Divorced Separated Widowed Never-married Cohabitants

If married, how long have you been married? _____

How would you rate the **quality** of your present marriage? **____Excellent ____Good ____Fair ____Poor**

If divorced, how long have you been divorced? _____

CHILDREN (Name(s) and age(s):

Please fill out this packet completely. If a question does not apply to you, please put N/A.
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Do you have **any** PRIOR OR CURRENT psychiatric, psychological, mental health, or chemical dependency treatment**?**

_____Yes _____No

If yes, please list below:

Dates of Treatment	Provider	Contact Phone#	Fax#

LEGAL HISTORY: (Current & past legal to include divorce/custody issues, DWIs, DUIs, criminal charges)

HISTORY OF TRAUMATIC EVENTS: (consider abuse/neglect, significant loss, etc…)

SPIRITUALITY:

Do you currently have coping skills? If so please list.

How would you describe your Physical Health?

____Excellent ____Good ____Fair ____Poor

Explain:

How would you describe your Mental/Emotional Health?

____Excellent ____Good ____Fair ____Poor

Explain:

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FAMILY STRESS LEVEL

Please rate the overall level of FAMILY stress:

_____Very Low ____Low _____Average _____High _____Very High

What is the greatest source of stress for you and/or your family at this time? _____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY: Has anyone in your family, who are biologically related had any of the following psychological disorders? **_____Yes or _____No**

If yes, please check all that apply and list who (list siblings, parents, maternal/paternal aunts, uncles, cousins, etc., back to great-grandparents)

Condition	Yes	Family Member(s)
General Developmental Delays or Cognitive Delay		
Speech or Communication Disorder		
Intellectual Disability (mental retardation)		
Attention-Deficit / Hyperactivity/Impulsivity		
Learning Problems / Disabilities		
Autism Spectrum / Asperger's Disorder		
Sleep disorders		
Generalized Anxiety (across many situations)		
Social Anxiety		
Obsessive-Compulsive Disorder		
Phobias		
Depression		
Manic-Depression / Bipolar Disorder		
Suicide attempts / Suicide		
Schizophrenia		
Psychotic Symptoms		
Alcohol / Substance Abuse		
Psychiatric Hospitalization		
Seizures or other neurological disorder		
Dementia / Alzheimer's Disease		
Genetic Disorder (e.g., Down Syndrome, Fragile X)		
Parkinson's Disease		

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Granville HEALTH SYSTEM

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Have you or any of your IMMEDIATE family had any of the following?

Check all that apply:					
Rheumatic Fever	☐ Self	☐ Family	Ulcer	☐ Self	☐ Family
Epilepsy	☐ Self	☐ Family	Meningitis	☐ Self	☐ Family
Tuberculosis	☐ Self	☐ Family	Gonorrhea/Syphilis	☐ Self	☐ Family
Diabetes	☐ Self	☐ Family	Anemia	☐ Self	☐ Family
High Blood Pressure	☐ Self	☐ Family	Jaundice/Hepatitis	☐ Self	☐ Family
Heart Disease	☐ Self	☐ Family	Thyroid problems	☐ Self	☐ Family
Cancer	☐ Self	☐ Family	Bone or joint disease	☐ Self	☐ Family
Stroke	☐ Self	☐ Family	Arthritis	☐ Self	☐ Family

MEDICAL HISTORY

Primary Care Physician (Family Doctor):

Physician's Address:

Physician's Phone/Fax Numbers:

When were you last seen by your primary care physician?

List any other physicians or health professionals you see on a regular basis. Such as Cardiology, Therapist, General Surgeon, Urology, Neurology, Nephrology, etc.)

How tall are you? _____ft, _____in. How much do you weigh: _____ lbs.

Do you have any vision problems?

Date of last vision test and who performed your primary care physician or an optometrist?

Do you have any hearing problems?

Are you: ____right-handed ____left-handed ____ ambidextrous (even handed)

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Do you have any other sensory concerns – aversion or sensitivity to light, sound, touch/texture, taste, food consistency, or smells?
List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical conditions you have had in space below:

List ALL medications you are currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements (include dosages and how you are taking it). ******Bring all prescription bottles and over-the-counter medications to your appointment.**
Are you allergic to or had bad reaction to medicine or food? **Yes _____** No_____ *__If yes, list:__

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Do you have any concerns about your eating habits? Such as: aversion to certain tastes, textures, overly restricted eating, overeating, and/or unhealthy eating.

Eating Habits: _____Poor _____Good _____ Excellent

What is your typical bedtime and wake time each day?

Any concern about your sleeping habits?

How would you describe:

Exercise Habits? _____Poor _____Good _____Excellent

Emotional Support System? _____ Poor _____Good _____Excellent

Have YOU had, or do you currently have any of the following symptoms?

