

**Saint Luke's Health System
Saint Luke's Physician Group**

Behavioral Health Specialists Office Policy

Office Hours and Appointment Information:

- This office is open Monday through Friday from 8:30am to 4:30pm. To schedule a visit please call during business hours at 816-932-1711. Please update our office staff of any changes of address, phone number or insurance coverage prior to your visit so it can be billed correctly.
- For your first visit, you will find your new patient paperwork assigned to you in the mySaintLuke's Portal. Please complete the eCheck-in and assigned questionnaires prior to your appointment. If you arrive after your scheduled visit time you may be asked to reschedule and be recorded as missing the visit.
- **In-office appointments:** If you do not have the mySaintLuke's Portal, the pre-registration and paperwork will be completed upon check-in on the day of your appointment. Please arrive 20 minutes prior to your scheduled appointment time to allow for check-in and pre-registration paperwork.
- **Virtual appointments:** We ask that you start your visit 10 minutes prior to your scheduled appointment time. Please call us if you experience any technical issues during your virtual visit so that we do not mark you as a no show.

Cancelation Policy: If you are unable to keep your scheduled appointment, then please cancel (via mySaintLuke's Portal or phone) at least 24 business hours prior to your appointment time. If not, after two missed appointments your provider may send a letter reminding you of our cancelation policy and the importance of keeping scheduled appointments. After three missed appointments your provider may choose to discharge you from our clinic; in which case you will receive a letter notifying you and providing you a release of information form so that you can establish with a new clinic.

Financial Policy: All copayments and payments towards any deductibles are expected at the time of service. If you do not provide current and accurate insurance information or address changes for each visit you may be financially responsible for those services provided. If you have a concern about your financial obligation, then please contact the office prior to your visit to discuss. There may be additional fees for completing forms, such as disability or FMLA requests.

Prescriptions and Messages: Prescription renewals and refill requests should be requested through your pharmacy. Questions for your provider can be submitted via phone or the mySaintLuke's Portal. These requests and questions to your provider will normally be processed within two business days although some may take longer to process. You will need to plan accordingly and request refills at least five business days prior to the end date on your prescription. In some cases, your provider may require an office visit to provide refills so please be sure to schedule and keep follow-up visits as requested by your provider.

Thank you in advance for your cooperation with our office policy. Your compliance will improve our ability to serve you and others. Please call our office staff with any questions.

Patient Registration Form

(Please Print)

Patient Demographics:

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ Birth Date: _____ SSN: _____

Sex assigned at Birth: Male Female Gender Identity: _____

Address: _____

City/State/Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Birth Place: _____ United States Citizen: Yes No

Marital Status: Single Married Divorced Legally Separated Widowed Other

Patient Language: English Spanish Other _____ Interpreter Needed: Yes No

Ethnic Group: Hispanic or Latino Not Hispanic or Latino Decline

Race: American Indian or Alaska Native Black or African American White or Caucasian

Asian Native Hawaiian or Other Pacific Islander Other Decline

Religion: _____ Place of Worship: _____

Education: _____

Patient Primary Care Physician Information:

Primary Care Physician: _____ Phone: _____

Practice Location/Address: _____

Patient Employment Information:

Employment Status: Full Time Part Time Self-Employed Full Time/Student Part Time/Student

Military Duty Not Employed Disabled Retired

Employer: _____

Initial Health History Packet
Saint Luke's Behavioral Health Division

GENERAL INFORMATION

Name: _____ DOB: _____

Education level: _____

Reason for visit: _____

Referring doctor: _____

PSYCHIATRIC & MEDICAL HISTORY

Please check any current or past diagnoses given by a clinician:

ADHD/ADD	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>
Anorexia nervosa	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	OCD	<input type="checkbox"/>
Autism spectrum disorder	<input type="checkbox"/>	ODD (Oppositional defiance disorder)	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	Panic disorder	<input type="checkbox"/>
Borderline personality disorder	<input type="checkbox"/>	Psychosis	<input type="checkbox"/>
Bulimia nervosa	<input type="checkbox"/>	PTSD	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Schizoaffective disorder	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Substance abuse	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>
Other, please specify: _____			

Please list any past or current psychiatrist/s, psychologist/s or mental health provider/s (name/address/phone number):

Please list any other doctor/s or specialist/s you see regularly (name, address, phone number):

Please list any family members that been diagnosed with any mental illness, substance abuse disorder, dementia or neurologic disorder. Please specify if family member is maternal or paternal if applicable.

