Memorial Psychiatry
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Welcome to Memorial Psychiatry! Please read this letter in its entirety, as it contains a lot of important information.

To make the best use of your appointment time, we require that you complete new patient paperwork prior to your appointment. A physical copy of the paperwork is included with this letter. It will also be sent to you electronically as part of the pre-registration process through MyChart if you prefer to fill out paperwork that way. You do not need to fill out the physical paperwork if you complete it through the electronic pre-registration process through MyChart.

If you do not complete your paperwork through MyChart prior to the time your appointment starts OR you do not have your completed physical paperwork ready to hand over at the time of your appointment, you must arrive at least 15 minutes before your appointment starts or your new patient visit will be rescheduled. The paperwork can take some time to complete, so we recommend arriving 30 minutes early to maximize how much time is available to meet with the psychiatrist.

We have also attached a copy of our current office policies and procedures for you to review. In addition, children are not permitted at appointment due to the sensitive nature of topics discussed. If you bring your child, you will be required to reschedule.

If you have any questions about the paperwork or need assistance filling it out, please contact our office at 937-578-4301.

We look forward to seeing you at your new patient appointment scheduled with Dr. Erica Holbrook on _____ at ___:_____ am/pm. Please remember to arrive 15 minutes early with completed paperwork in hand so that you are ready to be seen at your scheduled appointment time.

Thank you,
Memorial Psychiatry

PATIENT EDUCATION

Welcome to Your Memorial Medical Group Practice

Welcome to your medical home with Memorial Health, where we strive to provide best-in-class, compassionate care! Below is key patient/provider information that will help us meet your needs.

1. Arriving for your appointment

As we strive to keep our schedules running smoothly and on-time, we do have a policy that supports the provider requesting an appointment to be rescheduled if past the allowed "late" arrival time. Please discuss with your practice or provider what the allowed time is for their practice. If you are running late, it would best for you to call ahead to determine if you can still be seen.

2. No Show/late cancellations

- At Memorial, we want to be able to provide access to care for our patients, that is why it is vital to know in advance if a patient is unable to make an appointment they have scheduled. It allows us to use that spot to meet the needs of another patient.
- For **new patients,** our policy allows for two missed new patient appointments. For **established patients,** our policy allows for up to three No Shows in a rolling 12-month period, as we do understand life happens. You will receive a letter after the first and second No Shows reminding you of our policy. If you reach a third No Show, you may be dismissed from our practice.
- A "No Show" is when a patient **does not give an advanced 24-hour notice** of not being able to keep an appointment.

3. Pain/anxiety/stimulant medications

- If you are prescribed/take any controlled medications (pain, anxiety and/or stimulant medications), please note given the strict guidelines and expectations of the State Board of Pharmacy and State Medical Board of Ohio, our providers may choose to refer you to other specialists to manage those medications.
- Prescriptions for any controlled substances will only be considered after an initial assessment and a review of your medical history, as well as completion of additional testing, as necessary.
- If our providers prescribe these medications for you, there will be an agreement you must **read thoroughly and sign annually.** The agreement includes your understanding that random testing is required to ensure compliance with state/federal regulations. Testing for this may not be covered by your insurance so there may be an out-of-pocket cost to you.

4. Paperwork/forms completion

We are happy to complete any paperwork or forms that do not accompany an office visit. Please provide our team with seven days for completion. There is a $25 fee for this service that must be paid when the forms are dropped off. Forms can be sent directly to your employer, if preferred.

5. Insurance Co-Pays and Account Payments

- When you come in for any of your visits within Memorial, you will be asked to pay any co-pays required by your insurance company, in addition to paying on your outstanding balances.
- Memorial will bill your insurance company for payment of any services provided. As the patient, you will be responsible for anything not covered by your insurance. Memorial provides several options for making payments – payments can be made within MyChart, via phone, at the Cashier at Memorial Hospital, or by mail. Our team can also accept payments for Memorial Medical Group services at any of our offices.

Please see back side for more information.

6. Consent for minors – two different options

- Our team can provide "Consent to Treat Minor Children" forms for completion. These consent forms are valid indefinitely, unless revoked by a parent/guardian.
- For minors 16-17 years old: he/she can be seen by the provider alone, with a completed written consent form from a parent or legal guardian.
- For any minor under 16, or a minor not allowed to be seen by themselves: If anyone other than a parent or legal guardian will bring a minor to an appointment, we must have a specific consent designating another person to consent to treatment.

