Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT
3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

CONFIDENTIAL CLIENT INFORMATION

Welcome to Chrysalis Center. Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal laws, any information you provide is strictly confidential. ***If you do not complete these forms in their entirety prior to your first appointment, you will not be able to see any provider at Chrysalis Center.***

Demographic Information:

Name: _____ SSN: _____ Preferred Name: _____
Pronouns: _____ Gender: _____ Preferred Language: _____
Mailing Address: _____
_____
City: _____ State: _____ Zip Code: _____
Email Address: _____
Primary Phone: _____ Is it okay to leave a message? Yes No
Date of Birth: _____ Age: _____ Race: _____
Ethnic Group: _____ Religious Preference: _____
Relationship status: ____Single ____Cohabitating ____Married ____Separated ____Divorced ____Widowed
Emergency Contact: _____ Telephone: _____
Relationship to you: _____
Parent/Guardian Name (if relevant): _____
Address: _____ Telephone: _____

Referral/Clinical Information:

How did you find out about our services? _____
What type of services are you seeking/expecting? (Please check all that apply to you)

_____Individual Counseling
_____Group Counseling
_____Couples/Family Counseling
_____Nutritional Counseling
_____Bariatric Evaluation
_____Assessment
_____Intensive Outpatient Program

Employment/Education Information:

Are you currently employed? Yes No
If yes, where are you employed? _____
What is your job title? _____
Highest Level of Education Completed: _____
Are you currently a student? Yes No
If yes, where? _____ Year_____ Major_____

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RIGHTS & CONSENT TO TREATMENT

- ❑ You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- ❑ You have the right to be treated in accordance with professional and ethical standards of conduct.
- ❑ You have the right to confidentiality. We will not disclose any information outside of the Chrysalis Center without your written consent. Clinical records will be maintained in a secure, locked environment. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order. We will not sell your information to anyone for any reason.
- ❑ I understand that if Chrysalis shares any information, we will adhere to the "minimum necessary" rule to protect your confidentiality and we will not share Psychotherapy Notes with any third parties.
- ❑ You have the right to discontinue therapy at any time. However, it is expected that you will confer with your therapist rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- ❑ I understand that sessions run for 45-50 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.
- ❑ I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- ❑ I understand that there is no guarantee that any particular outcome will result from treatment.
- ❑ I understand and give my consent for the Chrysalis Center clinical staff to consult with each other as needed in order to provide me with the most effective, ethical treatment possible. The clinicians and nutritionists actively collaborate and consult about mutual cases, as well as share clinical notes.
- ❑ I understand that my therapist may consult and share clinical information with her supervisor and/or clinical board and/or university in order to provide legal and ethical treatment. She may also do so to meet the requirements set forth for licensure or certification. If I am being seen by an intern, I understand that they are not yet licensed and are practicing under the auspices of their graduate program, not Chrysalis Center.
- ❑ I understand that all communications with Chrysalis staff, including digital interactions, will be part of my clinical record. Any digital communication will be limited to that which does not compromise the clinical relationship or professional and ethical standards. I will discuss appropriate ways to use digital technology with my clinician. I understand that any communication via social media is prohibited. If I choose to communicate via digital media (cell phones, text, email, etc.), I understand that the confidentiality of these interactions cannot be guaranteed, although any Chrysalis-based digital communications will utilize appropriate security measures.

I have read and understood this document and will address any concerns or questions with my therapist and/or the office manager. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Client/Representative Signature _____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Clinician Signature _____ **Date** _____

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Acknowledgement of Receipt - Notice of Privacy Practices & Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____, and Chrysalis Center. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his or her name(s) here _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you, with others who need it to arrange payment for your treatment, or with others for other business or government functions. By signing this form you are agreeing to let us use your information and send it to others under the circumstances described in our Notice of Privacy Practices. Please read this Notice before you sign this form; it explains in more detail your rights and how we can use and share your information.

In the future we may change how we use and share your information; therefore our Notice of Privacy Practices may change. If this occurs, you can get an updated copy from our website, www.chrysaliscenter-nc.com, or by calling us at 910-790-9500. If you have any questions regarding the Notice or your privacy rights, you can also contact Kaitlyn Patterson, MA, LPA, Privacy Officer, at kaitlyn.patterson@chrysaliscenter-nc.com or at the address listed below.

