Ridgewood Clinics

Krishan K. Gupta, M.D.
1059 Ridgewood Place
Jackson, MS 39211

(601)957-3211 (PHONE)
(601)957-9753 (FAX)
www.webpsychmd.com

Welcome

Welcome to Ridgewood Clinics! We are pleased that you chose us to meet your mental health care needs. For over twenty years, Dr. Krishan K. Gupta and his team at Ridgewood Clinics have provided mental health care services to thousands of individuals across Mississippi. We offer a variety of services for children, adolescents, and adults. Our highly skilled and experienced clinicians are currently accepting new patients and dedicated to providing quality care to you and your family. We do have some important policies and instructions for you in this packet, so please read the following carefully.

Consent Forms and Clinic Policies – All policies of Ridgewood Clinics are available in the clinic and on our website. Our policies include important information regarding treatment, privacy, and payments. Our patients are responsible for reviewing and following all clinic policies. If there are any questions regarding this information, please ask for clarification. By signing consent forms, you voluntarily agree to treatment by providers of Ridgewood Clinics. By signing policy forms, you acknowledge you are aware of, understand, and agree to policies of Ridgewood Clinics.

Intake Packet – We ask that you please take the time to complete the following patient intake forms and bring these to your appointment. If you need assistance or have questions, please arrive 30 minutes prior to your scheduled appointment time. This includes a life history questionnaire, which is a lengthy list of questions. Some of the information requested is of a personal nature. Other than the exceptions mentioned in our privacy policy, this information is kept confidential. Also, answering these questions honestly will greatly assist us in providing the best care possible.

Please bring the following to EVERY appointment:

- Photo ID (Patient and/or Legal Guardian)
- Insurance Cards

Please bring these additional items to your FIRST appointment:

- Patient Questionnaire (included in this packet)
- Signed Consents (in this packet)
- Signed Acknowledgement of Policies (in this packet)

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Payment Policy

Payment is due at the time of service. Ridgewood clinics accept cash, credit or debit cards. Most insurance plans require a deductible or copay. This amount is the client's responsibility.

Insurance Claims

Ridgewood Clinics value our patients and we are here to assist you. As a courtesy, we file your insurance claims. However, you are responsible for insuring proper payment is received from your insurance company in a timely manner. All claims not paid within 90 days, will be transferred to the patient's responsibility. Our providers often order lab work or testing that some insurance plans do not cover. You are responsible for understanding services covered through your insurance plan.

Self-Pay

If you are a self-pay patient, payment is due at the time services are rendered.

Missed Appointments

If clients miss an appointment or fail to cancel an appointment 24 hours prior the scheduled time, they will be charged the full service fee. Exceptions may be made for emergencies at the discretion of the provider. As a courtesy, we call to remind clients of their appointment. All clients are responsible for providing accurate and updated contact information.

Unpaid Accounts

Accounts not paid within 90 days will be referred to a collection agency. Once your account is placed in collections, you will be responsible for any additional fees applicable. These may include collection agency fees, legal fees, interest accrued. We reserve the right to terminate the patient-clinician relationship for accounts that are past due after 90 days. If you are having financial problems, please let us know as soon as possible. We may be able to work out a payment plan.

Reports or Professional Consultations

Any reports, professional consultations, or clerical tasks will be billed per hour. This rate will be determined based on the requested service. We will inform you of this amount at your request.

Phone Calls

We will not bill for phone calls to schedule appointments, discuss possible reactions to recently prescribed medications, follow-up calls made by us, or calls to you to discuss payment. You may be billed for phone calls during or after normal business hours to discuss other treatment matters. Due to frequently changing healthcare costs, ask about current prices before speaking with a provider.

