General Information

WELCOME TO OUR PRACTICE

Thank you for scheduling your appointment with our provider. We look forward to meeting you!

GENERAL INFORMATION

Please arrive 15 minutes prior to the first appointment with your paperwork completely filled out (prior to your arrival in-person or virtually), along with your insurance card(s) and any other paperwork requested by our office.

It is our office policy that you provide us with payment in full at the time of each visit. Please contact our office in advance of your appointment to be told the exact amount you will need to pay at the time of your visit.

Please read and complete all forms!

→You will need to bring in:

1. Mental Health Intake questionnaire - FULLY COMPLETED
2. Return all other forms in this packet, signed and initialed.
3. A CLEAR copy of the FRONT and BACK of your driver's license or state ID for your appointment.

→It is your responsibility to contact your insurance company for reimbursement of treatment services.

→Ask for the "Insurance Claim Mailing Address" to submit your health claims.

You may also e-mail your completed packet to **marcelluswellness1@gmail.com**.

OFFICE POLICIES

APPOINTMENTS

Patients are seen only by appointment. Before you first visit in-person or virtually, please complete all of the forms which have been sent to you and be sure to bring them with you to your first appointment or emailed to the office.

This will allow the office staff and the providers to serve you in the most time efficient manner possible. If this information cannot be completed prior to your appointment, please arrive one hour early in order to complete the forms in-person. If they are already complete, please arrive 15 minutes before your first appointment so that the staff can prepare your chart.

Upon arrival at the office for any appointment, always check in with the receptionist as the staff will inform the providers you arrived.

PRESCRIPTION REFILL POLICY

During your appointment, your provider will write a prescription. Ensure you have an appointment with your provider for a medication refill follow-up at least two weeks before your medication runs out. At the time of your appointment, your provider will review your medications and write for appropriate refill. Medication refills will not be authorized over the phone or by fax.

Please verify the pharmacy we have on record is correct. Patients are asked to respect the privacy and time concerns of patients who have appointments. In consideration of both patients and providers, patients are reminded not to walk in to the office to request a prescription refill. All controlled substances require a monthly appointment.

CANCELLATIONS / MISSED APPOINTMENTS:
When you schedule an appointment, that time is reserved specifically for you. Appointment reminder sheets are printed on your check-out sheet whenever subsequent appointments are scheduled at the office. It is the patient's responsibility to remember and keep scheduled appointments. A minimum of 24 hours' notice is required for canceling or re-scheduling an appointment. *You will be charged $125 for missed appointments and appointments which are canceled with less than 24 hours' notice.*

DISCHARGE:
Failure to adhere to provider's treatment guidelines and recommendations will lead to discharge from practice.

FINANCIAL RESPONSIBLITY:
• Payments are due at time of service (in-person cash or credit card and virtually by credit card).

PAYMENT:
Payments are collected prior to your appointment. Payment in full is required and must be paid prior to your appointment at the time of check-in. We are happy to provide you with a HCFA 1500 form so you can submit a claim to your insurance company. Payment by your insurance company is not guaranteed. It is to be understood if your claim is denied or full payment is not reimbursed back to you; that Marcellus Wellness & Addiction Services or any provider in the practice assumes no responsibility.

CONFIDENTIALITY AND RELEASE OF INFORMATION
Information disclosed within sessions and the written records pertaining to those sessions are confidential and will not be released to anyone without the written consent of the patient or the parent/guardian, except where Marcellus Wellness & Addiction Services or any provider is mandated by the state law to report otherwise confidential information. Circumstances which are required by law to be reported are:

1. Patients who pose an imminent threat of danger to themselves or others.
2. Instances of suspected abuse or neglect of a child (physical, sexual and/or emotional abuse).
3. Instances of suspected abuse or neglect of a dependent adult.

Disclosure may also be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony from Marcellus Wellness & Addiction Services or any provider. Providers will use their clinical judgment when revealing such information.

Disclosure of confidential information may be required by your health insurance carrier, in order to process your claims. Only the minimum necessary information will be communicated to the carrier. Providers have no knowledge or control over what insurance companies do with the information submitted and assumes no responsibility for any actions which result from a third party misusing or re-releasing such information without his expressed consent.

