DAYSPRING
FAMILY MEDICINE

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PATIENT INFORMATION AND CONSENT

Our practice offers a Collaborative Care program for eligible patients to help support behavioral health management. Collaborative Care brings together other members of the health care team to work with the patient's primary care provider, including a behavioral healthcare manager and a psychiatrist.

Patients who are enrolled in collaborative care:

- Receive regular check-ins with the behavioral health care manager to monitor their progress.
- Benefit from the expertise of a psychiatrist who shares recommendations with the patient's primary care provider about their treatment plan and care.
- May see better results and improvement in their condition, compared to not being enrolled in the collaborative care program.
- May be more likely to receive timely behavioral health management within their medical home compared to being referred to an outside mental health provider or clinic.

I understand that:

- My participation in the collaborative care program is voluntary.
- I can stop participating at any time.
- I am required to cancel an appointment I cannot attend 24 hours or more before appointment time unless it is an emergency. Three missed appointments whether by no show or cancellation less than 24 hours notice or lack of communication with phone calls/texts/email/mailed letter will result in deactivation from the program. Reactivation is at counselor discretion.
- The average enrollment time in the program is approximately 6 months, but may vary depending on my treatment needs.
- Participating in the program does not take the place of my regular behavioral health visits with my primary care provider.
- My primary care provider and I are responsible for making all medical management decisions.
- I may still be referred to an outside mental health provider if my primary care provider determines that my condition would be more appropriately managed with a specialist.
- My insurance plan will be billed monthly while I am enrolled in the program. Some of this cost may be passed along to me by my insurance plan.
- The psychiatrist consultant provides recommendations only to my primary care provider and the behavioral healthcare manager. The consultant does not bill my insurance. The consultant does not meet with me while I am enrolled in the program.

I understand that failure to call to cancel appointments at least 24 hours in advance unless it is an emergency may result in being placed as inactive in the counseling program which will require being put back on the waiting list to be seen again. Also, I understand that Angela will try to contact me three times by two methods and if I do not respond I will be placed as inactive.

___ (initial)

I voluntarily consent to participating in the Dayspring Family Medicine Collaborative Care program.

___ (initial)

I give consent to Dayspring Family Medicine to share medically necessary information with the psychiatrist consultant while I am enrolled in the Collaborative Care program.

___ (initial)

I understand that my patient's rights under HIPAA which protect my health information apply while I am enrolled in the Collaborative Care program, just as they do in any of my visits or interactions as a patient of Dayspring Family Medicine.

___ (initial)

_____ _____

Patient Signature/ Parent or Guardian Signature (if minor) Date

_____

Patient Name/ Parent or Guardian Name (if minor)

_____

Patient's Primary Care Provider

_____

Behavioral Health Care Manager

INTAKE FORM

Please answer the following questions to the best of your abilities. This information is held to the same standards of confidentiality as our therapy.

Name:_____
(Last) (Given) (Preferred) (Middle Initial)

Birth date: ____/____/____ Age:_____ Gender: Male Female Transgender

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: _____Ages:_____

Home phone:_____ May we leave a message? Yes No

Cell/other: _____ May we leave a message? Yes No

Work phone: _____ May we leave a message? Yes No

Email:_____ May we email you?* Yes No

*NOTE: Emails may not be confidential

Emergency Contact: _____ Telephone number_____

Referred by: _____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No

Reason for change:_____

Are you currently taking any psychiatric prescription medication? Yes No

If yes, please list:_____

Have you been prescribed psychiatric prescription medication in the past? Yes No

If yes, please list:_____

Have you been psychiatrically hospitalized in the past? Yes No

If yes, please list dates and locations:_____

General Health Information

Are you having any problems with your sleep habits? Yes No

If yes, circle those that apply:

Sleep too much Sleep too little Poor quality Disturbing dreams Other:_____

Are there any changes or difficulties with your eating habits? Yes No
If yes, circle those that apply:
Eating less Eating more Bingeing Restricting Other:_____

Have you experienced a weight change in the last two months? Yes No

Do you exercise regularly? Yes No
If yes, how many days per week do you exercise? _____ How long per session: _____

Do you consume alcohol regularly? Yes No
In one month, how many times do you have 4 or more in 24-hours?_____

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never
What kinds of recreational drugs do you use: _____

Are you currently in a romantic relationship? Yes No
If yes, how long have you been in this relationship?_____
On a scale from 1-10 (10 being great), how would you rate the quality of your relationship? _____

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?_____

_____

Quick Check

Circle the issues below that apply to you.

Depressed mood	Panic Attacks	Memory Lapse	Relationship
Mood Swings	Phobias	Trouble planning	Hallucinations
Rapid Speech	Repetitive Behaviors	Sleep Disturbance	Eating
Suicidal Thoughts	Anxiety	Time loss	Body Complaints
Homicidal thoughts	Excessive Worry	Alcohol/Drug abuse	Traumatic Event

Have you felt depressed recently? Yes No
If yes, for how long?_____
Have you had any suicidal thoughts recently? Yes No
If yes, how often? Frequently Sometimes Rarely
Have you ever had suicidal thoughts in your past? Yes No
If yes, how long ago?_____

How often did you have these thoughts? Frequently Sometimes Rarely

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Depression	Yes	No	_____
Suicide	Yes	No	_____
Anxiety Disorders	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Sexual Abuse	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____

Religious/Spiritual Information

Do you practice a religion? Yes No

If yes, what is your faith? _____

Do you wish to integrate your faith into your treatment? Yes No

Occupational Information

Are you currently employed? Yes No

If yes, who is your employer? _____

What is your position? _____

Are you happy in your current position? Yes No

Does your work make you stressed? Yes No

If yes, what are your work-related stressors? _____

Other Information

List your strengths and what you like most about yourself: _____

_____

What are some ways you cope with life obstacles and stress?

What are your goals for therapy/what would you like to accomplish?

Name: DOB: Date:

Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation.

Food	Yes	No
Within the past 12 months, did you worry that your food would run out before you got money to buy more food?		
Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/Utilities		
Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home?		
Are you worried about losing your housing?		
Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
Do you feel physically or emotionally unsafe where you currently live?		
Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by anyone?		
Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Other Assistance		

Name: DOB: Date:

Do you need help finding clothing, support, substance abuse assistance, or pregnancy assistance?		

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. 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.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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