Revised 9.3.2019

PATIENT NAME: _____
DOB: _____

Thank you for filling out the below Education, occupational, family, and substance history questionnaire. Your clinician will receive this form (if you fill it out in advance) and may ask you some additional follow-up questions based upon the information you provide.

Please note that "You" used throughout the questionnaire is referring to "You" as the Patient. We recognize that the Patient may be a young child that a Parent is completing this form for. If that is the case, please fill out the form from the "You" as whomever the identified Patient is. "Me" and "I" that is used throughout the form is referring to the clinician that you have been assigned to to here at St. Louis Behavioral Medicine Institute.

EDUCATION AND OCCUPATION HISTORY

Are you currently in school? ☐ No ☐ Yes (describe):
Do you have any school/education concerns: ☐ No ☐ Yes (describe):

If not in school, what is your highest level of education: _____
Is there any relevant educational history I should know about?: ☐ No ☐ Yes (describe):

Are you currently employed? ☐ No ☐ Yes (describe):
Tell me about your job (or the circumstances around not working if that is the case). Any employment-related concerns?: ☐ No ☐ Yes (describe):

Do you have any military history? ☐ No ☐ Yes (describe relevant history/information, i.e., branch, when served, combat, injury/trauma)):

DEVELOPMENTAL, PSYCHOSOCIAL, AND SOCIOCULTURAL HISTORY

Current relationship status: _____
Any relationship history information that is important or current concerns?: ☐ None ☐ Yes (describe):

Number of children you have: Ages: _____
Any issues or concerns re: your children?: ☐ None ☐ Yes (describe):

Who do you go to for support? Any concerns you have for your social relationships?

Do you belong to any religious/spiritual or community groups that are important to you? describe:

Did you have any developmental concerns as a child? ☐ None ☐ Yes (List/describe):

PATIENT NAME: _____
DOB:

Family of origin:

Tell me about your Parents/caretakers? Any concerns with your relationship?:

Tell me about your siblings. How old are they? Any concerns with your relationship(s) to them?:

Any family mental health / substance abuse history? Who and What did they struggle with ☐ None ☐ Yes (describe):

Family medical history: ☐ None ☐ Yes (describe):

Do you have any other family information or concerns: ☐ None ☐ Yes (describe):

Do you have any legal history, such as being arrested in the past?: ☐ None ☐ Yes (describe):

Any other stressors going on in your life? ☐ None ☐ Yes (describe):

SUBSTANCE ABUSE HISTORY

Do you use tobacco ☐ No ☐ Yes (Amount):

Do you use alcohol ☐ No ☐ Yes (Amount):

Do you currently use other substances: ☐ No ☐ Yes (describe):

Have you used other substances in the past?: ☐ No ☐ Yes (describe):

What is your substance treatment history: ☐ None ☐ Yes (describe):

Is there any other substance history I should know about (i.e., family history, prescription drug misuse/overuse):
☐ No ☐ Yes (describe):

PATIENT NAME: _____
DOB: _____

Additional information you would like to let your clinician know:

***Please include ALL psychiatric and non-psychiatric medications**

ALL MEDICATION & MEDICAL SUMMARY LIST

SAINT LOUIS BEHAVIORAL
MEDICINE INSTITUTE

PATIENT NAME: _____

DOB: _____

Completed by Patient

For Clinician Use

Medication Name*	Medication Dosage & Frequency	Medical Condition	Prescribing Physician	Notes / If discontinued, Enter Date	Date/Initial at Each Review		

_____ _____

Signature of Staff Completing Initial Form Date

***Please include ALL psychiatric and non-psychiatric medications**

ALL MEDICATION & MEDICAL SUMMARY LIST

SAINT LOUIS BEHAVIORAL
MEDICINE INSTITUTE

PATIENT NAME: _____

DOB: _____

Completed by Patient				For Clinician Use			
Medication Name*	Medication Dosage & Frequency	Medical Condition	Prescribing Physician	Notes / If discontinued, Enter Date	Date/Initial at Each Review		

_____ _____

Signature of Staff Completing Initial Form Date

Revision Date: 5.1.2017

Request/Authorization to Release Confidential Records and Information

St. Louis Behavioral Medicine Institute
Central: 1129 Macklind • St. Louis, MO 63110 • 314-534-0200 • Fax: 314-534-7996
West County: 16216 Baxter Road, Suite 205 • Chesterfield, MO 63017 • 636-532-9188 • Fax: 636-532-9951

