

PRIMARY CARE PROVIDER (PCP) COORDINATION OF CARE

This release is for the purpose of coordination of care between your provider at Union Counseling and your Primary Care Provider/ General Practitioner. **COMPLETE TOP SECTION ONLY.**

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

Primary Care Provider (PCP) Name: _____

Address: _____

Phone: _____ Fax: _____

Optional Refusal (Initial):

_____ I **AM NOT** currently receiving services from a PCP or other medical practitioner

_____ I **DO NOT** want information shared with my PCP

***NOTICE:** By signing, I hereby authorize the behavioral health clinician/facility listed below to release information to the practitioner/provider listed above. The reason for disclosure is to facilitate continuity and coordination of treatment. **This consent will last one year from the date signed.** I understand that I may revoke my consent in writing at any time. I understand that my treatment is not conditional in any way on my consenting to this disclosure.*

Signature of Patient/Patient's Representative: _____ Date: _____

Print Name of Patient/Patient's Representative: _____

Relationship of Representative (parent, guardian, etc.) _____

(Please provide necessary documentation proving authority if requested)

THIS DOCUMENT IS FOR COORDINATION OF CARE ONLY FOR OUR MUTUAL PATIENT LISTED ABOVE

Should you have any further questions, please contact the office selected below.

Diagnosis: _____

Medications: _____

I recommend the following course of treatment for this patient:

THERAPY: _____ Individual _____ Family _____ Group _____ Couple

MEDICAL: _____ Medication Management _____ Substance Abuse Treatment

Provider Name: _____ Credential: _____

Provider Signature: _____ Date: _____

1311 Union Street Schenectady, NY 12308

Phone:(518)374-6263 Fax: (518)374-1778

5 Hemphill Place Malta, NY, 12020

Phone:(518)289-5072 Fax: (518)289-5225

DATE SENT _____

STAFF INITIAL _____

ADULT YEARLY APPT

Patient Name: _____

Date: _____

ADULT BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Presenting problems: _____

Duration (months): _____

Additional Information: _____

CURRENT SYMPTOM CHECKLIST (Rate intensity currently present)

None=This symptom not present at this time • **Mild**=Impacts quality of life, but not significant impairment of day-to-day functioning • **Moderate**= Significant impact on quality of life and/or day-to-day functioning • **Severe**=Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe	Unsure		None	Mild	Moderate	Severe	Unsure
Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Binging/purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laxative/diuretic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elimination disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circumstantial symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychomotor retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loose associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aggressive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Conduct problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oppositional behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generalized anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessions/compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	None	Mild	Moderate	Severe	Unsure		None	Mild	Moderate	Severe	Unsure
Guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dissociative states	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somatic complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance use/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Homicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concomitant medical cond.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempts:	_____ number of times				

Date of last attempt: _____

EMOTIONAL/PSYCHIATRIC HISTORY

Prior outpatient psychotherapy? _____ Yes _____ No

If yes on _____ occasions. Longest treatment by _____ for _____ sessions from _____/_____/_____ to _____/_____/_____

Prior provider name: _____

City: _____ State: _____

Phone: _____

Diagnosis: _____

Intervention/Modality: _____

Beneficial? _____

Prior inpatient treatment for a psychiatric, emotional, or substance use disorder? _____ Yes _____ No

If yes on _____ occasions. Longest treatment by _____ for _____ sessions from _____/_____/_____ to _____/_____/_____

Inpatient facility name: _____

City: _____ State: _____

Phone: _____

Diagnosis: _____

Intervention/Modality: _____

Beneficial? _____

Has any family member had outpatient psychotherapy? _____ Yes _____ No

Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder

If yes, who/why (list all): _____

MARITAL STATUS:

- Single Married Divorced Separated Live In
Never married How long _____ how long _____ how long _____ how long _____

Spouses/Significant Others Name: _____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Father

Full name: _____

Occupation: _____

Education level: _____

General health: _____

Mother

Full name: _____

Occupation: _____

Education level: _____

General health: _____

Describe childhood family experience:

- Outstanding home environment
 Normal home environment
 Chaotic home environment
 Witnessed physical/verbal/sexual abuse toward others
 Experienced physical/verbal/sexual abuse from others

Age of emancipation from home: _____ Circumstances: _____

Special circumstances in childhood: _____

List all persons currently living in patient's household:

Name	Age	Gender	Relationship to patient
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List children and age not living in same household as patient: _____

Frequency of visitation of above: _____

Describe any past or current significant issues in intimate relationship:

Describe any past or current significant issues in other immediate family relationships:

Substance use history:

Family alcohol/drug abuse history:

- Mother Stepmother/live-in Grandparent(s) Spouse/significant other
- Father Stepfather Uncle(s)/Aunt(s) Siblings
- Children Other (Specify) _____

Substances used by patient:

(complete all that apply)	First use age	Last use age	Current Use (yes/no)	Current frequency	Current amount
Alcohol	_____	_____	_____	_____	_____
Amphetamines/"speed"	_____	_____	_____	_____	_____
Barbiturates/"downers"	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____	_____
Crack cocaine	_____	_____	_____	_____	_____
Hallucinogens (e.g. LSD)	_____	_____	_____	_____	_____
Inhalants (e.g. glue, gasoline)	_____	_____	_____	_____	_____
Marijuana or hashish	_____	_____	_____	_____	_____
Nicotine/cigarettes	_____	_____	_____	_____	_____
PCP	_____	_____	_____	_____	_____
Prescription	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Consequences of substance use (check all that apply):

- Hangovers Seizures Assaults Loss of control of amount used Withdrawal symptoms Medical complications
- Blackouts Overdose Arrests Sleep Disturbance Suicidal Impulse Relationship conflicts
- Binges Job loss Tolerance changes Other _____

Patient alcohol and/or drug treatment history:

- Outpatient (age[s]_____)
- 12-step program (age[s]_____)
- Other (age[s]_____) describe:_____
- Inpatient (age[s]_____)
- Stopped on own (age[s]_____)

Socio-economic history (check all that apply for patient):

Living situation:

- Housing adequate
- Homeless
- Housing overcrowded
- Dependent on other for housing
- Living companion
- Living companion dysfunctional
- Housing dangerous/deteriorating

Financial situation:

- No current financial problems
- Large indebtedness
- Poverty or below poverty income
- Impulsive spending
- Relationship conflicts over finances

Education:

- Highest grade completed _____
- College # of years _____
- Graduate School

Name of school _____

Employment:

- Employed and satisfied
- Employed but dissatisfied
- Unstable work history
- Coworker conflicts
- Supervisor conflicts
- Unemployed

Please list your most recent work history

Occupation/Job title: _____ Employer: _____ Length of employment: _____

Occupation/Job title: _____ Employer: _____ Length of employment: _____

Occupation/Job title: _____ Employer: _____ Length of employment: _____

Occupation/Job title: _____ Employer: _____ Length of employment: _____

Occupation/Job title: _____ Employer: _____ Length of employment: _____

Social Support System:

- Supportive network
- Few friends
- No friends
- Substance-use based friends
- Distance from family of origin

Military history:

- Never in military
- Served in military-no incident
- Served in military with incident

Legal history:

- No legal problem
- Now on parole/probation
- Arrest(s) not substance-related
- Arrest(s) substance related
- Court ordered this treatment
- Describe last legal difficulty: _____
- Jail/prison ____ times
- Total time served: _____

Sexual history:

- Heterosexual orientation
- Homosexual orientation
- Bisexual orientation
- Currently sexually active
- Currently sexually satisfied
- Currently sexually dissatisfied
- Age of first sexual experience_____
- Age first pregnancy/fatherhood_____
- History of promiscuity, age_____
- History of unsafe sex, age _____

Cultural/spiritual/recreational history:

Cultural identity (e.g. ethnicity, religion):_____

	Yes	No
Currently active in community/recreation activities?	_____	_____
Formerly active in community/recreational activities?	_____	_____
Currently engage in hobbies?	_____	_____
Currently participate in spiritual activities?	_____	_____

If answered "yes" to any of the above, describe:_____

HEALTH SCREENING

Patient's Name: _____

Date: _____

Date of Birth: _____

Sex: _____ F _____ M

Allergies: _____

1. Do you have or have you ever had any of the following?
(please check yes or no)

	No	Yes	Please describe
Allergies			
Blood Disorder			
Bone or Joint Problems			
Cancer			
Diabetes			
Endocrine Disorders (e.g. thyroid)			
Epilepsy (seizures, convulsions)			
Gastrointestinal Disorders (stomach)			
Head injury			
Heart Disease			
HIV/AIDS Related Conditions			
Hypertension (high blood pressure)			
Hypoglycemia (low blood sugar)			
Liver Disease			
Lung Disease			
Physical Limitations			
Sexually Transmitted Disease (e.g. gonorrhea, syphilis)			
Other			

2. HOSPITALIZATIONS (list any operations, medical procedures, mental, drug, or alcohol abuse treatment)

Date	Procedure/treatment

3. MEDICATION currently taking (include prescription drugs; amount and frequency)

Name of Medication	Amount	Frequency	Date Started

4. MEDICAL PROCEDURES Physical exams; special test e.g. EKG, Blood Tests, X-rays, within past year

Exam/Test Performed	Date	Physician/Clinic

5. PRIMARY CARE DOCTOR

Name	Address	Phone	Date of Last Physical Exam

6. PREVIOUS MENTAL HEALTH TREATMENT

Date	Name of Provider	Address	Phone

Parent/Guardian/Patient's Signature: _____ Date: _____