Please note that it is your right to protect your information. If you have concerns about the use or share of your information for treatment, payment, or administrative purposes, please submit a written request to our Privacy Officer at Chrysalis Center about these concerns. (Although we will try to respect your wishes, we are not required to agree to these limitations.) Furthermore, you have a right to revoke this consent after you have signed it (by submitting a letter to the Privacy Officer). Any information used or shared prior to annulment of this consent cannot be changed.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to detail what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations; more information about these limitations is detailed in the Notice of Privacy Practices. If you object to any of these practices, you may discuss them with our staff and/or provide written documentation of your concerns. After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes as thoroughly as we are able to do so under the law.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Chrysalis Center's Notice of Privacy Practices. My signature indicates that I have reviewed this notice, understand its content, and agree to its stipulations.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Relationship to Client (if guardian or representative):_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (relationship to the client, power of attorney, healthcare surrogate, etc.).

☐ I would like to opt out of receiving any fundraising, business or marketing communications from Chrysalis.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

☐ ***Client Refuses to Acknowledge Receipt:***

Signature of authorized representative of this office or practice: _____

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OFFICE PROCEDURES AND FINANCIAL AGREEMENT

Please read, initial, complete, and sign below. You may request a copy for your records.

Chrysalis is a business office where a number of mental health professionals, registered dietitians, and a psychiatric provider practice. Your contract for services is with our office and applies to any and all providers you may see here.

APPOINTMENTS: All office visits are by appointment and scheduled through our administrative staff. Please arrive on time, as you cut down on your appointment time when you arrive late. Appointment lengths vary depending on the type of provider seen. If you arrive more than 15 minutes late for a 50 minute appointment or 7 minutes late for a 30 minute appointment, you will be asked to reschedule your appointment, which will result in a late cancellation charge.

RECORDING DEVICES: The use of recording devices by clients, clinicians, and other persons present during a session, group or other clinical interaction, whether face-to-face or taking place by live textual, audio, or video link is strictly prohibited. Administrative calls may be monitored for quality assurance.

BLUEPRINT: Blueprint respects the privacy of all users and will never sell any personally identifiable data. You own your data at all times and can always request your data and account to be deleted by sending an email to support@blueprint-health.com with the subject of "Account Deletion." You can view Blueprint's privacy policy in detail at www.blueprint-health.com/privacy. Measuring your progress through Blueprint may be considered a billable service by your provider towards your insurance plan and as a result may result in additional co-payments, amounts applied to deductibles, and other amounts that may be deemed the responsibility of the patient as required by contract with the insurance plan and state regulations.

PAYMENT: Payment is required at the time services are rendered, whether you are a self-pay client or have insurance coverage. Acceptable methods of payment include cash, check, VISA or Master Card. *The fee for returned checks is $35. If a check is returned, you will be asked to arrange another method of payment.*

All clients are required to place a credit card on file in order to facilitate collection of payment. If estimated payment (copay, deductible, coinsurance, cash rates) is not received by the end of the date of service, the card on file will be charged. In the case that insurance reimburses different amounts than the estimated payment (copay, deductible, coinsurance, cash rates) taken, credits and debits will be applied to the card as necessary. If the card declines, you will have until one business day prior to your next appointment to provide current and valid card information or your scheduled session will be canceled and payment in full will be required before you can reschedule. A patient portal via our electronic medical records system will be provided to view and track payments.

Name (as it appears on the card): _____

Card Number: _____

Phone number of credit card holder: _____ Billing Zip code: _____

Expiration Date: _____ CVV/CVC: _____

Late cancellations/No shows: For a missed or late cancelled appointment, you will be charged up to $90 for the appointment. Please note: both clinical and nutritional appointments must be cancelled no less than one business day before the scheduled appointment. Please be advised that reminders are a courtesy, and you will be billed for late cancellations and no-shows regardless of whether or not you received the reminder message. Repeated late cancellations and/or no-shows may result in dismissal from treatment, at our discretion.

INSURANCE: As a courtesy to you, we will bill rendered services to your insurance carrier. We do not accept Medicaid. Insurance co-payments, coinsurances, and deductible payments are due at the time of service. However, verification of eligibility and/or benefit information is not a guarantee of payment by your insurer. Your benefits will be determined once a claim is processed by your insurer, which will be based upon your eligibility and the terms of your certificate of coverage applicable on the date services were rendered. In the event of non-payment from your carrier, you are responsible for payment to Chrysalis for services rendered and you will be responsible for handling any disputes with your insurance carrier. It is your responsibility to be aware of your insurance benefits and needs for pre-authorization. Any services not covered by your insurance are your responsibility.