7. Physical/wellness exams

See the attached sheet about Physical Exams – you will be required to sign this form each time you have an appointment for a physical. Most physicals are covered by insurance, however, if other needs arise there could be a copay associated or a separate visit may be needed.

8. Patient-ordered labs

At Memorial, we have a great program for our patients who may have high deductible plans or may want to keep a close eye on certain lab work. We have a list of labs that do not require an order from your provider and can be done with a small self-pay fee paid at the time of the blood draw. The results can be mailed to you directly and/or faxed to your provider's office. We do request a copy be sent to your practice so that we can maintain an accurate medical record for our patients. Once scanned into your record, you can see them in MyChart, too.

9. After-hours on-call options

All of our non-hospital based outpatient offices, with the exception of Psychiatry, have an on-call service for after-hour concerns. You can simply call the office number, and it will provide you with options depending on what the needs/concerns are and the urgency of the issue.

10. Patient experience

When you are seen for a visit at a Memorial office, you may receive a survey to complete, regarding how your interactions before, during, and after your visit were managed. We know the survey can seem long, but we truly appreciate all your feedback. **We strive to deliver best-in-class care.** If we did not hit that mark, we want to hear about any issues you may have experienced, thereby allowing us the opportunity for improvement. This is also your chance to provide us with positive feedback and experiences, as well.

11. MyChart

MyChart is an electronic patient portal you can opt in to, so you can send messages directly to your providers and others within your care team. You can ask for refills of medication, make appointments, pay bills, and access your records, including After-Visit Summaries. Ask any team member during your visit how to get signed up for MyChart today!

12. For care at Memorial Medical Group Specialty Practices

Your provider may refer you to one of Memorial's Specialty Care Practices. These practices are an extension of your overall health care – please ensure you follow these guidelines.

- We encourage patients to keep all needed follow-up appointments.
- If you are prescribed medication or therapies, we ask that you complete them as directed/needed.
- If scheduled for any procedures or surgeries, please keep the office aware of any changes in insurance, medications, or health concerns, as these are all important to having successful outcomes.

13. Medical records

Patients can request their personal medical records at any time. If you need a copy, you can sign a Release of Information in the office or reach out to our Medical Records Department at Memorial Hospital at (937) 578-2365 from 8:00am to 4:30pm, Monday through Friday. Alternatively, medical records requests can be submitted through MyChart.

We appreciate you trusting Memorial Health with the care of you and your family!

Memorial HEALTH

☎ 937 644 6115 | 800 686 4677
memorialohio.com
500 London Ave., Marysville, OH 43040

Name: _____ MRN: _____ Date: _____

New Patient History

Please provide as much detail as you can. If you cannot remember a specific name or date, please write your best guess or anything you do remember.

Mental Health History

Have you ever been diagnosed with a mental health condition? ☐ NO ☐ YES

If yes, explain: _____

Have you ever been hospitalized for psychiatric reasons? ☐ NO ☐ YES

If yes, how many times? _____ Please provide details below.

Month/Year	Length of Stay	Where	Reason for Stay

Have you ever intended, planned, or attempted to kill yourself? ☐ NO ☐ YES

If yes, how many times? _____ Please provide details below.

_____

_____

_____

Are you **currently** seeing an individual therapist or attending group therapy? ☐ NO ☐ YES

If yes, explain: _____

Have you **ever** received psychotherapy or counseling?

Individual: ☐ NO ☐ YES: Month/Year: _____ Approx. # sessions: _____

Group: ☐ NO ☐ YES: Month/Year: _____ Approx. # sessions: _____

If you marked YES for any of the three previous boxes, what has been helpful and/or not so helpful about current/past psychotherapy/counseling experiences?