Please check any psychiatric medications you have taken in the past. If checked, please indicate years taken and effect.

Medication	Years Taken	Effect
Antidepressants		
Anafranil (Clomipramine)	<input type="checkbox"/>	
Torfranil (Imipramine)	<input type="checkbox"/>	
Desyrel (Trazodone)	<input type="checkbox"/>	
Amytriptyline (Elavil)	<input type="checkbox"/>	
Nortriptyline (Pamelor)	<input type="checkbox"/>	
Norpramin (Desipramine)	<input type="checkbox"/>	
Doxepin	<input type="checkbox"/>	
Celexa (Citalopram)	<input type="checkbox"/>	
Lexapro (Escitalopram)	<input type="checkbox"/>	
Zoloft (Sertraline)	<input type="checkbox"/>	
Paxil (Paroxetine)	<input type="checkbox"/>	
Prozac (Fluoxetine)	<input type="checkbox"/>	
Luvox (Fluvoxamine)	<input type="checkbox"/>	
Viibryd (Vilazodone)	<input type="checkbox"/>	
Nefazodone	<input type="checkbox"/>	
Effexor (Venlafaxine)	<input type="checkbox"/>	
Pristiq (Desvenlafaxine)	<input type="checkbox"/>	
Savella (Milnacipran)	<input type="checkbox"/>	
Cymbalta (Duloxetine)	<input type="checkbox"/>	
Wellbutrin/Zyban (Bupropion)	<input type="checkbox"/>	
Remeron (Mirtazepine)	<input type="checkbox"/>	
Marplan (Isocarboxazid)	<input type="checkbox"/>	

Nardil (Phenelzine)	<input type="checkbox"/>	
Parnate (Tranlylcypromine)	<input type="checkbox"/>	
Em Sam (Selegiline)	<input type="checkbox"/>	
Anti-Anxiety		
Buspar (Buspirone)	<input type="checkbox"/>	
Neurontin (Gabapentin)	<input type="checkbox"/>	
Atarax/Vistaril (hydroxyzine)	<input type="checkbox"/>	
Ativan (Lorazepam)	<input type="checkbox"/>	
Xanax (Alprazolam)	<input type="checkbox"/>	
Klonopin (clonazepam)	<input type="checkbox"/>	
Valium (Diazepam)	<input type="checkbox"/>	
Librium (Chlordiazepoxide)	<input type="checkbox"/>	
Pindolol	<input type="checkbox"/>	
Inderal (Propranolol)	<input type="checkbox"/>	
Tenex/Intuniv (Guanfacine)	<input type="checkbox"/>	
Clonidine/Kapvay,(Catapres)	<input type="checkbox"/>	
Antipsychotics		
Abilify (Aripiprazole)	<input type="checkbox"/>	
Saphris (Asenapine)	<input type="checkbox"/>	
Clozaril (Clozapine)	<input type="checkbox"/>	
Fanapt (Iloperidone)	<input type="checkbox"/>	
Latuda (Lurasidone)	<input type="checkbox"/>	
ZYprexa (Olanzapine)	<input type="checkbox"/>	
Invega (Paliperidone)	<input type="checkbox"/>	
Seroquel (Quetiapine)	<input type="checkbox"/>	
Risperdal (Risperidone)	<input type="checkbox"/>	
Chlorpromazine (Thorazine)	<input type="checkbox"/>	
Haldol (Haloperidone)	<input type="checkbox"/>	
Loxapine (Loxitane)	<input type="checkbox"/>	
Thioridazine (Mellaril)	<input type="checkbox"/>	
Mood Stabalizers		
Lithium (Eskalith)	<input type="checkbox"/>	
Depakote (Valproic Acid)	<input type="checkbox"/>	
Tegretol (Carbamazepine)	<input type="checkbox"/>	
Trileptal (Oxcarbazepine)	<input type="checkbox"/>	
Lamictal (Lamotrigine)	<input type="checkbox"/>	
Topamax (Topiramate)	<input type="checkbox"/>	
Neurontin (Gapapentin)	<input type="checkbox"/>	
Dilantin (Phenytoin)	<input type="checkbox"/>	