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Unless otherwise notified, the insurance policy holder will be financially responsible for any balance on the client's account. Please make one of our administrative staff aware if the billing address is different than the home address on file.

Please note: Treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

OUTSTANDING BALANCE: You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Chrysalis does not receive payment in full for services rendered, your treatment may be discontinued. If you are unable to pay your balance in full, a signed *payment plan agreement* will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuation of services. If you previously discontinued your care or were discharged from treatment and you desire to resume receiving services at Chrysalis, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with our administrative staff. Any balance not paid in 90 days will be subject to collections.

Late Fees: A late fee of $25 will be charged to delinquent accounts that are not paid within 90 days of the issue date of the first bill and may also be referred to a third-party collection agency. You will continue to be responsible for all associated collections and fees.

ADDITIONAL SERVICES: In some circumstances, depending on the time involved and nature of task, you may be charged for additional services, such as extended sessions, scoring psychological testing, preparing a psychological report, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment. Phone calls that are extended and/or that constitute therapy may require an additional fee. These additional services will be charged up to $100/hour.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes, insurance companies do notreimburse for testing. In this event, you will be responsible for uncovered testing costs at our self-pay rate.

Conjoint Sessions (with more than one therapist): Conjoint sessions will be billed according to your benefits, which may result in a self-pay rate.

Please note: No provider at Chrysalis will fill out any disability forms (FMLA, short or long term, etc.) for clients who are not already established at Chrysalis (5+ sessions with one provider), and at the clinician's discretion. We will send records as requested to other providers or agencies with a valid Release of Information on file. If records are sent, there may be a $25 administrative fee associated with sending the records or filling out any paperwork for a third party.

Changes to the Policy: Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

_____I have read, understand, and agree to the above policies.
_____I authorize Chrysalis to release any information acquired in the course of my therapy to my insurance company as needed.
_____I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred.
_____I have been offered a copy of these policies to take with me if I desire.
_____I understand that the credit card on file will be charged for services rendered if I do not make alternative arrangements at time of service
_____I have discussed these policies and addressed concerns and questions with the administrative staff if needed. Initial and date by administrative staff if questions were addressed:_____

_____ _____
Signature of Client Date

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

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**Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.*

Please Note: Your insurance carrier requires us to gather this information in order to use your benefits, andthe following information is not available on your insurance card. You must complete all fields on both pages of this form. If you do not provide us with accurate information, your claims may not be processed appropriately, and you will be charged the full rate for services already rendered.

_____Please initial if you do not want to use your insurance benefits; you will be chargedthe self-pay rate for services.

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): _____

Address: _____

Telephone: _____ Date of Birth: _____

Social Security Number: _____ Relationship to Policy Holder:_____

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

Policy Holder's Telephone: _____ Policy's Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number of Member ID Number: _____

Group Number: _____

Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): _____

Policy Holder's Address: _____

Policy Holder's Telephone: _____ Policy's Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Employer's Name: _____

Insurance Plan Name: _____

Subscriber Number of Member ID Number: _____

Group Number: _____

I have read and completed the information above and verify that it is correct. I understand that it is myresponsibility to update Chrysalis with any change in insurance information.

_____ _____

Name of Client (printed) Date

_____

Signature

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Communications Policy

Contacting Providers

When you need to contact your provider for non-emergent situations, these are the most effective ways to get in touch in a reasonable amount of time:

- By phone (910-790-9500). Our clinicians do not have direct voicemails, but you can leave a message or leave a confidential voicemail with our administrative staff.
- If you wish to communicate by email, please discuss further with your clinician. Please review the Rights and Consents about the potential confidentiality risks of doing so

Please refrain from making contact with any member of your treatment team using social media messaging systems. Any communication through social media is strictly prohibited as it can create significant security risks for clients.

Please refrain from contacting you provider using SMS (normal phone text messages).

Your provider may utilize HIPAA-compliant mobile and web platforms (e.g., Blueprint, Recovery Record) to support therapeutic goals and measure treatment progress.

