Saint Louis
BEHAVIORAL
MEDICINE
Institute

16216 Baxter Road, Suite 205 • Chesterfield, MO 63017 • (636) 532-9188 • www.slbmi.com

Dear Client,

Thank you for choosing St. Louis Behavioral Medicine.

Your appointment with Melanie McKean, D.O., Ph.D., is scheduled for ______________ at _______.

We are enclosing paperwork which is critical to your first appointment.

Please complete the attached forms in full, so we can make sure we have all of the information necessary to address your individual needs and concerns.

Also attached are 3 release forms:

a. One is for your Primary Care Provider (if you have one).
b. The second release is for your current or previous therapist or counselor (if you have seen one).
c. The third release is for your most-recent past psychiatrist (if you have seen one).

These release forms should have the full name of your doctor, his/her phone number and address.

We look forward to working with you.

St. Louis Behavioral Medicine Institute Staff

History Questionnaire

The purpose of this questionnaire is to provide a comprehensive picture of your past history and present situation so that we can design the most appropriate treatment for you. Write your answers in the blanks provided. If two or more choices are listed, circle the answer which best describes you or your situation. Please be as accurate and candid as possible. Your answers will be strictly confidential and no outsider will be allowed to see your records without your permission.

Demographic Information

1. Name: ________________________ 2. Date: ____________

3. Phone Number(s) : (home) ____________ (other) ____________

4. Height: ____ ft. ____ in. 5. Weight: ____ lbs.

The Problem

6. What present complaints are you seeking treatment for? ________________________

____

7. How long have you had these problems? ______ years ______ months

8. What do you believe is presently causing these problems? ________________________

____

9. What is your current pharmacy where you would like prescriptions sent to? ________________________

____
(address) (phone Number)

10. Have you sought mental health treatment before? Yes No
If yes, please list in chronological order the therapists/psychiatrists and dates seen.

Name of Therapist/Psychiatrist:	Reason for Therapy	Date Seen:
		to
		to
		to
		to

11. Have you ever been hospitalized for this or any other behavioral/psychological problem? Yes No
If yes, please list in chronological order the hospital and dates seen.

Name of Therapist/Psychiatrist:	Reason for Therapy	Date Seen:
		to
		to
		to
		to

Childhood/Development History

12. Do you know if you met all of your developmental milestones growing up (i.e. crawling, walking, talking) on time? Yes No

    If no, please explain: ____________________

    ____

13. Have you ever been diagnosed with a learning disorder or required special needs in school? Yes No

14. Mother's condition during pregnancy (as far as you know): ____________________

____

____

Education

15. List the schools you have attended and when you attended them.

	Name of School	Dates
Elementary		
High School		
GED		
College		
Technical Training		
Other:		

Family/Social History

16. Circle your sexual preference: Heterosexual Homosexual Bisexual

17. Marital Status: Married Single Divorced Separated Widowed

18. If you are divorced or separated, for what reason? ____________________

19. How many times have you been married? __________

20. Please list the name of your spouse or significant other: ____________________

21. Spouse or Significant other's age: __________

22. Spouse or Significant other's occupation: ____________________

23. How satisfied are you with your marital/intimate relationship?

    Very Dissatisfied Dissatisfied Somewhat Satisfied Satisfied Very Satisfied

24. Have you ever experienced any trauma or abuse (physical, emotional, or sexual)? Yes No
    If yes, please describe: ____________________

____

25. Do you have children? Yes No

If so, please list their names and ages:

Name	Birthdate	Age

26. List the people who currently live in your household and their relationship to you:

Name	Relationship (e.g., mother-in-law, daughter, etc.)

27. In what area (county, city), do you currently live in? ______________________

28. Are you currently employed? Yes No Current Job: ______________________

29. If presently working, please list a few of your major chores, duties, or responsibilities: ______________________

____

30. If you are not employed, when was the last time you worked and what was your profession? ______________________

____

31. Have you been in the military? Yes No

32. How well do you feel your parents get (got) along?

Not at all With Some Difficulty Fairly Well Very Well Exceptionally Well

33. Father: Living Deceased

If alive, give father's present age and occupation: ______________________

Describe his health: ______________________

34. Mother: Living Deceased

If alive, give mother's present age and occupation: ______________________

Describe her health: ______________________

35. How many siblings do you have? ________

List your siblings, their ages, and how you got along.