As a patient, you have the right to review or receive a summary of your records at any time (with notice of 10 or more working days), except in limited legal or emergency circumstances or when Marcellus Wellness & Addiction Services assesses that releasing such information might be harmful in any way. In such circumstances Wellness & Addiction Services may provide the records to a qualified mental health professional of your choice and that individual may then choose to review the information with you if it is deemed clinically appropriate. You will be charged an appropriate fee for any preparation time which is required to comply with an information request. All other requests to release information regarding your treatment and your condition must be authorized in writing specifically allowing the release of health/psychiatric records. Wellness & Addiction Services will provide you with a Release of Information form or you may choose to place your request in writing. There will be no charge for releasing records to other treating medical or mental health professionals. For all other requests to copy records, there will be a minimum charge of $25.00 to cover the expenses of photocopying, postage and handling.

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Patient Registration

Are these services Court ordered? ❑ Yes ❑ NO

PATIENT INFORMATION

❑ New Patient ❑ Information

Patient Name: _____ Social Security #: _____

Date of Birth: _____ Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Other

Address: _____ City: _____ States: _____ Zip: _____

Email Address: _____

Primary Contact Phone: _____ Secondary Phone: _____

Employer: _____ Occupation: _____

Work Address: _____ City: _____ States: _____ Zip: _____

Education Level: _____ Highest Grade Completed: _____

Race: ❑ Asian ❑ Black ❑ Native American ❑ White ❑ More than one race Preferred Language _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Smoking Status: Current Smoker ❑ Yes ❑ No History of Smoking: ❑ Yes ❑ No Stop Date: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician: _____ Driver's License #: _____

SPOUSE/ PARTNER INFORMATION (If relevant)

Spouse/Partner Name: _____

Date of Birth: _____ Sex: ❑ Male ❑ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

PHARMACY INFORMATION (Please fill out completely with correct address and phone number)

Pharmacy Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy Phone: _____ Pharmacy Fax: _____ Mail Order Pharmacy Phone: _____

265 Sunrise HWY. STE. 1-726
Rockville Centre, NY 11570

Phone: 516-728-0672
Fax: 929-810-3383

Marcelluswellness1@gmail.com

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Continuation of the Patient Registration

FINANCIAL RESPONSIBILITY

Responsible Party: _____ Social Security #: _____

Relationship to Subscriber: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

INSURANCE INFORMATION (not billable for opioid, alcohol, ADHD, anxiety & depression disorders)

Primary Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber ID #: _____ Group#: _____

Claim Mailing Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber ID #: _____ Group#: _____

Claim Mailing Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____

SIGNATURE and DATE

Patient or Responsible Party (Print): _____

Patient or Responsible Party (Sign): _____

Date: _____

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BUPRENORPHINE TREATMENT AGREEMENT

I am requesting that my doctor provide buprenorphine treatment for opioid _____ addiction.
I freely and voluntarily agree to accept this treatment agreement, as follows:

1. I agree to keep, and be on time to, all my scheduled appointments with the doctor and his assistant.
2. I agree to conduct myself in a courteous manner in the physician's office or virtually.
3. I agree to pay all office fees for this treatment at the time of my visits. I will be given a receipt that I can use to get reimbursement from my insurance company if this treatment is a covered service. I understand the medication cost may vary depending of pharmacy, insurance or cash price. The office visits are a separate charge.
4. I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not see me and I will not be given any medication until my next scheduled appointment.
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 recourse for appeal.
6. I understand that the use of buprenorphine/naloxone (Suboxone) by someone who is addicted to opioids could cause them to experience severe withdrawal.
7. I agree not to deal, steal, or conduct any other illegal or disruptive activities in or in the vicinity of the doctor's office.
8. I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.
9. I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.
10. I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines, such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), and/or other drugs of abuse including alcohol, can be dangerous. I also understand that a number of deaths have been reported in persons mixing buprenorphine with benzodiazepines.
11. I agree to take my medication as the doctor, and his assistant has instructed, and not to alter the way I take my medication without first consulting the doctor.
12. I understand that medication alone is not sufficient treatment for the disease and I agree to participate in the recommended patient education and relapse prevention program, to assist me in my treatment per physician's referral.
13. I understand that my buprenorphine treatment may be discontinued and I may be discharged from the practice if I violate this agreement.
14. I understand that there are alternatives to buprenorphine treatment for opioid addiction including:
    a. Medical withdrawal and drug-free treatment
    b. Naltrexone treatment
    c. Methadone treatment

My provider will discuss these with me and provide a referral if I request this.
My signature below signifies that I have read, understood, and agree to the above terms of the office policies.