- These services are HIPAA-compliant to keep patient information secure even when shared with treatment teams.
- These platforms do not give medical, legal, or psychological advice, diagnoses, or treatment. These services may provide helpful Health-Related Information, but are not intended to substitute for professional advice, diagnoses, treatment, or your judgment.
- Under no circumstances should these services be used to report emergencies to your providers. Chrysalis providers will not be monitoring these services at all times.

Confidentiality is vital to therapy. Please speak with your provider about any concerns you have regarding preferred communication methods.

Response Time

Our office is open Monday-Thursday 8:30am-5pm and Fridays 8:30am-4pm. Our administrative and clinical staff may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can expect a response within *48 hours* (weekends are excepted from this timeframe). It is likely you will receive a reply more quickly than that, but please be aware that this will not always be possible.

Be aware that there may be times when your clinician may be unable to receive or respond to messages, such as when out of cellular range or out of town.

Emergency Contact

If you are ever experiencing an emergency, including a mental health crisis, please call the local police by calling 911 or go to your nearest emergency department. Possible locations include:

New Hanover Regional Medical Center
910-343-7000
2131 17th St.
Wilmington, NC 28401

Cape Fear Hospital
910-452-8100
5301 Wrightsville Ave.
Wilmington, NC 28403

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Following your call to 911 or your visit to your nearest emergency department, if you need to reach your provider, the best methods of communication are:

- By the main office line: 910-790-9500
- If you cannot reach someone by phone, please leave a voicemail

Disclosure Regarding Third-Party Access to Communications

Please know that if we use electronic communications methods, such as email, texting, online video, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others. While we take precautions whenever possible to ensure the confidentiality of communication through these methods, we cannot always guarantee your confidentiality. Use of these modes of communication implies your understanding and consent to this limitation of confidentiality. Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

I have read and understood this document and will address any concerns or questions with my therapist and/or the practice manager. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime.

Client/Representative Signature _____ **Date**_____

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INFORMED CONSENT FOR PARENTS/GUARDIANS OF MINOR CHILDREN

Divorce, Custody or Legal Issues

As a mental health treatment facility, our primary focus, responsibility, and goal is the treatment and well-being of our identified clients. In the case of a minor as the primary client, it is essential that parents and legal guardians are not in conflict and are in fact in agreement as to the decision to treat, treatment goals, appointment times and the need to maintain client confidentiality. The therapeutic process is a team approach, especially in the case of a minor child. The following informed consent states that each parent, and/or any legal guardian with authority over the health care decisions of the child, will agree to these terms and communicate effectively with each other, as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible.

Although our responsibility to your child may require our involvement in conflicts between parents and guardians,we need your agreement that our involvement will be strictly limited to that which will benefit your child. This means, that you each agree as a condition of us treating your child that (please check to indicate you understanding):

- ☐ You shall treat anything that is said in any individual or group therapy session as strictly confidential;
- ☐ Our role is limited to providing treatment and you shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child from our treatment of your child;
- ☐ You shall not request or require us, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the another in any legal proceeding relating to the care and custody of your child; and
- ☐ If multiple parents or guardians desire to obtain treatment information and/or testimony from any one of our clinicians relating to your child in any legal proceeding you shall each consent to the disclosure by executing one or more authorization forms we send to you and you will each share in the cost of producing such records and/or written or live testimony at our established copying charges and/or hourly rates for our clinician's time.

If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor. We will not make any recommendations concerning the child's custody or custody arrangements, unless otherwise ordered by a court.

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Scheduling & Payment

I give my permission to the following people to make decisions regarding therapeutic interventions, scheduling appointments and cancelling appointments, if I am not physically present during any appointments:

Name	Relationship to Client	Contact Information (phone and/oremail)

- ☐ I accept the responsibility of communicating with appropriate parties after every appointment to be updated regarding any change in the treatment plan related to the minor child's therapy.
- ☐ I understand that as the custodial parent of the minor child, I am responsible for **any and all** payments due. Any payment received from the minor child's other parent, guardian, or family member will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, Chrysalis Center will look to me as the sole party responsible for the financial obligations of the account.
- ☐ I understand that if my child is over the age of 16, they may make and cancel their own appointments. I will be required to put a credit card on file and complete a Third-Party Payer Agreement that will be used to pay for your child's treatment.
- ☐ I understand that if my child has their 18th birthday during the course of treatment, they may be required to fill out new paperwork to give their consent to treatment, payment responsibility, and/or if you will still be permitted to speak with the treatment team without your child present. Your child may need to complete a Release of Information to allow you to speak with **any** administrative or clinical staff about their care or appointments.