Name of Brother/Sister	Age	How did you get along with him/her?

36. Does anyone in your family have psychiatric illness? (depression, anxiety, bipolar disorder, schizophrenia etc..) **Yes** **No**

If so, please list the family members and their diagnosis:

Family Member	Diagnosis

37. Has anyone in your family ever attempted or committed suicide? **Yes** **No**

38. Does anyone in your family have any substance abuse addictions (drugs or alcohol)? **Yes** **No**

If so, please list the family member and what substance they are/were addicted to: ____________________

____

39. Please give any further information about your family that you believe might be relevant to your present problem:

____

____

Substance Use History:

40. Do you drink? **Yes** **No** If so, how much/often? ____________________

____

41. Do you use tobacco products? **Yes** **No** If so, how much/often? ____________________

____

42. Have you ever used any illicit substances? **Yes** **No** If so, how much/often? ____________________

____

43. Have you ever abused any prescription drugs? (narcotics such as Percocet or Vicodin) **Yes** **No**

If so, how much/often? ____________________

____

44. Has anyone ever told you they think you have a problem with drugs or alcohol? **Yes** **No**

45. Has anyone ever told you they think you have a problem with tobacco usage? **Yes** **No**

Medical and Mental Health History

46. Do you have medical problems? (diabetes, hypertension, etc?) **Yes** **No**

If so, which ones? ______________________________

____

47. Are there any medical conditions that run in your family? (hypertension, diabetes, cancer, etc.) **Yes** **No**

If so, please list the family members and their diagnosis. ______________________________

____

____

48. Have you ever had and surgery? **Yes** **No**
If so, list the dates and what surgery was performed:

Surgery Performed	Date of Surgery

49. When was the last time you had a complete physical exam? ________ Month ________ Year

Results: ______________________________

____

50. Have you ever attempted to commit suicide? **Yes** **No**

If so, please list briefly and describe the incident. ______________________________

____

51. Have you ever attempted to injure yourself for some other reason other than a suicide attempt? **Yes** **No**

If so, please list and describe the incident. ______________________________

____

52. Have you ever been prescribed any psychiatric medications? Check all that apply.

___ Abilify (aripiprazole)
___ Adderall (amphetamine)
___ Anafranil (clomipramine)
___ Ativan (lorazepam)
___ Buspar (buspirone)
___ Celexa (citalopram)
___ Clozaril (clozapine)
___ Concerta (methylphenidate)
___ Cymbalta (duloxetine)
___ Depakote (valproic acid)
___ Desyrel (trazodone)
___ Effexor (venlafaxine)
___ Elavil (amitriptyline)
___ Emsam (selegiline)
___ Fanapt (iloperidone)
___ Geodon (ziprasidone)
___ Haldol (haloperidol)
___ Intuniv (guanfacine)
___ Invega (paliperidone)
___ Klonopin (clonazepam)
___ Lamictal (lamotrigine)
___ Latuda (lurasidone)
___ Lexapro (escitalopram)
___ Lithobid (lithium)
___ Luvox (fluvoxamine)
___ Pamelor (nortriptyline)
___ Paxil (paroxetine)
___ Pristiq (desvenlafaxine)
___ Prolixin (fluphenazine)
___ Prozac (fluoxetine)
___ Remeron (mirtazapine)
___ Risperdal (risperidone)
___ Ritalin (methylphenidate)
___ Saphris (asenapine)
___ Seroquel (quetiapine)
___ Sinequan (doxepin)
___ Strattera (atomoxetine)
___ Symbyax (olanzapine/fluoxetine)
___ Tegretol (carbamazepine)
___ Tofranil (imipramine)
___ Topamax (topiramate)
___ Trileptal (oxcarbazepine)
___ Valium (diazepam)
___ Viibryd (vilazodone)
___ Vistaril (hydroxyzine)
___ Vyvanse (lisdexamfetamine)
___ Wellbutrin (bupropion)
___ Xanax (alprazolam)
___ Zoloft (sertraline)
___ Zyprexa (olanzapine)

53. Do you have allergies to medications? Yes No

If so, which ones? ____

____

54. Please list all the medications including those for a physical or emotional problem you are presently taking:

Name of Medication	Dosage (mg/day)	What is this medication for?