Stimulants/ ADHD Meds	<input type="checkbox"/>		
Provigil	<input type="checkbox"/>		
Nuvigil	<input type="checkbox"/>		
Adderall (Amphetamine)	<input type="checkbox"/>		
Vyvanse	<input type="checkbox"/>		
Ritalin	<input type="checkbox"/>		
Concerta/Metadate	<input type="checkbox"/>		
Sleep Medications	<input type="checkbox"/>		
Ambien (Zolpidem)	<input type="checkbox"/>		
Lunesta (Eszopiclone)	<input type="checkbox"/>		
Pro-Som (Estazolam)	<input type="checkbox"/>		
Resotril (Temazepam)	<input type="checkbox"/>		
Sonata (Zaleplon)	<input type="checkbox"/>		
Trazodone (Desyrel)	<input type="checkbox"/>		
Rozerem (ramelteon)	<input type="checkbox"/>		
Over the counter or herbal supplements:	<input type="checkbox"/>		
Tylenol PM	<input type="checkbox"/>		
Melatonin	<input type="checkbox"/>		
Fish oil/Oemga-3 fatty acids	<input type="checkbox"/>		
St. John's Wort	<input type="checkbox"/>		
SamE	<input type="checkbox"/>		
5HTP	<input type="checkbox"/>		
Other	<input type="checkbox"/>		
Dementia/Cognitive	<input type="checkbox"/>		
Aricept (Donezpril)	<input type="checkbox"/>		
Excelon	<input type="checkbox"/>		
Namenda (Memantine)	<input type="checkbox"/>		

SOCIAL HISTORY

Tobacco use history

Smoke tobacco (Check one):

Current every day smoker	<input type="checkbox"/>	Never smoker	<input type="checkbox"/>
Current some days smoker	<input type="checkbox"/>	Passive smoke exposure-never smoker	<input type="checkbox"/>
Former smoker	<input type="checkbox"/>		<input type="checkbox"/>

If current or past smoker:

Start date: _____ Quit Date: _____

Type: _____ Packs/day: _____ **Smokeless**

tobacco (Check one):

Never used	<input type="checkbox"/>	Current user	<input type="checkbox"/>	Former user	Quit Date:	<input type="checkbox"/>
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Alcohol use history

Alcohol use (Circle one):

Yes	No
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If yes, please indicate amount:

Drinks	Number Per Week
Glasses of wine	
Cans/bottles of beer	
Shots of liquor	
Standard drinks	

Substance use history

Drug use (Circle one):

Yes	No
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If yes, indicate types: _____

If yes, indicate use per week: _____

Sexual history

Sexually active (Circle one):

Yes	No	Not currently
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If yes, indicate birth control/protection: _____

If yes, circle partner/s:

Female	Male
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Sexual Orientation-Gender Identity

Would you like to identify your sexual orientation? (Circle one):

Yes	No
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**To be filled out
by patient
ONLY**

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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	0	1	2	3

add columns + +

TOTAL:

10. If you checked off <i>any problems</i> , 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	_____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rs8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

To be filled out
by patient
ONLY

GAD-7

Over the last 2 weeks, how often have you
been bothered by the following problems?

Not
at all

Several
days

More than
half the
days

Nearly
every day

(Use "✓" to indicate your answer)

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 is 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

(For office coding: Total Score T ____ = ____ + ____ + ____)