MSU Health Care

MICHIGAN STATE UNIVERSITY
DEPARTMENT OF PSYCHIATRY

Thank you for your interest in *Michigan State University's Psychiatric Services*. A service of the Department of Psychiatry and the MSU HealthCare.

The enclosed packet of material needs to be completed and returned to our office before an appointment can be scheduled. Obtaining as much information as possible regarding your history will assist us in performing an accurate and thorough assessment. Please complete the enclosed forms as accurately and completely as possible and return them in the enclosed envelope.

If you have been under the care of a psychiatrist or had any psychiatric hospitalizations within the past year, please have those records forwarded to us.

We will ask you to sign a ***Patient Authorization for Disclosure of Health Information*** for your primary care physician in order to coordinate care.

***Please note that you will be seen for the purpose of assessment and treatment recommendations only. Decisions regarding continuing treatment will be made based on the assessment findings. Participation in the assessment does not mean that we will be assuming ongoing care. ***

The Department of Psychiatry is a training institution. You will be scheduled with a Resident who is supervised by a licensed Psychiatrist. Note that a medical student may be observing in your care.

Thank you for your prompt consideration. If you have any questions, please feel free to contact us at (517) 353-3070.

Psychiatry

West Fee Hall
909 Wilson Road
Suite B119
East Lansing, MI 48824

(517) 353-3070
Fax: (517) 884-1817
healthcare.msu.edu
psychiatry.msu.edu

Nikki Peterson

Intake Coordinator
Department of Psychiatry
Michigan State University
Telephone: 517-353-3070 Fax: 517-884-1817

MSU Health Care

Patient Registration

Last Name: _____ First Name: _____

First Name Used: _____ DOB: _____ SSN: _____

Legal Sex: _____ Assigned at birth: _____ Gender Identity: _____

Preferred Pronoun: ☐ he/him ☐ she/her ☐ they/them

Sexual Orientation: ☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Secondary Number: _____

Email (Not parent email if minor): _____

Language Preference: _____

Race: _____ Ethnicity: _____

Marital Status: _____

PRIMARY INSURANCE

Holder: _____

Group #: _____

Policy: _____

SECONDARY INSURANCE

Holder: _____

Group #: _____

Policy: _____

EMERGENCY CONTACT

Name: _____

Relation: _____

Phone Number: _____

Secondary Number: _____

NEXT OF KIN

Name: _____

Relation: _____

Phone Number: _____

PARENT/GUARDIAN(S)

Parent/Guardian #1 Name: _____

Phone: _____ Email: _____

Street Address (if different than patient): _____

City: _____ State: _____ Zip: _____

Parent/Guardian #2 Name: _____

Phone: _____ Email: _____

Street Address (if different than patient): _____

City: _____ State: _____ Zip: _____

Michigan State University
Department of Psychiatry

Personal History

Pt. Name:_____
Date:_____ MRN:_____

Name: _____ Birth Date: _____ Age: _____

Ethnicity: _____ Gender: _____

Who referred you to our practice? _____

Primary care physician: _____ Therapist: _____

HISTORY OF CURRENT PROBLEM

Please explain why you are coming in to treatment:

_____
_____
_____
_____

When did the problem start?

_____

Explain any associated factors that contributed or precipitated the above problem:

_____
_____

PAST PSYCHIATRIC TREATMENT

Past Psychiatrists:	Dates:
_____	_____
_____	_____
Past Therapists:	**Dates:**
_____	_____
_____	_____
Past Psychiatric Hospitalizations:	**Dates:**
_____	_____
_____	_____
_____	_____

Michigan State University
Department of Psychiatry

Personal History

Pt. Name:_____
Date:_____ MRN:_____

CIRCLE MEDICATIONS TRIED:

SSRIs:
Celexa (citalopram)
Lexapro (escitalopram)
Luvox (fluvoxamine)
Paxil (paroxetine)
Prozac (fluoxetine)
Zoloft (sertraline)

SNRIs:
Cymbalta (duloxetine)
Effexor (venlafaxine)
Pristiq (desvenlafaxine)

Other Antidepressants:
Brintellix (vortioxetine)
Remeron (mirtazapine)
Serzone (nefazasone)
Viibryd (vilazodone)
Wellbutrin (bupropion)

TCAs:
Anafranil (clomipramine)
Elavil (amitriptyline)
Norpramin (desipramine)
Pamelor (nortriptyline)
Silenor (doxepin)
Tofranil (imipramine)