Patient Name (Printed)_____ **Date of Birth** ___/___/___

I hereby give ST. LOUIS BEHAVIORAL MEDICINE INSTITUTE permission to execute the following:

OBTAIN, RELEASE, and CORRESPOND
my Protected Health Information FROM / TO:

Name: _____ Phone _____

Address: _____ Fax: _____

_____ Email: _____

_____ Relationship to patient: _____

Permissible means of communications (check all that apply) ☐ALL: ☐Phone ☐ Letter ☐Fax ☐E-Mail

Please check requested items:

☐All items can be released
☐ Initial Diagnostic Interview
☐ Psychiatric evaluations
☐ Psychological testing
☐ Admission Summary/plan
☐ Treatment plan
☐ Progress notes
☐ Discharge summary/plan
☐ Medication records
☐ Billing records
☐ Physician's orders
☐ Coordination of care
☐ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work
☐ Laboratory data
☐ Alcohol/Drug Abuse Treatment
☐ Other: _____

TERM OF AUTHORIZATION

Purpose of the exchange of information: ☐ to coordinate care ☐ at the request of the individual
☐ Other:_____

Disclaimers: This authorization may be revoked at any time, except to the extent that action will have already been taken upon this authorization. I understand that services provided by SLBMI are not conditional upon my signing this authorization unless the services are provided to me for the purpose of creating health information for a third party. **Expiration date:_____.**

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of your information and may no longer be protected by the HIPPA Privacy Rule. I also understand that if I have any questions or concerns about any part of this form, I can discuss it with an SLBMI staff member prior to signing.

I understand that the exchange of confidential information authorized by this form could include information about any of the following conditions from my medical history: alcohol and drug abuse, HIV/AIDS, psychological, psychiatric or other mental impairment, sickle cell anemia, sexually transmitted diseases, gene-related impairments and other health conditions. It may also include information about how my impairment affects my ability to complete tasks and activities of daily living, and copies of educational testing or evaluations, including individualized educational programs, triennial assessments, speech evaluations and any other records that can help evaluate function.

☐ I **agree** to provide consent for St. Louis Behavioral Medicine Institute to obtain, release, or correspond my protected health information to the above listed individual / organization.

☐ I **decline** to provide consent for St. Louis Behavioral Medicine Institute to obtain, release, or correspond my protected health information to the above listed individual / organization. I understand that if my referral source is my (current) healthcare provider, they will be notified of my name, date of birth, and date of my initial appointment with an SLBMI clinician, but no other information regarding my treatment at SLBMI will be provided.

X_____ _____ _____ _____

Patient Signature Date Signature of parent or authorized legal guardian Date

_____ _____

Witness Signature Date

Notice to those who receive information accompanying this form: This information has been disclosed to you from confidential records and is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.

PRIMARY CARE PHYSICIAN

Request/Authorization to Release Confidential Records and Information

St. Louis Behavioral Medicine Institute
Central: 1129 Macklind • St. Louis, MO 63110 • 314-534-0200 • Fax: 314-534-7996
West County: 16216 Baxter Road, Suite 205 • Chesterfield, MO 63017 • 636-532-9188 • Fax: 636-532-9951

Patient Name (Printed)_____ **Date of Birth** ___/___/___

I hereby give ST. LOUIS BEHAVIORAL MEDICINE INSTITUTE permission to execute the following:

OBTAIN, RELEASE, and CORRESPOND
my Protected Health Information FROM / TO:

Name: _____ Phone _____

Address: _____ Fax: _____

_____ Email: _____

_____ Relationship to patient: _____

Permissible means of communications (check all that apply) ☐ALL: ☐Phone ☐ Letter ☐Fax ☐E-Mail

Please check requested items:

☐All items can be released
☐ Initial Diagnostic Interview
☐ Psychiatric evaluations
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☐ Billing records
☐ Physician's orders
☐ Coordination of care
☐ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work
☐ Laboratory data
☐ Alcohol/Drug Abuse Treatment
☐ Other: _____

TERM OF AUTHORIZATION

Purpose of the exchange of information: ☐ to coordinate care ☐ at the request of the individual
☐ Other:_____

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X_____ _____ _____ _____

Patient Signature Date Signature of parent or authorized legal guardian Date

_____ _____

Witness Signature Date

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