I have read and understood this document and will address any concerns or questions with the practice manager.
I have read the above consent over carefully and understand its content and hereby agree to the terms and conditions and consent to the treatment of my child under these terms and conditions set forth above by signing below.
Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website. This informed consent is signed in additionto the forms regarding Client Rights and Consent to Treatment, HIPAA/Confidentiality, Financial Agreement, and any Release of Information on file.

Minor Child Name **(please print)**:_____

Parent/Guardian **Name (please print):** _____

Parent/Guardian **Signature:**_____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions, if any. The parent/guardian appears fully competent to give informed consent.

Staff Signature_____ Date _____

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THIRD PARTY PAYER AGREEMENT

I accept full financial responsibility for the treatment of_____(client name) and agree to the provisions of the Office Procedures & Financial Agreement.

Please indicate preferred Method	Payment Options
	Credit card payment: You may provide the client with a credit card to present atthe time of service or we can manually enter your credit card information (VISA/MC only) Card Number: _____ Exp Date:_____CVC Code:_____Zip code: _____
	Payment at the time of service: You may provide the client with cash or check toremit when he/she comes in for an appointment. If, for whatever reason, the client runs a balance, you will need to provide a credit card number we can maintain on file.

You may elect to have a statement sent to you at the beginning of each month. The statement will reflect all payments you made for the previous month. If you would like a statement sent to you, please indicate your preferred method and include necessary information:

_____ _____
Email Fax Number

_____

_____
Mailing Address

_____ _____
Signature of Third-Party Payer Date

_____ _____
Print Name of Third-Party Payer Contact Phone Number

Below to befilled out by client (if over 18)

I,_____(client name) authorize the above to accept full financial responsibility forany services rendered at Chrysalis. I understand that by authorizing a Third-Party Payer, that individual may obtain financial or billing information about my services at Chrysalis such as date of service, type of service, fee for service, and service provider. No clinical information will be given without a separate Release of Information.

_____ _____ _____
Signature of client Date Date of Birth

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Medication Management Intake Form

Date_____

Name_____ Age_____

Address_____

Home phone_____ Work phone_____ Cell phone_____

Other names used _____

Other states resided, in the last 6 years _____

What issue(s) bring(s) you to the Psychiatry Clinic?

_____

_____

_____

What has been stressing you of late? (Family,job,recent loss of loved one, financial issues)

_____

_____

_____

Are you currently having any of the following problems (please circle)?

• Depression? • Loss of interest in activities? • Feeling hopeless, worthless? • Poor energy? • Poor self-esteem? • Change in appetite? • Increased or decreased? • Fatigue? • Poor focus? • Problems going to sleep? • Thoughts of not being alive? • Periods of euphoria or • unusually good mood? • Having very high energy for no reason? • Going days without needing to sleep? • Talking too fast?	• Worrying excessively? • Having tense muscles? • So anxious you feel you cannot rest? • Having panic attacks? • Traumatic events that come back in nightmares, flashbacks? • Feeling awkward in public? • Thoughts that replay? • Repetitive or compulsive • behaviors? • Phobias or fears? • Grunts, tics, or jerks? • Inattentiveness at work or school? • Hyperactive or fidgety? • Acting impulsively (spending, speeding)?	• Hearing voices? • Seeing things? • Feelings people were trying to watch or harm you? • Concerns about alcohol use? • Drug use? • Concerns about eating too much.? • Getting lost easily? • Eating too little? • Memory problems? • Forgetting how to do tasks? Problems finding words? • Problems caring for yourself (cooking, dressing)?

Past Psychiatric Care

Have you been ever diagnosed with a mental health condition by a medical provider (e.g. Depression, bipolar, schizophrenia, ADHD)? If so, please list.

Have you ever been seen by a psychiatrist or therapist/counselor? Please list and describe.

Date(s) seen? By whom?	For what problem?	What treatment (meds, ECT, therapy)?

Have you ever been hospitalized for psychiatric care? Please list and describe.