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Privacy Policy

Any information provided during your treatment at Ridgewood Clinics, verbal and written, will be kept confidential. We will not share this protected health information. You may request for Ridgewood Clinics to send your medical records to another provider. Also, you may give Ridgewood Clinics permission to request your previous records from another provider. In order to send or receive these records, we must have the patient or patient's responsible party provide written consent. There are a few exceptions to our privacy policy. At times providers may be legally obligated to share your protected health information. This information may be discussed with others under the following circumstances:

Duty to Warn and Protect:

As licensed mental health professionals, we have a legal obligation to make efforts to protect our clients from harming themselves or others. If a client verbalizes thoughts of self-harm or a plan for suicide, providers should notify legal authorities and attempt to inform the client's family or emergency contact. If a client discloses intentions or plan to harm another person, providers are required to inform the intended victim and legal authorities.

Abuse of Vulnerable Persons:

If a provider becomes aware of or suspects abuse of a child or vulnerable adult, they are required to report this information to social services and legal authorities. This may include abuse of a client or abuse reported by a client. We also may report admitted prenatal exposure to potentially harmful controlled substances.

Parents/Legal Guardians:

Parents and legal guardians have a right to access minor clients' medical records.

Insurance Providers:

Insurance providers and/or additional third-party payers may be provided with a client's protected health information, at their request, regarding services provided through Ridgewood Clinics.

I agree to the above privacy policy. I understand the meaning of this policy and times when protected health information may be discussed with individuals other than Ridgewood Clinics' providers.

_____

Client Signature (Legal Guardian if under 18)

_____

Date

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Grievance Policy

Ridgewood Clinics' Policy is to provide an effective and timely process for any complaints. Your comfort, satisfaction, and safety are important to us. We hope to meet all of your needs at our clinic. However, if you or your family members have concerns, please let us know immediately. We will do our best to resolve any issues as soon as possible.

Who to Contact

Please contact our office regarding complaints. If the issue is unable to be resolved through telephone conversations, an appointment will be scheduled to discuss your concerns with appropriate clinic personnel. You may also submit complaints in writing and mail them to:

Ridgewood Clinics
Attn: Compliance Officer
1059 Ridgewood Place
Jackson, MS 39211

If the client or client's legal guardian feel clinic efforts to resolve concerns were unsatisfactory, they may contact:

Mississippi Board Medical Licensure
1867 Crane Ridge Drive, Suite 200-B
Jackson, MS 39216
(601) 987-3079
mboard@msbml.ms.gov

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Consent to Treatment

I, _____, do hereby voluntarily consent to care and treatment by providers of Ridgewood Clinics. Providers of Ridgewood Clinics may include psychiatrists, nurse practitioners, psychologists, social workers, counselors, or supervised interns. Treatment includes, but is not limited to, medication management, psychotherapy, individual and family counseling, and hypnosis. This consent form allows staff of Ridgewood Clinic to provide services to you. If for some reason your usual provider is unavailable, this consent allows alternative providers of the clinic to treat you as well.

Treatment at Ridgewood Clinics is always voluntary. While many individuals greatly benefit from our services, we cannot guarantee your treatment will be successful. You, or your provider, may discontinue treatment at any time deemed necessary. If at any time you wish to discontinue treatment, we encourage you to discuss your concerns with a provider. Your safety is important to us. If you so choose, we will gladly assist you in finding services elsewhere. If you have any questions or concerns regarding treatment, it is your responsibility to ask your providers. You are an active participant in treatment. If you withhold information from providers or do not clearly understand our recommendations, this could negatively impact your treatment outcome.

By signing this consent, you acknowledge that you fully understand all matters discussed in this form. You attest that you are entering treatment voluntarily. If the client is a minor, you attest that you are this client's legal guardian and you voluntarily consent for them to enter treatment. Further, you acknowledge that risks and benefits of mental health treatment have been explained to you.

_____ _____

Client Name (Print) Ridgewood Clinics Provider (Print)

_____ _____

Client Signature (Legal Guardian if under 18) Ridgewood Clinics Provider (Signature)

_____ _____

Date Date

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Controlled Substance Policy

During your treatment at Ridgewood Clinics, you may be prescribed a controlled medication. Your safety is important to us, so we want you to understand your responsibilities as a client.

Take medications only as prescribed by your provider.

Your provider will discuss risk and benefits of medications to you. If there is anything you do not understand, please ask.