Check all that apply	Yes		Yes
Eye Problems		Ear problems	
Sinus Problems		Mouth or throat problems	
Fainting Spells		Loss of consciousness	
Convulsions or seizures		Paralysis	
Dizziness		Frequent or severe headaches	
Memory Problems		Extreme tiredness or weakness	
Enlarged glands		Skin problems	
Frequent or lingering cough		Chest pain	
Coughing up blood		Night sweats	
Shortness of breath		Palpitations or heart fluttering	
Swelling of hands and feet		Back, arm, or leg pain	
Varicose Veins		Kidney stones	
Bladder problems		Difficulty in urinating	
Excessive thirst		Stomach pains or indigestion	
Constipation		Frequent or loose bowel movements	
Hemorrhoids		Rectal bleeding	

If you checked any of the above items, please provide brief information about dates and treatments received:_____
_____
_____
_____
_____
_____

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List any activities, including sports, clubs, hobbies, lessons, etc. that you have and enjoy:

Sports (list):	Music (list):
Clubs/Groups (list):	Dance (list):
Church/Religious:	Other:

Is there anything else we should know about you that was not covered by this form, or additional information you would like to share?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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NEW CLIENT INFORMATION

Welcome to the Granville Health System's Behavioral Health Services (BHS). This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask our administrative staff about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY:

Communication between you and your doctor is considered privileged and confidential. We will not release any information without your written release. The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes.

The only exception to these conditions may occur in situations such as child abuse, danger to life or workers ' compensation where by law other action is permitted. Please discuss this with your doctor or administrative staff.

Office Hours and Appointment Information:

Our psychiatrist hours 8:30 am to 4:30 pm week days and closed for lunch from 12:00pm- 1:00pm every day. The psychiatrists have multiple appointments each day and require a safe, quiet, and private environment for each patient they see; therefore:

- *It is unacceptable for UNATTENDED children/adolescents under the age of 15 to be in the waiting room area without an adult.*
- *Please make plans for the childcare of siblings or bring a family member or friend with you to monitor your children/adolescents during the session.*
- *The psychiatrist WILL need to meet with you individually, without your children present; therefore arrangements for childcare should be made BEFORE your appointment.*
  The office staff is NOT responsible for monitoring your children.

All patients need a quiet and peaceful environment for positive and full engagement in the therapeutic process, so please utilize respect and consideration for others while in our offices.

Appointments: To schedule, reschedule, or cancel an appointment, please call the main business number at 919-690-3217 and select option 1.

*If you need to cancel or reschedule an appointment, a minimum of a 24-hour notice is required.

FEES:

BHS is owned by Granville Health System. Services are billed as Outpatient Facility. Many Commercial Insurance Plans have a deductible that must be paid by you before insurance will pay for claims. This means, if you have, for example a $1,000 deductible, but have only paid $200 towards it during the calendar year, you

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will pay the difference which is your outstanding deductible amount of $800 as fees are incurred, if we are in network. If we are out of your insurance plan network, please check with your insurance plan to determine benefits.
Patients are expected to be aware of their individual insurance benefit plan, know if they have met their annual deductible, and their co-insurance amounts.

Additionally, it is the patient's responsibility to notify our staff in the event your insurance carrier changes or coverage has lapsed. Self-pay payment/co-insurance/copay for services is due and payable at the time they are rendered. All clients are expected to take care of their fees as services are rendered.

Self-pay fees for patient without insurance:

As self-pay, patient agrees to pay **$180.00** for initial psychiatric evaluation for medication management by psychiatrist.

If continued treatment is required, charges per visit are as follows:

$ 200 for psychiatrist 60-minute follow-up in office or telehealth.
$ 175 for psychiatrist 45-minute follow-up in office or telehealth
$ 150 for psychiatric 30 minute follow up in office or telehealth
$ 100 for 10-15-minute medication management in office or telehealth

(Rates Subject to Change)

No Show Policy

- Appointment times are reserved specifically for you, and the schedule is set accordingly.
- A "No Show" is considered such when someone misses an appointment without cancelling this appointment **within 24 hour notice** OR arrives late.
- No show fees of $50 may be charged and all future appointments will be cancelled until the No Show fee has been paid in full. **Does not apply to Medicare or Medicaid patients**

3 missed appointments in a 12 month period without 24 HOUR notification may result in termination of services for patients, as missed appointments suggest non-compliance with treatment. . **Attendance Requirement – 75% participation in any 18 month period for Psychiatric Medication Management.

*****For New Patients,** if 2 (two) Initial Psychiatric Evaluation appointments are missed (without at least 24-hour notice), they will not be able to reschedule.

- We notify your referral source of the missed appointments.

*****By signing below, you are acknowledging and accepting the No Show policy as stated.**

Prescriptions and Prescription Refills

Prescription refills are the responsibility of the patient or parent/guardian. All refills need to be called in to your pharmacy for **refills at least 5 days** before medication runs out. Again, **you must contact your pharmacy for all prescription refills.**

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The pharmacy will in turn contact BHS office for approval and/or authorization. This allows needed time to review your chart, submit Prior Authorization, and contact the pharmacy. Some medications require you to call this office for new prescriptions, **such as stimulants like Adderall, Ritalin, Concerta, Metadate, etc**… Stimulant or controlled substance refills may take longer to process and cannot be called in to the pharmacy, and you will be required to pick up the prescription OR we can mail the prescription through certified mail service.

This process is why we ask that you call I n the refill or request **5 days** prior to giving out of the medication.

Medication changes will **NOT** be done by telephone contact except in urgent or emergent situations as determined by the physician.

ALL PATIENTS MUST BE SEEN BY THE PHYSICIAN AT MINIMUM ONCE EVERY 90 DAYS for continued medication management teatment.

*****A complete copy of BHS policies will be given at first appointment.**

I have read and understand these policies.

I acknowledge responsibility for all fees incurred.

Client's Name:_____ **Date:**_____

Signature of Patient/Patient Representative

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