Medical History Questionnaire

This is your medical history form, to be completed prior to your session with Shawn Joseph LPCS, LMFT, NCC. All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin therapy. The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. Your answers will help me design a comprehensive program that meets your individual needs.

If you have questions or concerns, I will help you with those after this form is completed. I realize that some parts of the form will be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the medical history form.

Name: ____

Date: ____

☎ (225) 397-5706 ✉ g2candc@gmail.com
www.mentallytakecareofyou.com 9800 Airline Hwy Suite 215 Baton Rouge, LA 70816

MEDICAL HISTORY AND SCREENING FORM

General Information

Participant:

Name ______________________________

Address ______________________________

Contact phone numbers ______________________________

Birth date ______________________________

Family Physician and/or Primary Health Care Provider:

Doctor/Other______________________ Phone ______________________

Address ______________________ City ______________________

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

☐ Yes ☐ No

Signature:

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sex:

☐ Male ☐ Female

Education:

☐ Grade School ☐ Jr. High School ☐ High School

☐ College (2-4 years) ☐ Graduate School ☐ Degree ______________

Occupation:

Position ______________________ Employer ______________________

Address ______________________________

Phone

Legal

CURRENT STATUS

Do you have any Legal issues (s) that are active?

(Please explain) ____
____
____
____
____

Are you involved in active cases (traffic, civil ,criminal)? _____YES _____ NO

Are you presently on probation or parole? ____YES _____NO

If yes, please describe: ____

Education

Fill in all that apply: Years of education: ____ Currently enrolled in school? ____ YES ____NO

___ High School Graduate ___ GED

___ Vocational: Number of years:__ Graduated: ___ YES ___ NO____ Major: _________________

___ College: Number of years: ____ Graduated:___ YES____NO____ Major: _________________

___ Graduate: Number of years:___ Graduated:___ YES____NO_____Major: _________________

Other training:____

Special circumstances (e.g., learning disabilities, gifted): ______________________________

Are you currently in treatment with another therapist? (Circle one) Yes/ No

If yes, please list the therapist's name: ____

Have you seen a therapist in the past? (Please provide names and dates of previous therapists) :

Name:________________ Dates:___/___/___ to ___/___/___

Name:_________________ Dates:___/___/___ to ___/___/___

Name:_________________ Dates:___/___/___ to ___/___/___

Are you currently taking medication to treat a psychological/ psychiatric problem? Yes/ No if yes, please list name, address, and telephone number of your prescribing physician:

Name: ________________________ (circle One) Psychiatrist/ internist/ Nurse prac/ Other

Address: ____

City: _________________________ State: ___________________ Zip Code: ______________________

Phone: ( ) ___________________ Email: ____ if yes, please list the names, dosage, and dates of your current medications:

Rx Name: ___________________ Dosage: __________mg Start Date: ___/____/_______

Rx Name: ___________________ Dosage: __________mg Start Date: ___/____/_______

Rx Name: ___________________ Dosage: __________mg Start Date: ___/____/_______

Have you previously taken medication for a psychiatric problem? (Circle One) Yes/ NO if yes, please list the names, dosage and approximate dates you took the medication.

Rx Name: ___________________ Dosage: __________mg Start Date: ___/____/_______

Rx Name: ___________________ Dosage: __________mg Start Date: ___/____/_______

Rx Name: ___________________ Dosage: __________mg Start Date: ___/____/_______

Present Medical History

Check those questions to which you answer yes (leave the others blank).

- ☐ Trauma History and/ or risk factor (s)?
- ☐ Substance abuse?

Comments: ____

____

____

____

Women only answer the following. Do you have:

- ☐ Menstrual period problems?
- ☐ Significant childbirth - related problems?
- ☐ Urine loss when you cough, sneeze or laugh?

Date of the last pelvic exam and / or Pap smear ____________________

Comments: ____________________

____

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____

Are you on any type of hormone replacement therapy?____________________

Men and women answer the following:

List any prescription medications you are now taking: ____________________

List any self-prescribed medications, dietary supplements, or vitamins you are now taking: ____________________

Date of last complete physical examination: ____________________

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last chest X-ray: ____________________

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last electrocardiogram (EKG or ECG): ____________

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last dental check up: ____________

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

List any other medical or diagnostic test you have had in the past two years: ____________________

List hospitalizations, including dates of and reasons for hospitalization: ____________________

List any drug allergies: ____________________

Past Medical History

Check those questions to which your answer is yes (leave others blank).

