Psychiatric Patient Practices and Consent

Welcome to Creekside Counseling. In anticipation of your upcoming appointment, I'd like to provide you with information regarding patient practices that I maintain. Please review the following and sign, indicating your understanding and consent to the following as a patient under my care.

Emergency or Crisis

If there is an emergency, or if you feel you are having a safety crisis, I advise you to **call 911** and or go to the emergency department of the closest hospital. Another resource is the Behavioral Health Crisis Center of East Idaho, located at 1650 N Holmes Ave, Idaho Falls (on the corner of Holmes and Anderson).

Communication

You may contact me at 208-529-5777. Please leave a detailed message with my office staff who will communicate your message to me. I will do my best to respond to calls within 24-48 hours. If you have a non-urgent issue occurring after office hours, you may call the office at the above number and leave a recorded message. Recorded messages will be reviewed and addressed on the following regular office day. Again, if you feel that your issue is urgent, an emergency or crisis, call 911 or go to your nearest emergency room, or the crisis center.

Prescription Refills

When you need a refill: contact your pharmacy. Your pharmacy will send a refill request to my office. Medications will not be refilled for patients who have not attended follow up appointments as directed.

Prescription refills are not an emergency. It is your responsibility to follow your medications closely and contact your pharmacy with enough notice for your refill to be processed without running out of the medication. Refills will be addressed as soon as possible, during regular business hours only, but may take up to 2-3 business days. Refill requests are not processed after 5PM, or on weekends, holidays, days the office is closed or days that I am not in the office.

Refills will be considered only for established patients who have been seen by the prescribing provider within the last 6-12 months; however, some conditions and medications require more frequent evaluation, such as every 1 to 3 months. For safety reasons, certain prescriptions may require an office visit in order to be refilled; in those cases, you will be contacted to schedule an appointment.

E-Prescribing and Prescription Record History Consent

To prescribe safely and conveniently, I utilize an electronic prescribing system to send your prescriptions and communicate with your pharmacy. This system may also communicate with your Pharmacy Benefits Manager (PBM: a third-party administrator used by companies and insurances to process and pay prescription drug claims). In order to prescribe to you safely, it is important that I am aware of any and all medications currently being prescribed to you by reviewing your prescription drug history.

Patients Who Currently Take or Anticipate Taking Controlled Substances

(Such as medications for pain, sleep, anxiety, and/or ADHD)

It is my policy to obtain prescription records from pharmacies, and required by law to review your history of controlled substance usage through the Idaho Prescription Monitoring Program, or through the controlled substance databases in states where you have resided.

I do not prescribe opiate or pain medications.

Documentation

If you require paperwork to be filled out regarding your psychiatric treatment, there may be a charge for completing the documentation, depending on the time involved

Please sign below indicating you have read, understand, agree and consent to the above

Print Patient Name | Print Guardian Name (if Applicable) | Patient/Guardian Signature | Date

PSYCHIATRIC INTAKE INFORMATION

PLEASE DESCRIBE THE PROBLEM(S) WHICH HAVE LED YOU TO SEEK TREATMENT OR EVALUATION TODAY:
PLEASE INDICATE ANY PSYCHIATRIC DIAGNOSES THAT YOU HAVE RECEIVED OR BELIEVE YOU MAY BE STRUGGLING FROM:
☐DEPRESSION ☐ BIPOLAR DISORDER ☐ PSYCHOTIC DISORDER ☐ ADHD ☐ PERSONALITY DISORDER ☐ AUTISM ☐ IMPULSE CONTROL
☐ ANXIETY ☐ OCD ☐ PTSD ☐ HAIR PULLING/SKIN PICKING ☐ EATING DISORDER ☐ SUBSTANCE USE ☐ OTHER:

MEDICATIONS: PLEASE CIRCLE THE NAME OF ANY OF THE MEDICATION LISTED BELOW THAT HAS BEEN PRESCRIBED TO YOU:

ANTIDEPRESSANTS		MOOD STABILIZERS	ANTI-ANXIETY	SLEEPING AGENTS	STIMULANTS/ADHD	OTHERS
PROZAC	VIIBRYD	LITHIUM	XANAX	AMBIEN	RITALIN	RISPERDAL
ZOLOFT	FETZIMA	DEPAKOTE	KLONOPIN	SONATA	ADDERALL	INVEGA
PAXIL	TRINTELLIX	TEGRETOL	ATIVAN	TRAZODONE	VYVANSE	ZYPREXA
CELEXA	SERZONE	LAMICTAL	VALIUM	LUNESTA	CONCERTA	GEODON
LEXAPRO	WELLBUTRIN	NEURONTIN	TRANXENE	RESTORIL	PROVIGIL	SEROQUEL
LUVOX	AMITRIPTYLINE	TOPAMAX	LIBRIUM	HALCION	NUVIGIL	ABILIFY
EFFEXOR	NORTRIPTYLINE	GABAPENTIN	BUSPAR	ROZEREM	STRATTERA	IATUDA
PRISTIQ	DESIPRAMINE	TRILEPTAL	PROPRANOLOL	BELSOMRA	CLONIDINE	VRAYLAR
REMERON	CLOMIPRAMINE	LYRICA			INTUNIV/GUANFACINE	CAPLYTA
CYMBALTA					QELBREE	HALDOL
						THORAZINE
OTHER:		**OTHER:**	**OTHER:**	**OTHER:**		CLOZAPINE
					OTHER:	ANTABUSE
						NALTREXONE

SUBSTANCE USE/ABUSE

ALCOHOL	DRUGS	TOBACCO	CAFFEINE
Do you drink alcohol? ☐ No, I have never drunk. ☐ Yes, in the past. ☐ Yes, now. ☐OCCASIONALLY ____X/MONTH ☐ I drink___ days/week ☐ I quit years ago ☐ I, or significant others, believe I have, or have had, a drinking problem.	Have you ever used illicit drugs or misused prescription drugs? ☐ Never ☐ Yes, in the past. ☐ Yes, now. Date of last Use: If yes, what drugs and ages with use:	DO YOU USE TOBACCO PRODUCTS? ☐ NEVER ☐ YES, IN THE PAST. ☐ YES, NOW. TYPE: _____ HOW MUCH PER DAY? _____	DO YOU DRINK SODA, COFFEE, ENERGY DRINKS, OR TEA? ☐ I DO NOT DRINK CAFFEINE. ☐ I DRINK _____ COFFEE/DAY. ☐ I DRINK _____ SODA/DAY. ☐ I DRINK _____ ENERGY/DAY. ☐ I DRINK _____ TEA/DAY.

PRINT PATIENT/YOUR NAME: _____

CREEKSIDE COUNSELING

PSYCHIATRIC INTAKE INFORMATION

MEDICAL HISTORY

WHAT LOCAL PHARMACY DO YOU WANT YOUR PRESCRIPTIONS SENT TO/DO YOU FILL AT? _____

☐ I HAVE NO KNOWN DRUG ALLERGIES ☐ I HAVE DRUG ALLERGIES TO:

☐ MY PRIMARY CARE PROVIDER IS: ☐ I DO NOT HAVE A PRIMARY CARE PROVIDER	LAST PHYSICAL

PAST/PRESENT MEDICAL CONDITIONS AND Surgeries:

DO YOU OR HAVE YOU HAD ANY PROBLEMS WITH: (IF SO, DESCRIBE ↓)

☐	DIZZINESS/BALANCE		☐	NEUROLOGIC
☐	HEADACHE		☐	REPRODUCTIVE
☐	EAR/NOSE/THROAT		☐	MUSCLE/BONE/JOINT
☐	HEART		☐	SKIN
☐	RESPIRATORY		☐	BLOOD/IMMUNE SYSTEM
☐	GASTROINTESTINAL		☐	PAIN
☐	URINARY		☐	OTHER

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:

☐	SEIZURES
☐	HEAD TRAUMA
☐	LOSS OF CONSCIOUSNESS
☐	AMNESIA
☐	OTHER PERTINENT ISSUE:

FOR FEMALE PATIENTS ONLY (PLEASE COMPLETE ALL APPLICABLE)

☐	POST-MENOPAUSAL	AGE AT ONSET OF MENSTRUATION:
☐	HYSTERECTOMY	DATE OF LAST MENSTRUAL CYCLE / /
☐	PREGNANT	
METHOD OF BIRTH CONTROL?		DATE OF LAST PELVIC/PAP EXAM: / /

CURRENT MEDICATIONS

(ALL MEDICATIONS USED IN LAST 3 MONTHS INCLUDING PRESCRIBED, OTC, HERBS, VITAMINS, ETC. ATTACH ADDITIONAL SHEETS IF NEEDED)

MEDICATION	DOSE	TIME(S) TAKEN	WHAT CONDITION IS THIS MEDICATION FOR?	PRESCRIBER

FAMILY MEDICAL HISTORY

RELATIVES WITH: ☐ **HIGH BLOOD PRESSURE** ☐ **HIGH CHOLESTEROL** ☐ **STROKE** ☐ **HEART ATTACK** ☐ **OTHER CARDIAC:**
☐ **DIABETES** ☐ **THYROID PROBLEMS** ☐ **CANCER** ☐ **NEUROLOGIC DISORDERS** ☐ **OTHER:**

FAMILY PSYCHIATRIC HISTORY: PLEASE IDENTIFY ANY PSYCHIATRIC PROBLEMS IN YOUR BIOLOGICAL RELATIVES, SUCH AS DEPRESSION, BIPOLAR (MANIC-DEPRESSION), PANIC, ANXIETY, PTSD, SCHIZOPHRENIA, ADD/ADHD, ALCOHOL OR DRUG ABUSE, ANGER, SUICIDE

RELATIVE	YES	NO	UNSURE	TYPE OF PROBLEM
MOTHER	☐	☐	☐	
MOTHER'S PARENTS AND SIBLINGS	☐	☐	☐	
FATHER	☐	☐	☐	
FATHER'S PARENTS AND SIBLINGS	☐	☐	☐	
YOUR SIBLINGS	☐	☐	☐	
YOUR CHILDREN	☐	☐	☐	

PRINT PATIENT/YOUR NAME: _____