_____

_____

_____

Have you ever seen a psychiatrist or other psychiatric provider in the past? ☐ NO ☐ YES

Please list any psychiatric medication you have taken or are currently taking:

Medication/Dosage	Month/Year	Duration	Benefits/Side Effects

Medical History

Are you allergic to any medications? ☐ NO ☐ YES

If yes, explain: _____

Do you have any health problems? ☐ NO ☐ YES—please list below:

_____

_____

_____

Are you being actively managed for any physical health conditions? ☐ NO ☐ YES

If yes, explain: _____

List any non-mental health-related medications or supplements you are currently taking:

_____

_____

_____

_____

Do you have any food-related allergies? ☐ NO ☐ YES

If yes, explain: _____

Are you in any pain currently? ☐ NO ☐ YES: _____/ 10 (1-10, where 10 is most severe)

If yes, explain quality/location: _____

Family History

Do any of your biological relatives (e.g. parents, grandparents, brothers or sisters, children) have current/past problems with:

...depression, anxiety, hearing voices, or other mental health problems? ☐ NO ☐ YES

...alcohol or other drug use? ☐ NO ☐ YES

...suicide attempts or death by suicide? ☐ NO ☐ YES

If you marked YES for any of the three previous boxes, please explain below:

Please mark if any of your biological relatives have or had any of the following medical conditions and what their relation is to you, using the lines below if needed:

Aneurysm	☐ _____	Heart failure	☐ _____
Birth defects	☐ _____	High cholesterol	☐ _____
Bleeding problems	☐ _____	High blood pressure	☐ _____
Cancer: _____	☐ _____	Inflammatory bowel	☐ _____
Dementia	☐ _____	Stroke	☐ _____
Diabetes	☐ _____	Thyroid problems	☐ _____
Heart attack	☐ _____	Other: _____	☐ _____

Social History

How do you like to be addressed? ☐ First name ☐ Nickname: _____

☐ Title and last name: ☐ Mr. ☐ Ms. ☐ Other title: _____

☐ Pronouns: _____ ☐ Another name: _____

What best describes your sexual orientation? ☐ Prefer not to answer ☐ Straight

☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other: _____ ☐ Unsure

What is your legal marital status?

☐ Single ☐ Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Widowed

What is your relationship status, if different from the above? ☐ N/A, same as above

☐ Dating ☐ Committed ☐ Engaged ☐ Domestic partnership ☐ Other: _____

☐ Partner's name: _____ ☐ Time together: _____

Have you ever been married? ☐ NO ☐ YES—how many times, for how long?

Do you have children? ☐ NO ☐ YES—please list age, sex, parentage below:

In what sort of place do you live currently? Do you rent or own?

☐ House ☐ Condo ☐ Apartment ☐ Duplex/multi-family housing ☐ Couch-surfing
☐ Mobile home/trailer ☐ Other: _____ ☐ Homeless: _____
☐ Rent ☐ Own ☐ Other: _____ ☐ Financial difficulties with affording housing

Who lives with you at home (including pets)?

Do you feel safe at home? ☐ NO ☐ YES

If no, explain: _____

Where were you born and raised? _____

How would you describe your childhood generally? _____

Did you witness or experience verbal, physical, emotional, or sexual abuse in childhood?

☐ NO ☐ YES: _____

Who raised you? _____

Did you grow up around sibling(s)? ☐ NO ☐ YES—list names/ages/genders:

Do your family and/or friends know you are seeking mental health care? ☐ NO ☐ YES

If no, explain: _____

Do you have someone close that you can turn to for help in times of need? ☐ NO ☐ YES

Have you ever experienced a traumatic event, like the loss of a loved one or an episode of violence, that continued to affect you weeks/months/years afterwards?

☐ NO ☐ YES—if you can, please describe the event and its impact(s) on you briefly:

Is your cultural background or ethnicity important to your identity? ☐ NO ☐ YES

If yes, explain: _____

Do you speak any other languages? Do you have a preferred language (if not English)?

_____

Do you consider yourself a religious or spiritual person? ☐ NO ☐ YES

If yes, explain: _____

Are you a member of a church or faith community? ☐ NO ☐ YES

What do you do for fun? What do you do to relax? What are you really good at?

_____

_____

_____

Please mark any/all of the following that apply to you:

☐ Working full-time ☐ Working part-time: _____ hours/week ☐ Self-employed

☐ Multiple jobs ☐ Home manager ☐ Disabled due to: _____

☐ Retired ☐ Unemployed, looking for work ☐ Unemployed, not looking for work

Other Income: ☐ Retirement ☐ SSDI ☐ Unemployment ☐ Alimony/Child Support

If applicable, where do you work? What kind of work do you do? Is your job stressful?