Patient Name (Printed): _____ Date: _____
Patient Signature: _____ Witness Signature: _____ Date: _____

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TELEPHONE APPOINTMENT REMINDER CONSENT

I _____ give Marcellus Wellness & Addiction Services and members of his staff
Patient Name (print)
working at the location indicated below, my permission to call or text me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):

☐ Home _____
May we leave voicemail? ☐ Yes ☐ No

☐ Work _____
May we leave voicemail? ☐ Yes ☐ No

☐ Cell _____
May we leave voicemail? ☐ Yes ☐ No

Yes, this office may leave (check all that apply):

☐ Messages with _____at my Home

☐ Messages with _____at my Work

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated by the physician practice specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician practice specified above is otherwise notified by me.

Patient Name (printed): _____

Patient Signature: _____

Date: _____

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SUBOXONE NEW PATIENT

Patient Name: _____ Date of Birth: _____ Date: _____

Reason for seeking treatment:

Substance: _____ How Long Using: _____

How Much: _____ How Often: _____

Has your drug use ever result in medical or legal problems? ❑ Yes ❑ No

Have you ever been treated for substance dependence or misuse (e.g. detoxification program)? ❑ Yes ❑ No
Please describe setting, length: _____
_____
_____

Have you ever tried to quit on your own? ❑ Yes ❑ No Please Describe: _____
_____
_____

Have you ever been treated by a psychiatrist? ❑ Yes ❑ No Please describe treatment, setting and length: _____
_____
_____
_____

Does anyone in your family (mother, father, bother/sister, child, aunt/uncle or grandparents) have a history of Substance abuse?
❑ Yes ❑ No _____
_____

Do have any medical conditions (diabetes, HIV +, epilepsy, STD's)? ❑ Yes ❑ No _____
_____

Are you currently taking any medication to treat these conditions? ❑ Yes ❑ No List medication and dosage: _____
_____
_____

Are you pregnant? ❑ N/A ❑ Yes ❑ No ❑ Not Sure
Are there any current legal issues we should be aware of (probation, parole)? ❑ Yes ❑ No

Are you currently employed? ❑ Yes ❑ No How many hours per week on average? _____

Please describe your living arrangement: _____

Is there anything else you would like us to know? _____
_____
_____

Patient Name (printed): _____
Patient Signature: _____
Date: _____

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AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of PHI on the above named individual which may contain medical, mental health, or substance abuse history and treatment information.

Name of organization or individual authorized to disclose the information:

Name: Relationship: _____

Name: Relationship: _____

Are there any restrictions on PHI to be disclosed? ❑ Yes ❑ No
_____ No one other than myself may have access to my medical records:

May our office leave a message on your answering machine? ❑ Yes ❑ No

I consent to the use or disclosure of my protected health information by Marcellus Wellness & Addiction Services for the purposes of diagnosis of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Marcellus Wellness & Addiction Services. I understand that diagnosis or treatment of me by Marcellus Wellness & Addiction Services may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information (PHI) is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Marcellus Wellness & Addiction Services is not required to agree to the restrictions that I may request. However, if Marcellus Wellness & Addiction Services agrees to restriction that I request, the restriction is binding on Marcellus Wellness & Addiction Services I have the right to revoke this consent, in writing, at any time, except to the extent that Marcellus Wellness & Addiction Services has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This PHI relates to my past, present or future physical or mental condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that the "Notice of Privacy Practices" describes how Marcellus Wellness & Addiction Services may disclose and use my protected health information (PHI).

I am encouraged to read the "Notice of Privacy Practices" in full.