We are not responsible for lost or stolen medications or prescriptions.

You must inform providers of all medications you are taking and inform them of any changes made by other providers.

Your provider may order a urine drug screen or alcohol breath test.

You should not allow anyone else to take medications prescribed to you.

If you fail to comply with this policy, your provider may discharge you from their services.

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Client's Bill of Rights

The medical staff and administration of Ridgewood Clinics are dedicated to providing clients with quality care in a manner which protects their privacy and dignity. In order to accomplish this, a set of "Client's Rights" have been identified. These "Rights" included the following:

Respect

The client has the right to considerate, respectful care and recognition of his/her personal dignity at all times and under all circumstances.

Non-Discriminatory Treatment

Clients' shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, or sources of payment for care.

Confidentiality

The patient has the right, within the law, to personal and informational privacy as manifested by the following rights:

To be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.

To expect that any discussion or consultation involving his/her case will be conducted discreetly and that individuals not directly involved in his care will not be present without his/her permission.

To have his/her medical record read only by individuals directly involved in his treatment or in the monitoring of its quality and by other individuals only on his written authorization or that of his/her legally authorized representative.

To expect all communications pertaining to his/her care to be treated as confidential information.

Personal Safety

Clients have the right to expect reasonable safety insofar as the clinic practices and environment are concerned.

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I, _____, have reviewed and fully understand all policies of Ridgewood Clinics including the following:

Payment Policy

Grievance Policy

Privacy Policy

Patient's Bill of Rights

Controlled Substance Policy

_____

Signature

_____

Date

These policies are subject to change. Patients will be informed of such changes as they are made.

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Patient Information

Date _____ Account Number _____ First Name _____ Last Name _____ Middle Name _____

Social Security# _____ DL # _____ D.O.B _____ Age _____ Gender _____ Race _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____ Email Address _____

Patient's Spouse or Patient's Guardian

First Name _____ Last Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____ Email Address _____

Person Responsible for Payment

First Name _____ Last Name _____ Social Security # _____

Emergency Contact Information

First Name _____ Last Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____ Email Address _____

Referral Source

How did you hear about our clinic? _____

Method of Payment and Insurance Information

How do you intend to pay for services provided by Ridgewood Clinics?

Cash Credit Card Debit Card Insurance Other _____

Insurance Information

Primary Insurance _____ ID # _____ Group # _____

Address _____ City _____ State _____ Zip _____ Phone _____

Subscriber Name _____ Subscriber D.O.B. _____ Subscriber SSN _____ Relationship to Patient _____

Secondary Insurance _____ ID # _____ Group # _____

Address _____ City _____ State _____ Zip _____ Phone _____

Subscriber Name _____ Subscriber D.O.B. _____ Subscriber SSN _____ Relationship to Patient _____

I, _____, attest the insurance information provided is accurate. I assign payment directly to providers of Ridgewood Clinics. I understand that I am responsible for all charges not covered through insurers. Also, in order to secure payment for services, I authorize Ridgewood Clinics to release any information necessary to insurers.

NOTE: Please notify us immediately of any changes in this information during your course of treatment.

Subscriber Signature _____ Date _____

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Explanation of Treatment for Opioid Dependence

Explanation of First Visit

This is usually your longest visit. Please plan to stay 1 to 4 hours. If possible, you should make your appointment in the morning.

You should arrive to your appointment already experiencing moderate opioid withdrawal symptoms. Medications prescribed will lessen these symptoms. However, if opioids are already in your system, your withdrawal symptoms may worsen.

Prior to Appointment

**no methadone or long-acting pain killers for at least 24 hours

**no heroin or short-acting pain-killers for at least 4 to 6 hours

If your provider chooses to prescribe maintenance medications, these may cause drowsiness and slowed reaction times. You should make arrangements for a ride home.

You may not want to return to work after this visit, so plan accordingly.

Bring ALL medications with you to your appointment.

ALL paperwork must be completed prior to seeing your provider. If you have not done this, arrive to your appointment 30 minutes early to complete patient forms.