_____

_____

Do you access resources through assistance programs (e.g. SNAP)? ☐ NO ☐ YES

If yes, explain: _____

Are you currently having financial problems? ☐ NO ☐ YES

If yes, explain: _____

Are you currently or have you ever been in the military? ☐ NO ☐ YES

Branch of service: _____ Date entered service: _____

Date discharged: _____ Type of discharge: _____

Did you have any disciplinary actions taken against you? ☐ NO ☐ YES: _____

Did you serve in a combat zone? ☐ NO ☐ YES—when/where/for how long?

_____

Are you troubled today by any of the experiences you had in the military? ☐ NO ☐ YES

If yes, explain: _____

Have you ever been arrested or charged with a crime? ☐ NO ☐ YES

If yes, explain: _____

Have you ever been found guilty of a crime? ☐ NO ☐ YES

Have you ever been on probation/parole/community control? ☐ NO ☐ YES

Have you ever served a prison sentence (in full or in part)? ☐ NO ☐ YES

Have you had any other legal problems (civil or criminal) in the past? ☐ NO ☐ YES

If yes, explain: _____

Please mark any/all of the following that apply to you:

☐ Dropped out in grade _____ ☐ High school diploma ☐ GED ☐ Some college

☐ Trade/technical school: _____ ☐ Apprenticeship in _____

☐ Associate degree in _____ ☐ Bachelor's degree in _____

☐ Graduate degree in _____ ☐ Professional degree in _____

☐ Other: _____

When you were in school, did you have any problems/needs with academics or behavior?

☐ None ☐ Speech/language impairment ☐ Learning disability: _____

☐ Speech therapy ☐ IEP / 504 (circle one) for _____ in grades _____

☐ Special education class(es): _____

☐ Supplementary aid(s): _____

☐ Repeated grade(s): _____ ☐ Truancy ☐ Fighting ☐ Juvenile legal involvement

Do you have access to or own firearms? ☐ NO ☐ Access but I don't have any in my home

☐ YES—I/my family own (#, type): _____

Security: ☐ Gun safe ☐ Locked ☐ Stored unloaded ☐ Ammunition separated

Explain: _____

<u>Substance Use History</u>

How many caffeinated beverages do you drink in a day?

Coffee: _____ Soda Pop: _____ Tea: _____ Energy Drinks: _____

Do you use or have you ever used any tobacco/nicotine-containing products? ☐ NO ☐ YES

Cigarettes: ☐ Currently ☐ Previously Explain: _____

Pipe/Cigars: ☐ Currently ☐ Previously Explain: _____

Smokeless: ☐ Currently ☐ Previously Explain: _____

Vape/E-cig: ☐ Currently ☐ Previously Explain: _____

Are you interested in reducing your use of nicotine/tobacco? ☐ N/A ☐ NO ☐ YES

Please answer the following questions based on your use of alcoholic beverages **during this past year**. One drink of an alcoholic beverage is a bottle of beer, a glass of wine, or one standard shot of liquor.

How often have you had a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4+ times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7, 8, or 9 ☐ 10 or more

How often did you have 6 or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Please mark if you have used/currently use any of the following substances regularly:

	NO	YES	If yes, how long, how much, and date last used:
Cannabis	☐	☐	_____
Amphetamines	☐	☐	_____
Methadone	☐	☐	_____
Opioid pain medication	☐	☐	_____
Sedatives (e.g. Xanax)	☐	☐	_____
Cocaine	☐	☐	_____
Ecstasy/MDMA	☐	☐	_____
Heroin	☐	☐	_____
Inhalants e.g. (whip-its)	☐	☐	_____
Ketamine	☐	☐	_____
LSD	☐	☐	_____
Ever used IV/injected	☐	☐	_____
Other:_____	☐	☐	_____

Has your use of substances (including alcohol) ever caused you any problems?

☐ NO ☐ YES, in the following area(s): ☐ Legal ☐ Job-related ☐ Financial
☐ Housing-related ☐ Social ☐ Other: _____

Have you ever attended a substance treatment program (including for alcohol)?

☐ NO ☐ YES—please list dates, locations, and for what substance(s) below:

_____

_____

Are you interested in reducing your alcohol/substance use? ☐ N/A ☐ NO ☐ YES

Feel free to use the back of this page as additional writing space for any question.

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: DOB: MRN:

PHQ9 **Over the last <u>two weeks</u> how often have you been bothered by the following problems?**		0 Not at all	1 Several Days	2 More than half the days	3 Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

GAD7 **Over the last <u>two weeks</u> how often have you been bothered by the following problems?**	0 Not at all	1 Several Days	2 Over than half the days	3 Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult