IMAGINE PROGRAMS • 1947 K AVE. Suite A100, Plano, TX 75074 • **P** (972) 423-6007 • **F** (972) 423-6861 www.imagineprograms.net

NEW PATIENT INFORMATION

DATE:

PATIENT INFORMATION

Name:		Sex: ☐ M ☐ F
Date of birth:	SSN:	Phone: ( )
Current address:		
City:	State:	ZIP Code:

Email address: _____

Please note that all email communications are not secure, and may inadvertently result in disclosure of protected health information to third parties. Please use email communications with discretion, as we are not able to guarantee complete privacy of internet communications.

Preferred method of contact: ☐ Phone ☐ Email ☐ Mail Can we leave a message? ☐ Yes ☐ No	

EMPLOYMENT INFORMATION

Current employer:	Position:
Work phone #:	

EMERGENCY CONTACT

Name:		
Relationship:		Phone: ( )
Address:	State:	ZIP Code:

PARTY RESPONSIBLE FOR PAYMENT

☐ Self ☐ Parent (Name:_____)

☐ Other (Name:_____Relationship_____Contact number:__(_____)_____)

Address of party responsible for payment (if other than patient):

INSURANCE INFORMATION

Name of Insurance Company:	Phone:
Policy Number:	Group number:
Policy Holder Name:	Relationship to patient:
SSN (policy holder):	DOB (policy holder):

REFERRALS

Referred by
☐ Primary Care Physician ☐ Other physician ☐ Self-Referral ☐ Probation / Court Services ☐ Social Services

Referral Contact Information: *Please let us know about your referral source so that we can coordinate care or provide information about treatment services.*

Name: Phone: Email:

PRIMARY CARE PHYSICIAN

Do you have a primary care physician? ☐ Yes ☐ No

If yes, what is their name or name of practice?_____What is their phone number? (_____)_____

PERSONAL INFORMATION

MEDICAL HISTORY

When was your last appointment with your **primary care physician**:

Medical conditions:

Please list any **laboratory** abnormalities that may have been found recently (such as electrolytes, thyroid, liver function, etc.):

Please list any **Food Allergies:**

Medications **currently** taking (including psychiatric, sleep medications and herbal supplements):

Allergies to medications (please list): OR No Known Drug Allergies ☐

Women: date of last menstrual period_____ Method of contraception:_____

Is there a possibility that you are pregnant? ☐ Yes ☐ No

MENTAL HEALTH HISTORY

Prior psychiatrist/psychologist/therapist:

Date last seen (approximate):

Have you ever tried psychotherapy? ☐ Yes ☐ No
Was it helpful? ☐ Yes ☐ No

Prior psychiatric diagnoses:

Prior medications:	Did they help? (Y/N):	Side effects/Adverse events:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you **smoke**/Use nicotine?: ☐ Yes ☐ No Last use_____Average amount per day_____

Do you drink **alcohol**?: ☐ Yes ☐ No Last drink_____
How many servings per week on average? (shot, beer, glass of wine)_____

In the past 3 months, have you used:

☐ **Marijuana** ☐ **Cocaine** ☐ **PCP** ☐ **LSD** ☐ **Amphetamines** ☐ **Ecstacy** ☐ Other _____

Have you ever used **IV drugs** (heroin, etc)? ☐ Yes ☐ No

Have you ever received **treatment** (such as inpatient, 28 day program, outpatient treatment) for substance abuse? ☐ Yes ☐ No

PERSONAL INFORMATION

Have you ever been **hospitalized** in an inpatient psychiatric hospital? ☐ Yes ☐ No

If yes, how many times?_____ Where (most recent)?_____

When was the last time you were hospitalized?_____

Have you ever had thoughts of **suicide**? ☐ Yes ☐ No

Are you having thoughts of suicide now? ☐ Yes ☐ No

Do you have any plans to act on these thoughts? ☐ Yes ☐ No

Have you ever attempted to commit suicide? ☐ Yes ☐ No If yes, how?_____

Have you experienced any significant trauma in the past? ☐ Yes ☐ No

Any prior abuse? ☐ Yes ☐ No

FAMILY PSYCHIATRIC HISTORY

Do you have any close relatives (parents, siblings, grandparents, children) diagnosed with any **psychiatric illnesses** or **substance abuse** issues, or any who have attempted/committed **suicide**?

Relation	Diagnosis	Hospitalized? (Y/N)

REVIEW OF SYSTEMS

Have you experienced any of the following within the last 2 weeks?

Persistent headache	☐ Yes	☐ No	Nausea/vomiting	☐ Yes	☐ No	Numbness/tingling	☐ Yes	☐ No
Vision changes	☐ Yes	☐ No	Frequent heartburn	☐ Yes	☐ No	Painful urination	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No	Chest pain	☐ Yes	☐ No	Extreme thirst	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	**Suicidal** thoughts	☐ Yes	☐ No
Seasonal allergies	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No	Loss of consciousness	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No	Profuse Sweating	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No	Hyperactivity	☐ Yes	☐ No	Other pain	☐ Yes	☐ No

REASON FOR SEEKING TREATMENT

Please list **primary reasons** for coming to the clinic:

_____

_____

_____

_____

_____

Consents: I give consent for Imagine Programs staff to conduct a substance abuse screening / evaluation and understand that I have the right to have the results of the evaluation explained in to me. I give further consent to Imagine Programs to seek third party payment for services (if applicable) as well as provide necessary health related information to third party payers for approval and payment for services.

Patient Signature:_____ Date: _____

Parent / Guardian Signature:_____ Date:_____

PARENT QUESTIONNAIRE

DATE:

PARENT INFORMATION

Name:		Sex: ☐ M ☐ F
Date of birth:	Relation:	Phone: ( )
Current address:		
City:	State:	ZIP Code:

EMPLOYMENT INFORMATION

Current employer:	Position:
Work phone #:	

ASSESSMENT OF PROBLEMS

Has your child abused alcohol or other drugs?

If yes, please select from the following:

☐ Marijuana ☐ Cocaine ☐ PCP ☐ LSD ☐ Amphetamines ☐ Ecstacy ☐ Alcohol ☐ Other _____

To your knowledge, how often has your child used the selected substances: _____

_____

Has your child experienced any legal problems due to use of substances? (If yes, please describe)_____

_____

SEVERITY OF PROBLEMS

Has your child experienced the following in the past 90 days: (check all that apply)

Unexcused absence from school	☐	Have grades dropped	☐	Excessive Gaming	☐
Experienced bullying at school	☐	Lost interest in school activities	☐	Given up on hobbies	☐
Been in detention or suspended	☐	Hanging out with bad influences	☐	Avoids family	☐
Arrested in the past 90 days	☐	Sneaking out	☐	Anger problems	☐
Mood Swings	☐	Depressed	☐	Believes drug use is ok	☐
Spent time in Jail	☐	Lying	☐	Has drug paraphernalia	☐

HISTORY OF SUBSTANCE ABUSE PROBLEMS

Has there been a family history of substance abuse or mental illness? ☐ Yes ☐ No If yes, please explain:	Has your child been treated for substance abuse or mental health problems in the past? ☐ Yes ☐ No If yes, please explain:

SEVERITY RATING

Please circle the number that best describes your answer (1 = No Problem to 10 = Extreme Problem)

How bothered have you been by your child's substance abuse problems?	1	2	3	4	5	6	7	8	9	10
Your child can stop using substances on his/her own?	1	2	3	4	5	6	7	8	9	10
Your child is influenced by friends to abuse substances?	1	2	3	4	5	6	7	8	9	10
Your child has developed an addiction problem?	1	2	3	4	5	6	7	8	9	10
Your child needs help changing behaviors?	1	2	3	4	5	6	7	8	9	10

Please tell us about any other concerns you would like us to know about: _____

_____