Be prepared to provide a urine sample for a urine drug screen.

Your provider may order an alcohol breath test and/or blood work.

Your provider may recommend a complete physical exam by your primary care provider.

Your provider will perform a substance dependence assessment and mental status evaluation.

Your provider will discuss maintenance medication with you and your expectations for treatment.

If maintenance medication for opioid dependence is ordered, your first dose will be administered in the clinic. Your provider may have you fill your prescription at the pharmacy and return to the clinic for medication administration and observation. You should feel better within 30 minutes of your first dose. Be honest about how you feel, so your provider can determine the most appropriate dose. If a prescription is given to you, medication must be taken exactly as prescribed.

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When you leave the clinic, your provider may write a prescription that will last until your next appointment. Appointments may be monthly, weekly, or more frequent.

Your provider may recommend counseling sessions to increase your likelihood of a good outcome.

Follow-Up Appointments

Payment is due at the time of each visit as discussed in our payment policy.

Bring ALL medications and inform your provider of any medication changes.

Always be prepared to provide a urine sample for a drug screen.

Your provider may order an alcohol breath test and/or blood work.

Print out the online withdrawal questionnaire available on our website. Complete and bring this form to each follow-up appointment.

Frequency of follow-up visits will be determined by your provider as treatment progresses. These may be monthly, weekly, or more frequent based on individual needs and safety concerns.

Your provider may discharge you from this program at any time for noncompliance with recommendations or if treatment progress is ineffective.

Your provider will discuss with you and decide on the most appropriate time to begin slowly tapering and discontinuing your maintenance medication.

Your provider and/or counselor will develop and discuss a relapse management plan with you.

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Opioid Dependence Treatment Consent

I, _____, acknowledge that I fully understand all matters discussed in the
(print name)
explanation of treatment for opioid dependence form. I attest that I am entering treatment voluntarily. I understand the possibility of discharge from treatment for noncompliance with provider recommendations or for ineffective progress towards treatment goals. I acknowledge that risks and benefits of treatment for opioid dependence have been explained. I have reviewed patient education forms regarding treatment with Suboxone* (buprenorphine/naloxone) and Subutex* (buprenorphine) and understand the risks and benefits of these medications.

Patient Signature _____ Date _____

(Suboxone and Subutex are registered trademarks of Reckitt Benckiser Pharmaceuticals, Inc.)

Pain Treatment with Opioid Medications: Patient Agreement*

I,_____, understand and voluntarily agree that
(initial each statement after reviewing):

_____I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____I will participate in all other types of treatment that I am asked to participate in.

_____I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____I will use only one pharmacy to get all on my medicines:_____
Pharmacy name/phone#

_____I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203

_____I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

_____I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

_____I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

_____I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement

We here at_____are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We

will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

_____	_____	_____
Patient signature	Patient name printed	Date
_____	_____	_____
Provider signature	Provider name printed	Date

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203

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PATIENT TREATMENT CONTRACT

Patient Name: _____ **Date:**_____

As a participant in medication treatment for opioid misuse and dependence. I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep, and be on time to, all my scheduled appointments and always seen at least once a month or more if deemed necessary by the doctor. If I miss an appointment and do not call regarding the missed appointment, it will be assumed that I no longer desire buprenorphine treatment. If notice is not given to change appointment within 24 hours of scheduled appointment, a $50 no show fee will be applied.
2. I will adhere to the payment plan outlined by the clinic. Payment plan is as follows: $400 for first visit and $175 for follow up visits. Each visit requires a $75 drug screen. Payment is due at the time service is rendered. NO refund will be given. No prescriptions will be called in following a missed appointment. Lost medication will not be replaced regardless of reasons for such loss.
3. I agree to conduct myself in a courteous manner and not to conduct any illegal or disruptive activity in the doctor's office. I agree to not arrive to office intoxicated or under the influence of drugs.
4. I agree to report my history and symptoms honestly to my doctor and the office staff. I will inform my doctor about any medications (prescription and non-prescription) that I am taking. I will report any changes in my medical history, such as becoming pregnant.
5. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
6. I understand that my medication must be stored safely, where it cannot be stolen or taken accidentally by children or pets. If anyone else, including a child, takes my medication, I will call 911 or Poison Control at 1-800-222-1222 immediately.
7. I agree not to deal drugs, steal, or conduct any illegal or disruptive activities in or around the doctor's office.
8. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
9. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
10. I will be careful with my take-home prescription supplies of my medication. If I report that my supplies have been lost or stolen, my doctor may not provide me with a replacement supply.
11. I understand that every visit, my doctor may ask me to bring my unused supply of medication for a medication count and that I may not get a refill if I do not bring my medication with me.