MAOIs:
Emsam (selegiline)
Marplan (isocarboxazid)
Nardil (phenelzine)
Parnate (tranylcypromine)

Anticonvulsants / Mood stabilizers:
Depakote (valproic acid)
Keppra (levetiracetam)
Lamictal (lamotrigine)
Lithobid / Eskalith (lithium)
Lyrica (pregabalin)
Neurontin (gabapentin)
Tegretol (carbamazepine)
Trileptal (oxcarbazepine)
Topamax (topiramate)

Anxiolytics :
Atarax / Vistaril (hydroxyzine)
BuSpar (buspirone)

Benzodiazepines:
Xanax (alprazolam)
Ativan (lorazepam)
Klonopin (clonazepam)
Valium (diazepam)

Antipsychotics:
Abilify (aripiprazole)
Clozaril (clozapine)
Fanapt (iloperidone)
Geodon (ziprasidone)
Haldol (haloperidol)
Invega (paliperidone)
Pimozide (Orap)
Prolixin (fluphenazine)
Risperdal (risperidone)
Saphris (asenapine)
Seroquel (quetiapine)
Thorazine (chlorpromazine)
Zyprexa (olanzapine)
Cogentin (benztropine)

Stimulants:
Adderall (amphetamine)
Concerta / Daytrana / Ritalin / Methylin (methylphenidate)
Dexedrine (dextroamphetamine)
Focalin (dexmethylphenidate)
Vyvanse (lisdexamfetamine)

Non stimulant:
Intuniv / Tenex (guanfacine)
Kapvay (clonidine)
Strattera (atomoxetine)

Sleep:
melatonin
Rozerem (ramelteon)
Benadryl (diphenhydramine)
NyQuil / Unisom (doxylamine)
Desyrel (Trazodone)
Ambien (zolpidem)
Lunesta (eszopiclone)
Restoril (temazepam)

Substance treatment:
Zyban (bupropion)
Chantix (varenicline)
Antabuse (disulfiram)
Campral (acomprosate)
Subutex (buprenorphine)
Suboxone (buprenorphine /naloxone)
methadone
Vivitrol / ReVia (Naltrexone)

Thyroid medication

Other(s):_____

FOR EACH MEDICATION CIRCLED, PROVIDE ADDITIONAL INFORMATION BELOW:

Medication:	Date Started	Date Ended	Side Effects	Reason For Discontinuation	Helpful?

Michigan State University
Department of Psychiatry

Personal History

Pt. Name:_____
Date:_____ MRN:_____

DEVELOPMENTAL HISTORY:

Your birth: ☐ Premature ☐ Full Term ☐Post Term

How you were delivered: ☐ Vaginal ☐ C-section ☐ Other: _____

Did your mother use substances during pregnancy: ☐ No ☐ Yes If Yes, describe: _____

_____

Did you reach milestones (talking, walking, feeding self… etc.) on time?
☐ Yes ☐ No If No, describe: _____

Have you ever received special education accommodations?
☐ No ☐ Yes If Yes, describe: _____

Highest level of education completed? _____

History of being bullied as a child: ☐ No ☐ Yes If Yes, describe: _____

_____

History of childhood abuse (sexual/emotional/physical): ☐ No ☐ Yes If Yes, describe:

_____

_____

_____

Check the appropriate box below for any family member who had / has a psychiatric diagnosis:

		Paternal (Father) Family:					Maternal (Mother) Family:				
	Sibling	**Father**	Aunt	Uncle	Grandparent	Cousin	**Mother**	Aunt	Uncle	Grandparent	Cousin
Depression											
Anxiety											
Obsessions or Compulsions											
Mania or Bipolar Disorder											
Psychosis or Schizophrenia											
Attention or Concentration Problems											
Hyperactivity Problems											
Learning Problems											
Mental Retardation											
Alcohol Problems											
Drug Use Problems											
Legal Problems											
Abuse or Neglect											
History of Suicide Attempts											
History of Self Harming											
History of Harming Others											
Psychiatric Hospitalizations											
Use of Psychiatric Medications											

Michigan State University
Department of Psychiatry

Personal History

Pt.