Date(s)	Where and for what?	What treatment (meds, ECT, therapy)?

Have you ever been treated with any of the following medications? Circle all that apply and list any good or bad effects of the medications.

Med	Good/bad effects	Med	Good/bad effects	Med	Good/bad effects
Abilify		Haldol		Ritalin	
Ambien		Klonopin		Saphris	
Adderall		Invega		Serax	
Anafranil		Lamictal		Seroquel	
Antabuse		Latuda		Serzone	
Ascendin		Lexapro		Soma	
Atarax		Librium		Sonata	
Ativan		Lithium		Stelazine	
Buspar		Lunesta		Strattera	
Campral		Luvox		Suboxone/ subutex	
Celexa		Marplan		Symmetrel	
Chloral hydrate		Mellaril		Tegretol	
Clonidine		Methadone		Thorazine	
Clozaril		Miltown		Tofranil	
Cogentin		Nardil		Topomax	
Concerta		Norpramine		Traxene	
Cymbalta		Orap		Trazodone	
Dalmane		Pamelor		Trileptal	
Depakote		Parnate		Valium	
Dexedrine		Paxil		Vibryd	
Doral		Prosom		Vistraril	
Effexor		Pristiq		Vivitrol	
Elavil		Prolixin		Wellbutrin	
Fanapt		Remeron		Xanax	
Geodon		Restoril		Zoloft	
Halcion		Risperdal		Zyprexa	

Any other psychiatric medications you have taken?

_____

_____

Past Medical Care

Do you have a primary care doctor? Name_____

Last Seen?_____

What medical illnesses do you have? /Surgeries in the past

Please list all medications you are currently taking, including over-the-counter medications, herbals, and supplements.

Medication	Dosage	# Times per day	For what condition	Who prescribes it

Describe any allergies you have (e.g. to medications, foods).

For women-

Last menstrual period? _____

Do you use any birth control? **Yes/No** If yes, please list. _____

Have you been pregnant before? **Yes/No**

If yes, how many times? _____

Miscarriages? **Yes/No**

Elective abortions? **Yes/No**

Any depression or unreal thoughts
around pregnancies? **Yes/No**

Patient Health Questionnaire

Name _____ Date _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?		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 columns: _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:** _____

10. 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** _____

CHECKLIST: Review of Systems

Patient Name:_____ Date of visit: _____

CONSTITUTIONAL:
Yes No
- ☐ ☐Weight Loss
- ☐ ☐Fatigue
- ☐ ☐Fever

EYES:
Yes No
- ☐ ☐Glasses/Contacts
- ☐ ☐Eye Pain
- ☐ ☐Double Vision
- ☐ ☐Cataracts

EAR,NOSE,THROAT:
Yes No
- ☐ ☐Difficulty Hearing
- ☐ ☐Ringing in Ears
- ☐ ☐Vertigo
- ☐ ☐Sinus Trouble
- ☐ ☐Nasal Stuffiness
- ☐ ☐Frequent Sore Throat

CARDIOVASCULAR:
Yes No
- ☐ ☐Murmur
- ☐ ☐Chest Pain
- ☐ ☐Palpitations
- ☐ ☐Dizziness
- ☐ ☐Fainting Spells
- ☐ ☐Shortness of Breath
- ☐ ☐Difficulty lying Flat
- ☐ ☐Swelling Ankles

ENDOCRINE:
Yes No
- ☐ ☐Loss of Hair
- ☐ ☐Heat/Cold Intolerance

RESPIRATORY:
Yes No
- ☐ ☐Cough Easy
- ☐ ☐Coughing Blood
- ☐ ☐Wheezing
- ☐ ☐Chills

GASTROINTESTINAL:
Yes No
- ☐ ☐Heartburn/Reflux
- ☐ ☐Nausea/Vomiting
- ☐ ☐Constipation
- ☐ ☐Change in BMs
- ☐ ☐Diarrhea
- ☐ ☐Jaundice
- ☐ ☐Abdominal Pain
- ☐ ☐Black or Bloody BM

GENITOURINARY:
Yes No
- ☐ ☐Burning/Frequency
- ☐ ☐Nighttime
- ☐ ☐Blood in Urine
- ☐ ☐Erectile Dysfunction
- ☐ ☐Abnormal Discharge
- ☐ ☐Bladder Leakage