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12. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
13. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
14. I understand that mixing this medication with other medications, especially benzodiazepines (for example, Valium, Klonopin, or Xanax), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in a higher than recommended therapeutic doses).
15. I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events.
16. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
17. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
18. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine).
19. I agree to provide random urine samples and have my doctor test my blood alcohol level.
20. I understand that violations of the above may be grounds for termination of treatment.

_____ _____

Patient Signature Date

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EXPLANATION OF FIRST VISIT

Your first visit is generally the longest and may last anywhere from 1 to 4 hours. When preparing for your first office visit, there are a couple of logistical issues you may want to consider:

- You may not want to return to work on the day of your visit—this is very normal, so just plan accordingly.
- Because the medication can cause drowsiness and slow reaction times, particularly during the first few weeks of treatment, you may want to make arrangements for a ride home.

It is very important to arrive for your first visit already experiencing moderate opioid withdrawal symptoms. If you are in withdrawal, the medicine is supposed to help lessen the symptoms. However, if you are *not* in withdrawal, the medicine will "override" the opioids already in your system, which will *cause* severe withdrawal symptoms.

The following guidelines are provided to **ensure you are in withdrawal for the visit.** (If this concerns you, it may help to schedule your first visit in the morning; some patients find it easiest to skip what would normally be their first dose of the day.)

- No methadone or long-acting painkillers for at least 24 hours.
- No heroin or short-acting painkillers for at least 4-6 hours.

Bring ALL medication bottles with you to your first appointment.

Before you can be seen by the doctor, all of the paperwork your doctor provided must be completed. If your doctor provided the paperwork to you prior to this visit, bring it completed or arrive about 30 minutes early to fill it out.

Urine drug screening is a regular procedure of treatment because it provides physicians with important insights into your health and your treatment. Your first visit will include urine drug screening and may also entail a Breathalyzer* test and blood work. If you haven't had a recent physical exam, your doctor may require one. To help ensure that this medicine is the best treatment option for you, your doctor will perform a substance dependence assessment and mental status evaluation. Lastly, you and your doctor will discuss the medicine and your expectations of treatment.

After this portion of your visit is completed, your doctor will administer your first dose. Your doctor may have you fill the prescription at the pharmacy and return to the doctor's office so you can take the medication under observation.

Once you take your first dose, you should begin to feel better within 30 minutes. Your doctor may choose to give you additional doses while you are in the office. It's important that you are honest about how you are feeling during induction[‡] so your doctor can find the appropriate dose for you.

*Breathalyzer is a registered trademark of Draegar Safety, Inc., Breathlyzer Division
[‡] SUBOXONE™ (buprenorphine and naloxone) Sublingual Film (CIII) is not indicated for induction

Selected Safety Information
Suboxone Film should not be used by patients hypersensitive to buprenorphine or naloxone, as serious adverse reactions, including anaphylactic shock have been reported.

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When you leave the office, the doctor will likely give you a prescription that will last until your next appointment. The doctor may also want to discuss counseling with you since medication plus counseling has been shown to produce better results. At the same time, your doctor may suggest enrolling in the Here to Help program, which can provide you with an added support system.

Your doctor may ask you to keep a record of any medications you take at home to control withdrawal symptoms. You will also receive instructions on how to contact your doctor in an emergency, as well as additional information about treatment.