Name: _____

MRN: _____

MEDICAL HISTORY

Medical problems: (Check all that apply)

□ High Blood Pressure	□ Emphysema/COPD	□ Heart Disease	□ Diabetes
□ Heart Failure	□ GERD/Reflux	□ Sleep Apnea	□ HIV/AIDS
□ Gastric Bypass	□ Concussion	□ Liver Disease	□ Stroke
□ Thyroid disease	□ Kidney Disease	□ Epilepsy/Seizures	□ Asthma
□ Multiple Sclerosis	□ Fibromyalgia/CFS	□ UC/Crohn's Disease	□ Cancer:
□ Arthritis	□ High Cholesterol	□ Other:	□ Other:

Surgeries: _____

_____

Medication allergies: _____

Current medications: _____

_____

Other providers you see:

_____

_____

SOCIAL HISTORY

Marital Status – (please circle):

Single Dating Married/Partner Married for second or more times

Divorced – not remarried Separated Widowed/er

Who lives in your household: _____

List ages of your children: _____

Current occupation: _____

Past occupation (s): _____

List and explain any legal problems:

_____

_____

Michigan State University
Department of Psychiatry

Personal History

Pt. Name:_____
Date:_____ MRN:_____

SUBSTANCE USE

Drug Type or Name	Age of First Use	Amount Used at Height of Use	Current Amount Used and Frequency	Last Use	Never Used
Marijuana					
Alcohol					
Nicotine					
Cocaine					
Heroin					
LSD					
PCP					
Stimulants					
Pain Medications (List below): _____ _____					
Other: _____					

REVIEW OF SYSTEMS

Please check box marked YES if you have experienced any of the following:

Yes **CONSTITUTIONAL**
- ☐ Fevers/ chills
- ☐ Weight loss/ gain
- ☐ Changes to energy level
- ☐ Sleep problems

Yes **HEENT**
- ☐ Glasses
- ☐ Double vision
- ☐ Hearing problems
- ☐ Ear infections/ ear pain
- ☐ Seasonal / environmental allergies
- ☐ Strep throat
- ☐ Sinus problems

Yes **NEUROLOGY**
- ☐ Vision changes or problems
- ☐ Head injury/ concussion
- ☐ Trouble walking / clumsiness
- ☐ Seizures
- ☐ Headaches
- ☐ Numbness/ tingling

Yes **CARDIOVASCULAR**
- ☐ Chest pain
- ☐ Fainting
- ☐ Feeling heart beating or racing
- ☐ Problems with blood pressure
- ☐ Heart murmur

Yes **PULMONARY**
- ☐ Wheezing or asthma
- ☐ Trouble breathing

Yes **ENDOCRINE**
- ☐ Intolerance to heat or cold
- ☐ Unusual weight changes
- ☐ Problems with blood sugar
- ☐ History of diabetes
- ☐ Change in hair or nails

Yes **HEMATOLOGY**
- ☐ Bleeding problems
- ☐ Abnormal bruising

Yes **GASTROENTEROLOGY**
- ☐ Frequent stomach aches
- ☐ Nausea and/or vomiting
- ☐ Diarrhea
- ☐ Constipation

Yes **GENITOURINARY**
- ☐ Problems urinating
- ☐ Bladder or kidney infections
- ☐ Incontinence

Yes **MUSCULOSKELETAL**
- ☐ Joint pain / swelling
- ☐ Muscle weakness

Yes **SKIN**
- ☐ Rashes
- ☐ Picking
- ☐ Large or unusual birthmark

BAI

NAME _____ **DATE** _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant, but I could stand it.	SEVERELY I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

PEARSON

PsychCorp

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58 59 60 61 62 63 64 65 66 67 68 A B C D E 281553-4 6543

Product Number 0158018427

BDI-2

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

2. Pessimism
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness
- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying
- 0 I don't cry any more than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

_____ Subtotal Page 1 Continued on Back

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

MSU Health Care

Patient Name (Last, First, Middle) _____

Date of Birth: _____ Phone # _____

I authorize the disclosure of my protected health information between the parties below:

Department of Psychiatry	_____
909 Wilson Rd, West Fee Hall Room B119 Address	_____ Address
East Lansing, MI 48824-6537 City, State, Zip Code	_____ City, State, Zip Code
Phone: (517) 353-3070 Fax: (517) 884-1817 Phone/Fax Number	Phone: Fax: _____ Phone/Fax Number

SEND RECORDS TO _____ REQUEST RECORDS FROM _____ (PLEASE MARK ONE)

SPECIFY THE INFORMATION TO BE DISCLOSED: Please specify date(s)

☐All of my behavioral health information _____

☐Ongoing Communication, as needed, between the parties named above _____

☐Progress Notes / Encounters _____ ☐Treatment Summaries _____

☐Psychiatric / Psychological Assessments _____

☐Psychological Testing _____ ☐Psychotherapy Notes _____

☐Lab Reports _____ ☐Immunizations _____

☐ Medications _____ ☐Consultations _____

☐Information from other healthcare providers/facilities (please specify)_____

☐Other (please specify)_____

PURPOSE OF THIS DISCLOSURE:

☐Continuing Care ☐Insurance ☐Legal ☐Disability ☐Patient Request ☐Workers Comp

Other (please specify)_____

I UNDERSTAND that if the person/entity that receives this information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may not be protected from further disclosures.