ALLERGIC/IMMUNOLOGIC:
Yes No
- ☐ ☐Hives/Eczema
- ☐ ☐Hay Fever

PSYCHIATRIC:
Yes No
- ☐ ☐Anxiety/Depression
- ☐ ☐Mood Swings
- ☐ ☐Difficult Sleeping

HEMATOLOGY/LYMPH:
Yes No
- ☐ ☐Easy Bruising
- ☐ ☐Gums Bleed Easily
- ☐ ☐Enlarged Glands

MUSCULOSKELETAL:
Yes No
- ☐ ☐Joint Pain/Swelling
- ☐ ☐Stiffness
- ☐ ☐Muscle Pain
- ☐ ☐Back Pain

SKIN:
Yes No
- ☐ ☐Rash/Sores
- ☐ ☐Lesions
- ☐ ☐Itching/Burning

NEUROLOGICAL:
Yes No
- ☐ ☐Loss of Strength
- ☐ ☐Numbness
- ☐ ☐Headaches
- ☐ ☐Tremors
- ☐ ☐Memory Loss

Substance Use History

How often have you used the following substances?

	Last time used?	Approximately how often (# of times per week, month or year)?	How much do you use in a sitting if/when you do use?
Tobacco			
Alcohol			
Marijuana or K2/"spice"			
Cocaine			
Opiates (e.g. Heroin, morphine, Percocet, oxycodone, Tylenol #3, Dilaudid/hydromorphone)			
Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)			
PCP or LSD			
Mushrooms			
Others			

Family History

Please list blood relatives who have been diagnosed with the following conditions.

Alcoholism _____

Anxiety disorders _____

Bipolar disorder _____

Cancer _____

Depression _____

Diabetes _____

Drug abuse _____

Heart disease/high blood pressure/arrhythmias _____

Osteoporosis _____

Seizures _____

Schizophrenia _____

Strokes _____

Suicides _____

Thyroid

disease_____

Social History

Where do you live?

_____

Who lives with you?

_____

_____

How far did you go in school/highest level of education?

_____

What is your current job/occupation?

_____

What jobs have you had in the past?

_____

_____

Are you married? **Yes/No**

If so, for how long? _____

Have you been married in the past? Yes/no # of times?

_____ Do you have children? Yes/no

If so, how many _____

what are their ages?_____

What do you do in your free time to relax?

Do you have any religious beliefs? **Yes/ No**

How important are your religious/spiritual beliefs to your life?

Have you had any legal issues (arrests, charges, time in jail)? If so, please describe.

Safety

Have you ever been the victim of a violent crime? Yes/No

Have you ever been a victim of physical abuse? Emotional? Sexual abuse or rape? **Yes/No**

Do currently have thoughts of hurting yourself? **Yes/No** If so, please explain.

Have you tried to hurt yourself in the past? **Yes/No** If so, please explain.

Do you currently have thoughts of hurting anyone else? **Yes/No** If so, please explain.

Have you tried to hurt anyone in the past? **Yes/No** If so, please explain.

Do you own any guns or knives?

Global Psychotrauma Screen (GPS)

Gender ☐ Female ☐ Male ☐ Other

Age (years) |_|_|_|

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic.

Briefly describe the event or experience that currently affects you the most:

.....

This event happened: ☐ last month ☐ last half year ☐ last year ☐ longer ago

This event:

☐ was a single event occurring, at age |_|_|

☐ happened during a longer period / multiple times, between ages |_|_| and |_|_|

Which of the below characterize the event (more answers possible):

Physical violence:	☐ to yourself	☐ happened to someone else
Sexual violence:	☐ to yourself	☐ happened to someone else
Emotional abuse:	☐ to yourself	☐ happened to someone else
Serious injury:	☐ to yourself	☐ happened to someone else
Life threatening:	☐ to yourself	☐ happened to someone else

☐ Sudden death of a loved one

☐ You causing harm to someone else

☐ Corona virus (COVID-19)

Considering the above event, <u>in the past month</u> have you....