Signature: _____ Date: _____
(Patient Signature or Authorized Representative and relationship)

Printed Name: _____

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HIPAA INFORMATION and CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This is a read "friendly" version. A complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

(Patient Signature or Authorized Representative and relationship)

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Printed Name: _____

MENTAL HEALTH INTAKE FORM

Patient Name: _____ Date of Birth: _____

Primary Care Physician _____

Do you give permission for ongoing regular updates to be provided to your primary care physician? ❑ Yes ❑ No

Current Therapist/Counselor: _____ Therapist's Phone: _____
Referred by: _____

What are the problem(s) for which you are seeking help?
1. _____
2. _____
3. _____

What are your treatment goals? _____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

❑ Depressed mood
❑ Unable to enjoy activities
❑ Loss of interest
❑ Concentration/forgetfulness
❑ Increase in appetite
❑ Decrease in appetite
❑ Excessive guilt
❑ Fatigue
❑ Racing thoughts
❑ Increased libido
❑ Decreased libido
❑ Impulsivity
❑ Increased risky behavior
❑ Decreased need for sleep
❑ Increased need for sleep
❑ Excessive energy
❑ Increased Irritability
❑ Crying spells
❑ Excessive worry
❑ Anxiety attacks
❑Avoidance
❑ Hallucinations
❑Suspiciousness
❑ _____
❑ _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ❑ Yes ❑ No. If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you don't want to live? ❑ Yes ❑No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (10 being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____
_____
_____

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Past Medical History:

Medication Allergies: ❑ Mild ❑ Moderate ❑ Severe
Current Weight: _____ Height: _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements: _____
_____

Current medical problems: _____
Past medical problems, non-psychiatric hospitalization, or surgeries: _____
_____

Have you ever had an EKG? ❑ Yes ❑ No If yes, when: _____
Was the EKG? ❑ Normal ❑ Abnormal ❑ Unknown

For women only:

Date of last menstrual period: _____

Are you currently pregnant or do you think you might be pregnant? ❑ Yes ❑ No

Are you planning to get pregnant in the near future? ❑ Yes ❑ No

Birth control method: _____ How many times have you been pregnant? _____

How many live births? _____ How many miscarriages/D& C? _____

Do you have any concerns about your physical health that you would like to discuss with us? ❑ Yes ❑ No

Date and place of last physical exam: _____

Is there any additional personal or family medical history? ❑ Yes ❑ No If yes, please explain: _____
_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth? _____

Past Psychiatric History:

Outpatient treatment: ❑ Yes ❑ No If yes, please describe when, by whom, and nature of treatment: _____
_____

Psychiatric Hospitalization: ❑ Yes ❑ No If yes, describe for what reason, when and where: _____

_____

_____

Personal and Family Medical History: (place a check in the "you or family box)

Type of Disease	You	Family	Which Family Member?
Anemia			
Asthma/Respiratory Problems			
Cancer (type)			
Chronic Pain			
Diabetes			
Epilepsy (seizures)			
Fibromyalgia			
Head Trauma			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Liver Disease			
Liver Problems			
Stomach Problems			
Thyroid Disease			
Other			

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember)

Antidepressants Medications	Dates	Dosages	Response/Side-Effects
Anafranil (clomipramine)			
Antidepressants			
Celexa (citalopram)			
Cymbalta (duloxetine)			
Effexor (venlataxine)			
Elavil (amitriptyline)			
Fetzima			
Lexapro (escalopram)			
Pamelor (nortrptyline)			
Paxil (paroxetine)			
Prisiq			
Prozac (fluoxetine)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Trazodone (destrel)			
Trofranil (imipramine)			
Vilbrd			
Wellbutrin (bupropion)			
Zoloft (sertraline)			
Other			

Mood Stabilizer Medications	Dates	Dosages	Response/Side-Effects
Depakote (valproate)			
Invega			
Lamictal (lamotrigine)			
Latuda			
Lithium			
Tegretol (carbamazepine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			

Antipsychotic/Mood Stabilizer Medications	Dates	Dosages	Response/Side-Effects
Abilify (aripiprazole)			
Clozaril (clozapine)			
Geodon (ziprasidone)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Seroquel (quetiapine)			
Zyprexa (olanzapine)			
Other			

Sedative/Hypnotic Medications	Dates	Dosages	Response/Side-Effects
Ambien (zolpidem)			
Restoril (temazepam)			
Rozerem (ramelteon)			
Sonata (zaleplon)			
Other			