CHECKLIST FOR FIRST VISIT:

- ✓ Arrive experiencing moderate opioid withdrawal symptoms
- ✓ Arrive prepared to give a urine sample for screening
- ✓ Bring completed forms (or come 30 minutes early)
- ✓ Bring ALL medications bottles
- ✓ Co-pay/fees due at time of visit (cast or check)

Please see your doctor or pharmacist for full Product Information for your medicine.

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Opioid Dependence Intake Information

In your own words, please explain the reason for your visit and when these problems began.

In your own opinion, how severe are these problems?

Mild Moderate Severe

Have you previously discussed these problems with anyone? If yes, who was this?

Briefly describe yourself.

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Please circle ALL words or phrases that apply to you

Difficulty Sleeping / Sad or Depressed / Chest Pain or Racing Heart / Confident
Uncontrollable Emotions / Suicidal Thoughts / Homicidal Thoughts / Nausea or Vomiting / Worrier
Low Energy / Racing Thoughts / Headaches / Dizziness / Shortness of Breath /Perfectionist
Increased Energy /Anxious/ Chills or Hot Flashes /Feeling Empty / Appetite Problems / Fearful
Nightmares or Flashbacks / Hallucinations / Stressed / Powerful / Reckless / Feeling Guilty / Helpless /
Hopeless / Forgetful / Goal-Oriented / Intelligent / Angry / Irritable / Physical Aggression / Outcast
Mistreated / Unorganized / Anxious / Worthless / Tense / Job Problems / Family Problems

Complete the following sentences.

I am _____

I feel _____

I think _____

I wish _____

My fears are _____

I get anxious when _____

I get angry when _____

I am able to calm down when _____

My hobbies are _____

I am interested in _____

If people know the "real me," they _____

Ridgewood Clinics

Krishan K. Gupta, M.D.
1059 Ridgewood Place
Jackson, MS 39211

(601)957-3211 (PHONE)
(601)957-9753 (FAX)
www.webpsychmd.com

Psychiatric History

Have you ever been treated by a mental health professional, such as a psychiatrist or counselor? If yes, please list names of providers, dates, and reason for treatment.

Have you ever been admitted to a psychiatric hospital? If yes, what hospitals and when?

Please list any past mental health treatments or medications, including ECT. Were these treatments helpful?

Have you ever been abused physically, emotionally, or sexually? If yes, at what age and by whom?

If your blood relatives have any of the following mental health diagnoses, please identify their relationship to the patient.

ADD/ADHD _____ Bipolar Disorder _____

Depression _____ Anxiety _____

Schizophrenia _____ Alcohol Abuse _____

Drug Abuse _____ PTSD _____

ODD _____

Any other emotional or behavioral problems _____

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Medical History

Primary Care Provider_____ Phone #_____

Date of last physical exam_____

HT._____ WT._____

Please list all other providers currently caring for you.

List **ALL** allergies (e.g., medications, foods, etc.).

Please list **ALL** current medications (i.e., all Prescribed, Over-the-Counter, Vitamins, or Herbal Supplements)

Please list any medical problems (e.g., high blood pressure, diabetes, etc.).

Please list any previous injuries and surgeries dates of these.

Describe your health during childhood and adolescence, including illnesses.

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Sleep History

Do you have problems with sleep? If yes, please explain.

Are you excessively tired or sleepy during the day?

Has anyone ever told you that you snore during sleep?

Have you ever had a sleep study?

Menstrual/Reproductive History (If Applicable)

Age at first period _____

Date of last period _____

Are your periods regular? Average # of Days _____

Does your mood changes with your period?

Have you ever been pregnant? If yes, how many times?

Have you ever had a miscarriage?

Have you ever had an abortion?

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Sexual History

Are you currently sexually active?

If yes, is your current sexual relationship satisfying?

Is your sexual preference male, female, or both?

Do you have one partner or multiple partners?

Do you have any concerns or problems related to sex or masturbation? For example, do you ever feel anxious or guilty?

Have you ever been told you had a sexually transmitted infection or disease? If yes, what?