1.	... had nightmares about the past traumatic life event(s) you have experienced or thought about the event(s) when you did not want to?	☐ No	☐ Yes
2.	... tried hard not to think about past traumatic life event(s) or went out of your way to avoid situations that reminded you of the event(s)?	☐ No	☐ Yes
3.	... been constantly on guard, watchful, or easily startled?	☐ No	☐ Yes
4.	... felt numb or detached from people, activities, or your surroundings?	☐ No	☐ Yes
5.	... felt guilty or unable to stop blaming yourself or others for past traumatic life event(s) or any problems the event(s) caused?	☐ No	☐ Yes
6.	... tended to feel worthless?	☐ No	☐ Yes
7.	... experienced angry outbursts that you could not control?	☐ No	☐ Yes
8.	... been feeling nervous, anxious, or on edge?	☐ No	☐ Yes
9.	... been unable to stop or control worrying?	☐ No	☐ Yes
10.	... been feeling down, depressed, or hopeless?	☐ No	☐ Yes
11.	... been experiencing little interest or pleasure in doing things?	☐ No	☐ Yes
12.	... had any problems falling or staying asleep?	☐ No	☐ Yes
13.	... tried to intentionally hurt yourself?	☐ No	☐ Yes

14.	… perceived or experienced the world or other people differently, so that things seem dreamlike, strange or unreal?	☐ No	☐ Yes
15.	… felt detached or separated from your body (for example, feeling like you are looking down on yourself from above, or like you are an outside observer of your own body)?	☐ No	☐ Yes
16.	… had any other physical, emotional or social problems that bothered you?	☐ No	☐ Yes
17.	… experienced other stressful events (such as financial problems, changing jobs, moving to another house, relational crisis in work or private life)?	☐ No	☐ Yes
18.	… tried to reduce tensions by using alcohol, tobacco, drugs or medication?	☐ No	☐ Yes
19.	… missed supportive people near you that you could readily count on for help in times of difficulty (such as emotional support, watch over children or pets, give rides to hospital or store, help when you are sick)?	☐ No	☐ Yes
20.	During ***your childhood*** (0-18 years), did you experience any traumatic life events (e.g., a serious accident or fire, physical or sexual assault or abuse, a disaster, seeing someone be killed or seriously injured, or having a loved one die)?	☐ No	☐ Yes
21.	Have you ***ever*** received a psychiatric diagnosis or have you ever been treated for psychological problems (for example, depression, anxiety or a personality disorder)?	☐ No	☐ Yes
22.	Do you ***generally*** consider yourself to be a resilient person?	☐ No	☐ Yes

23. How would you rate your present functioning (at work/home)?

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name	Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

Release of Information

The purpose of this form is to authorize the parties indicated to disclose and exchange client information to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services with Chrysalis Center clinicians. The original of this form will be placed in your record and a copy may be sent to other parties.

I, _____ (client name), authorize the Chrysalis Center clinicians or administrative staff to exchange the specified information for the purpose of coordinating care. I understand that:

- I have the right to be told and to review the information being exchanged.
- Information may be exchanged via phone, fax, email or in person.
- This information will only be disclosed to parties specifically indicated, at which time those parties are responsible for maintaining the privacy of your information. Please be aware that if this information is disclosed to the court it may be made part of the court record and therefore available to the public by federal and state law.
- I may refuse or revoke my consent at any time by writing a letter to Chrysalis Center. I understand that the revocation will not apply to any information already used or disclosed under this authorization.
- This consent will be valid for one year following conclusion of treatment at Chrysalis Center, unless otherwise indicated.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the Chrysalis Center, nor will it affect my eligibility for benefits.
- For further information regarding privacy practices, please see you "Rights and Consent to Treatment" and "Notice of Privacy Practices" given to you at the time of intake.

Company/Individual Name **Phone/Fax/Address**

_____

_____

_____

The following information may be shared: (check all that apply)

_____ Attendance (including cancellations)
_____ Billing records
_____ Diagnosis(es) (current and/or past)
_____ Discharge Notes/Summaries
_____ Evaluations and reports of consultants
_____ Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living
_____ Intake Notes and/or bio-psycho-social history
_____ Medications (current and/or past)
_____ Nutrition Records
_____ Other: _____
_____ Progress or similar notes
_____ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries
_____ Recommendations
_____ Testing records
_____ Treatment, recovery, rehabilitation, aftercare plans and other similar plans
_____ Complete copy of the medical record (excludes psychotherapy notes)
_____ Psychotherapy notes/records

Signature: _____ Date: _____
(of client or representative)
for:
Name (print): _____ Date of Birth: _____
& relationship to client (if representative)