- ☐ Heart attack if so, how many years ago? ________
- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ Sexually Transmitted Diseases
- ☐ Pregnant
- ☐ Diabetes or abnormal blood-sugar tests

- ☐ Underweight
- ☐ Overweight
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Cancer
- ☐ Cirrhosis
- ☐ Infectious mononucleosis
- ☐ Nervous or emotional problems
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Abnormal chest X-ray
- ☐ Other lung disease
- ☐ Injuries to back, arms, legs or joint
- ☐ Broken bones
- ☐ Chronic Pain

Comments: ____

____

____

____

Family Medical History

Father:

☐ Alive Current age ____________

My father's general health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

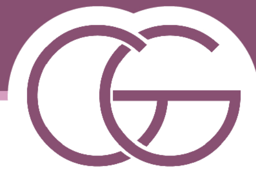
Reason for poor health: ____

☐ Deceased ☐ Age at death ______________

Cause of death: ____

Mother:

☐ Alive Current age _____________



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My mother's general health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Reason for poor health:____

☐ Deceased ☐ Age at death ____________

Cause of death: ____

Siblings:

Number of brothers _______ Number of sisters _______ Age range ______________________________

Health problems ____

Smoking

Have you ever smoked cigarettes, cigars or a pipe?

☐ Yes ☐ No

(If no, skip to diet section)

If you did or now smoke cigarettes, how many per day? ____________ Age started ____________

If you did or now smoke cigars, how many per day? ________ Age started

If you did or now smoke a pipe, how many pipefuls a day? ____________ Age started ____________

If you have stopped smoking, when was it? ____

If you now smoke, how long ago did you start? ____

Alcohol

Do you ever drink alcoholic beverages?

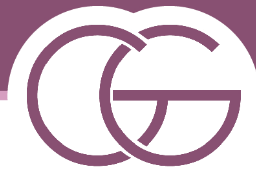
☐ Yes ☐ No

If yes, what is your approximate intake of these beverages?

Beer:

☐ None ☐ Occasional ☐ Often If often, _____ per week

Wine:



☐ None ☐ Occasional ☐ Often If often, _____ per week

Hard Liquor:

☐ None ☐ Occasional ☐ Often If often, _____ per week

At any time in the past, were you a heavy drinker (consumption of six ounces of hard liquor per day or more)?

☐ Yes ☐ No

Comments: ____

____

____

____

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NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGEMENT OF NOTICES

Patient/Client Name: ____

Birth date : ____

SSN #: ____

I hereby acknowledge that I have received and have been given an of Gordon & Gordon Privacy Practices. I understand that if I have questions regarding the notice on my privacy rights, I can contact the privacy officer at __________________.

____

Signature of Patient/ Client

____

Signature or Parent, Guardian or Personal Representative

____

Date

If you are signing as a personal representative of an Individual, please describe your legal authority to act for this individual (power of attorney, healthcare, surrogate, etc.) .

☐ Patient/ Client Refuses to Acknowledge Receipt.

____

Signature of Staff Member Date

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

Professional Include:

CLIENT/THERAPIST RELATIONSHIP: You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your therapist can best server your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILIABLE SERVICES: Gordon & Gordon offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed professional counselors, licensed clinical social workers, and doctors of psychology. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/ or psychotherapy.

COUNSELING: We provide short- term counseling designed to address many of the issues our clients are dealing with you. Your first visit will be an assessment session in which you and your Therapist will determine your concerns, and if both agree that Shawn C. Joseph, LPC can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your therapist, services to you may be terminated.

The goal of Gordon & Gordon is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current therapist to determine if transferring to a more suitable Therapist is right for you. If you and your therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well – being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we ask that you call our office at Gordon & Gordon at least 24 hours in advance, whenever possible. This will free your appointment time for another client

FEE SCHEDULE: Diagnostic & Evaluation Session (1st visit)	$120.00
Regular Office Visits (50 minutes) (Individuals, Couples & Play Therapy)	$75.00
Family Sessions (90 minutes)	$85.00
Psychological or Educational Testing	$N/A
Biofeedback Sessions	$N/A
Outside Office Work (inpatient visits, court, collaborative law services)	$200.00
Written Reports (insurance companies, supervisors, etc. pro rated at	$50.00
Returned check fee per check	$30.00

A reasonable fee will be charged for copies of any records requested by the client.

PAYMENT/ INSURANCE FILING: Payment of fees, including any required co- pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, Gordon & Gordon will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are using a Managed Care PPO/HMO insurance plan and wish to file your own claim we expect full payment at the time of service and we will provide you with a statement for services rendered. Monthly payments arrangements are available if needed for clients who have established a payment record for three months.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule to you as soon as possible to offer other options. Because clients may be scheduled back- to back, it is not always possible to return a call immediately. However, we will make every effort to respond in a timely manner. If your emergency arises after hours or on weekend, your