Family Medical History

If your blood relatives have any of the following medical problems, please identify their relationship to the patient.

Diabetes _____ High Blood Pressure _____

Heart Disease _____ Thyroid Problems _____

Stomach Problems _____ Seizure Disorders _____

Other _____

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Drug and Alcohol Information

Do you use tobacco?

If yes, what kind of tobacco (e.g., cigarettes, cigars, or smokeless tobacco)?

How often? How much? When did you start?

Do you drink alcohol?

If yes, what kind of alcohol (e.g., beer, wine, or liquor)?

How often? How much? When did you start?

Do you use any other drugs?

If yes, what kind of drugs (e.g., marijuana, cocaine, prescription medications, etc.)?

How often? How much? When did you start?

In your opinion, is drug or alcohol use a problem for you?

Have you ever had personal or legal problems related to drug or alcohol use (e.g., DUIs, divorce, etc.)?

Do other people feel drug or alcohol use is a problem for you?

Have you ever been in treatment for drug or alcohol use (e.g., AA or a rehab facility)? If yes, please describe treatment and provide dates of treatment.

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Social and Developmental History

Childhood and Adolescence

Where were you born?

Were you adopted?

Do you know if your mother experienced any complications during pregnancy or childbirth?

Were you raised by your parents? If not, who raised you?

Briefly describe your childhood. For example, was this a happy time and how was your relationship with your family?

Describe your parents' relationship with each other.

Did you have step-parents? If yes, describe your relationship with them.

How were you and your siblings disciplined?

Circle any of the following that applied to you.

Bedwetting	Thumb-sucking	Nail-biting	Sleep-walking
Nightmares	Speech Problems	Fire-setting	

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Education

Did you enjoy school?

Did you make friends easily?

Were you ever bullied or teased?

How were you grades?

What type of classes were you in? For example, were you in special education or gifted classes?

Did you ever repeat any grades? If yes, which grades?

What were your strengths and weaknesses in school?

Did you graduate from high school? If not, what was the last grade you completed?

Did you attend or graduate from college? If yes, please provide details.

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Work/Income

Are you currently employed? If yes, describe your job. If not, what is your source of income?

Are you satisfied with your job?

What types of jobs have you had in the past?

Is your current income enough to meet your needs?

Do you have any financial problems?

What were your past professional goals?

What are your current professional goals?

Environment

Who do you currently live with? Please list all household members and their relationship to you.

Describe your current residence (e.g., house, apartment, hotel, etc.).

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Intimate Relationships

What is your current relationship status?

Single Married Engaged Divorced Separated

Widowed Remarried Other_____

If you are in a committed relationship, how long have you been together?

Have you been married more than once? If yes, please provide dates of marriages and length of time you stayed married.

If divorced, how many times and for what reason?

Briefly describe your relationship with your spouse or partner.

How would your spouse or partner describe you?

What is your partner's occupation?

Do you get along with your partner's family?

Has anyone else interfered in your relationship or your family affairs?

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Family Relationships

Mother

Is she living or deceased? If deceased, what was her cause of death and how old were you at that time?

What was her occupation?

How was her health?

Describe her personality and attitude towards you.

Describe your current relationship.

Father

Is he living or deceased? If deceased, what was his cause of death and how old were you at that time?

What was his occupation?

How was his health?

Describe his personality and attitude towards you.

Describe your current relationship.

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Siblings

Please list names and ages of your siblings.

Describe your current relationship with your siblings.

Children

If you have children, please list each child's gender, age, and identify any specific problems.

If you have children, describe your current relationship with them.

Friendships

Do you have any close friends?

Do you make friends easily?

Do you maintain friendships over time?

Describe your relationships with friends.

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Legal

Have you ever had any legal problems? If yes, please explain.

Have you have been arrested? If yes, please explain.

Religious Background

What is your current religious preference?

Did you grow up with these religious beliefs or have they changed?

Treatment Plan

What are your goals for treatment at Ridgewood Clinics?

Is there any additional information you would like us to know?