ADHD Medications	Dates	Dosages	Response/Side-Effects
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Vyvanse			
Other			

Anti-Anxiety Medications	Dates	Dosages	Response/Side-Effects
Ativan (lorazepam)			
Buspar (buspirone)			
Klonopin (clonazepam)			
Tranxene (clorazepate)			
Valium (diazepam)			
Xanax (alprazolam)			

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You're Exercise Level:

Do you exercise regularly? ❑ Yes ❑ No
How many days a week do you get exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

Has anyone in your family been diagnosed with or treated for: (place a check in the "you or family box)

Type of Disease	You	Family	Which Family Member?
Alcohol Abuse			
Anger			
Anxiety			
Bipolar Disorder			
Depression			
Post-Traumatic Stress			
Schizophrenia			
Suicide			
Violence			
Other Substance Abuse			

Has any family member been treated with a psychiatric medication? ❑ Yes ❑ No
If yes, who was treated, what medications did they take, and how effective was the treatment? _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ❑ Yes ❑ No
If yes, for which substances? _____
If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____What is the most? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ❑ Yes ❑ No

Have people annoyed you by criticizing you're drinking or drug use? ❑ Yes ❑ No

Have you ever felt bad or guilty about your drinking or drug use? ❑ Yes ❑ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?
❑ Yes ❑ No

Do you think you may have a problem with alcohol or drug use? ❑ Yes ❑ No

Have you used any street drugs in the past 3 months? ❑ Yes ❑ No If yes, which ones? _____

Have you ever abused prescription medication? ❑ Yes ❑ No If yes, which ones and for how long? _____

Drug Use	Yes	No	If yes, how long and when did you last use?
Alcohol			
Cocaine			
Ecstasy			
Heroin			
LSD or Hallucinogens			
Marijuana			
Methadone			
Methamphetamine			
Pain Killer (not as prescribed)			
Tranquilizer/Sleep Pills			
Other			

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How many packs per day on average? _____ How many years? _____
In the past? ❑ Yes ❑ No How many years did you smoke? _____ When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? ❑ Yes ❑ No In the past? ❑ Yes ❑ No
What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? ❑ Yes ❑ No Where did you grow up? _____
List your siblings and their ages: _____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents' divorce? ❑ Yes ❑ No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with? _____
Describe your father and your relationship with him: _____
Describe your mother and your relationship with her: _____
How old were you when you left home? _____
Has anyone in your immediate family died? _____ Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ❑ Yes ❑ No
Please describe when, where and by whom: _____
_____
_____
_____
_____
_____

265 Sunrise HWY. STE. 1-726
Rockville Centre, NY 11570

Phone: 516-728-0672
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Marcelluswellness1@gmail.com

Educational History:

Highest level of education completed? _____Where: _____
Did you attend college? ❑ Yes ❑ No Where: _____
Are you currently: ❑ Working ❑ Student ❑ Unemployed ❑ Disabled ❑ Retired
How long in present position? _____What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? ❑ Yes ❑ No If so, what branch and when? _____
Honorable discharge: ❑ Yes ❑ No Other type discharge: _____

Relationship History and Current Family:

Are you currently: ❑ Married ❑ Partnered ❑ Divorced ❑ Single ❑ Widowed How long? _____
If not married, are you currently in a relationship? ❑ Yes ❑ No If yes, how long? _____
Are you sexually active? ❑ Yes ❑ No
How would you identify your sexual orientation? ❑ Straight/Heterosexual ❑ Lesbian/Gay/Homosexual ❑ Bisexual
❑ Transsexual ❑ Unsure/Questioning ❑ Asexual ❑ Other ❑ Prefer not to answer

What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other: _____
Have you had any prior marriages? ❑ Yes ❑ No If so, how many? _____ How long? _____
Do you have children? ❑ Yes ❑ No If yes, list ages and gender: _____
Describe your relationship with your children: _____
List everyone who currently lives with you: _____
_____
_____

Legal History:

Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ❑ Yes ❑ No
If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ❑ More helpful ❑ Stressful

Is there anything else that you would like us to know? _____
_____
_____

Signature: _____ Date: _____
(Patient Signature or Authorized Representative and relationship)

Printed Name: _____

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