55. Have you ever had a disturbing experience while taking medications? **Yes** **No**

If so, please explain: ____

____

Menstrual History

56. Age at first period? ____________

57. Were you informed or did it come as a shock? ____________________

58. Are (Were) you regular? **Yes** **No**

59. How many days do your periods last? ____________

60. Are (Were) your periods painful? **Yes** **No**

61. Do (Did) your periods affect your mood or behavior? **Yes** **No**

If so, please explain: ____

____

Review of Systems: Please check or list problems in each body system. If problem is not listed write it in the space provided.

Ears, Nose, Mouth, Throat:

___ Hearing Loss
___ Ringing in the Ears
___ Ear Pain
___ Nasal Congestion
___ Nasal Drainage
___ Nosebleeds
___ Mouth/Throat Irritation
___ Tooth Problem

Other Problems: ______

Eyes:

___ Blurry Vision
___ Double Vision
___ Vision Loss
___ Pain Sensitivity to Light
___ Glaucoma
___ Tearing
___ Redness

Other Problems: ______

Constitutional:

___ Fever
___ Weight Gain
___ Appetite Change
___ Night Sweats
___ Fatigue
___ Chills

Other Problems: ______

Cardiovascular:

___ Chest Pain/Pressure
___ Heart Racing
___ Palpitations
___ High Blood Pressure
___ Low Blood Pressure
___ Sweating
___ Leg Swelling

Other Problems: ______

Pulmonary:

___ Cough
___ Wheezing
___ Blood in Sputum
___ Shortness of Breath
___ Yellow/Green Sputum

Other Problems: ______

Gastrointestinal:

___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Pain
___ Blood in Stool
___ Blood in Vomitus
___ Heartburn
___ Difficulty Swallowing

Other Problems: ______

Genitourinary:

___ Incontinence
___ Abnormal Bleeding
___ Abnormal Discharge
___ Urinary Frequency
___ Urinary Hesitancy
___ Pain
___ Impotence
___ Sexual Problem
___ Infection
___ Urinary Retention

Other Problems: ______

Musculoskeletal:

___ Arthritis
___ Back Pain
___ Weakness
___ Pain in Joints
___ Stiffness in Joints
___ Joint Redness/Warmth
___ Muscle Wasting
___ Sprain
___ Fracture

Other Problems: ______

Neuro:

___ Headache
___ Weakness
___ Dizziness
___ Change in Voice
___ Change in Taste
___ Change in Vision
___ Change in Hearing
___ Change in Sensation
___ Trouble Walking
___ Balance Problem
___ Coordination Problem
___ Shaking Speech

Other Problems: ______

Endocrine:

___ Missed Periods
___ Hot Flashes/Sweats
___ Change in Body Hair
___ Cold or Heat Intolerance
___ Blood Sugar Problem
___ Weight Gain or Loss
___ Change in Libido
___ Increased Thirst
___ Increased Urination

Other Problems: ______

Heme/Lymph:

___ Swelling
___ Bleeding Problem
___ Anemia
___ Bruising
___ Enlarged Lymph Node

Other Problems: ______

Allergic/Immunologic:

___ Itch
___ Post-Nasal Drip
___ Watery/Itchy Eyes
___ Nasal Drainage
___ Immunosuppressed

Other Problems: ______

NON-SLBMI THERAPIST

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.

PREVIOUS PSYCHIATRIST

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.

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X______________________ __________ ____________________________________ __________

Patient Signature Date Signature of parent or authorized legal guardian Date

________________________ __________

Witness Signature Date

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PRIMARY CARE PHYSICIAN

Request/Authorization to Release Confidential Records and Information

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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:____

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X______________________ __________ ____________________________________ __________

Patient Signature Date Signature of parent or authorized legal guardian Date

________________________ __________

Witness Signature Date

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