PRMARY 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
Depressed mood	☐	☐	☐	☐	☐
Appetite disturbance	☐	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	☐
Elimination disturbance	☐	☐	☐	☐	☐
Fatigue/low energy	☐	☐	☐	☐	☐
Psychomotor retardation	☐	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐	☐
Poor grooming	☐	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐	☐
Agitations	☐	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	☐
Generalized anxiety	☐	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	☐
Obsessions/compulsions	☐	☐	☐	☐	☐

	None	Mild	Moderate	Severe	Unsure
Binging/purging	☐	☐	☐	☐	☐
Laxative/diuretic abuse	☐	☐	☐	☐	☐
Anorexia	☐	☐	☐	☐	☐
Paranoid ideation	☐	☐	☐	☐	☐
Circumstantial symptoms	☐	☐	☐	☐	☐
Loose associations	☐	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	☐
Aggressive behaviors	☐	☐	☐	☐	☐
Conduct problems	☐	☐	☐	☐	☐
Oppositional behavior	☐	☐	☐	☐	☐
Sexual dysfunction	☐	☐	☐	☐	☐
Grief	☐	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	☐
Social isolation	☐	☐	☐	☐	☐
Worthlessness	☐	☐	☐	☐	☐

	None	Mild	Moderate	Severe	Unsure
Guilt	☐	☐	☐	☐	☐
Elevated mood	☐	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	☐
Dissociative states	☐	☐	☐	☐	☐
Somatic complaints	☐	☐	☐	☐	☐
Self-mutilation	☐	☐	☐	☐	☐
Significant weight gain/loss	☐	☐	☐	☐	☐
Concomitant medical cond.	☐	☐	☐	☐	☐
Emotional trauma victim	☐	☐	☐	☐	☐

	None	Mild	Moderate	Severe	Unsure
Physical trauma victim	☐	☐	☐	☐	☐
Sexual trauma victim	☐	☐	☐	☐	☐
Emotional trauma perpetrator	☐	☐	☐	☐	☐
Physical trauma perpetrator	☐	☐	☐	☐	☐
Sexual trauma perpetrator	☐	☐	☐	☐	☐
Substance use/abuse	☐	☐	☐	☐	☐
Homicidal ideation	☐	☐	☐	☐	☐
Suicidal ideation	☐	☐	☐	☐	☐

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 Never married ☐ Married How long ____ ☐ Divorced how long ____ ☐ Separated how long ____ ☐ Live In 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	☐	☐	☐
Father	☐	☐	☐
Stepmother	☐	☐	☐
Stepfather	☐	☐	☐
Brother(s)	☐	☐	☐
Sister(s)	☐	☐	☐
Other (specify)	☐	☐	☐

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

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: _____