I UNDERSTAND that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, except in very limited circumstances. I may inspect or receive a copy of the information disclosed in accordance with this Authorization.

I UNDERSTAND that I may revoke this Authorization at any time by contacting the Psychiatry Clinic except to the extent that action has been taken in reliance on this Authorization. This Authorization expires _____ (or one year from the date signed).

_____ _____

Signature of Patient or Personal Representative (Required) Date (Required)

_____

Name of Personal Representative and Relationship to Patient (or description of authority to act on behalf of the patient

Patient	
MRN	

MSU DEPARTMENT OF PSYCHIATRY
FINANCIAL POLICY

Thank you for choosing the Michigan State University Department of Psychiatry. We are committed to providing our patients with the best possible care and minimizing administrative costs. Please review the information below.

- Insurances vary in their coverage, and it is the **patient's responsibility** to understand his/her mental health benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. **Patients are responsible for any co-payments and deductibles at the time of service. This is an insurance company policy.** Payment for professional services can be made with cash, check, VISA, MasterCard, Discover, or American Express.

- We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for psychiatric care is a contract between **you** and the **carrier**. You should direct any questions and/or complaints regarding coverage to your insurance carrier, your employer (if in a group plan), or to your agent.

- Our staff is happy to help with insurance questions related to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by your insurance company. Please contact Customer Service at the number listed on your insurance card.

- You will be asked to review your information, including demographics and insurance information, every year. Out of date information can cause unnecessary delays in the payment of your claim.

- **No Insurance:** Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our billing office.

- **Missed Appointments/Late Cancellations:** Missed appointments (no-shows) or appointments not cancelled with 24 hours' notice will be charged a $50 no-show fee. Charges for missed appointments are not covered by insurance. The charge will be billed directly to you, and you will be required to pay this fee prior to your next appointment. Recurrent no-shows (more than 2 within 6 months) or cancellations (more than 3 in 6 months) will result in a discharge from care.

- **Outstanding Balances:** We urge you to keep your account current. Account balances past due over 120 days will be sent to an outside agency for collection, at which time you will be discharged from care. Payment arrangements can be made with our Billing Office at (517) 884-2998.

Again, thank you for choosing us as your healthcare provider.

_____ _____

Patient/Parent/Guardian signature Date

MSU Psychiatry Clinic

Patient	
MRN	

No-Show Policy

Quality care for our patients is our top priority. Please take a few minutes to review our No-Show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a No-Show Appointment

MSU Psychiatry Clinic defines a No-Show appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment.
- Cancels with less than 24 hours' notice.
- Arrives more than 10 minutes late and is consequently unable to be seen.

Impact of a No-Show Appointment

No-show appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient fails to show up for a scheduled appointment it:

- Potentially jeopardizes the health of the patient.
- Is unfair (and frustrating) to other patients who would have taken the appointment slot.
- Is disrespectful of the provider's time.

How to Avoid Getting a No-Show

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours'** notice to cancel appointment

1. Appointment Confirmation

MSU Psychiatry Clinic will attempt to contact you 2-3 business days before your scheduled appointment to confirm your visit. If our automated system is unable to confirm with you over the phone, we will leave a message with your appointment date and time.

2. Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our clinic 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions, and to complete any necessary paperwork before the scheduled visit.

3. Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or reschedule an appointment, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care, as well as giving us the opportunity to rebook the vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call at 517-353-3070.

Consequences of No-Show Appointments

1. You will be charged a $50 no-show fee for each missed appointment.
2. If you miss 3 or more appointments within a year, you will be discharged from the clinic.
3. If you are discharged from the clinic, your remaining scheduled appointments will be cancelled.
4. Only emergency medical treatment will be offered within the first 30 days of discharge.

I have read and understand the MSU Psychiatry Clinic "No Show" policy as described above.

Patient/Guardian Signature _____ Date _____