Adult Psychiatry Outpatient Clinic Intake Form

Date _____

Name _____ Age _____

Address _____

Home phone _____ Work phone _____ Cell phone _____

What issue(s) bring(s) you to the Psychiatry Clinic?

_____

_____

_____

_____

What has been stressing you of late (e.g. family, job, recent loss of loved one, financial issues)?

_____

_____

_____

_____

Are you currently having any of the following problems (please circle)?

Depression? Loss of interest in activities? Feeling hopeless, worthless? Poor energy? Poor self-esteem? Change in appetite? Increased or decreased? Fatigue? Poor focus? Problems going to sleep? Thoughts of not being alive? Periods of euphoria or unusually good mood? Having very high energy for no reason? Going days without needing to sleep? Thoughts racing? Talking too fast? Acting impulsively (spending, speeding)?	Worrying excessively? Having tense muscles? So anxious you feel you cannot rest? Having panic attacks? Traumatic events that come back in nightmares, flashbacks? Feeling awkward in public? Thoughts that replay? Repetitive or compulsive behaviors? Phobias or fears? Grunts, tics, or jerks? Inattentiveness at work or school? If so, since what age? Hyperactive or fidgety?	Hearing voices? Seeing things? Feelings people were trying to watch or harm you? Concerns about alcohol use? Drug use? Concerns about eating too much? Eating too little? Memory problems? Getting lost easily? Forgetting how to do tasks? Problems finding words? Problems caring for yourself (cooking, dressing)?

Past Psychiatric Care

Have you ever been diagnosed with a mental health condition by a medical provider (e.g. depression, bipolar, schizophrenia, ADHD)? If so please list:

_____

_____

Have you ever been seen by a psychiatrist or therapist/counselor? Please list and describe:

Date(s) seen? By whom?	For what problems?	What treatment (meds, ECT, therapy)?

Have you ever been hospitalized for psychiatric care? Please list and describe:

Date(s)	Where and for what?	What treatment (meds, ECT, therapy)?

Have you ever been treated with any of the following medications? Circle all that apply and list any good or bad effects of the medications.

Med	Good/bad effects	Med	Good/bad effects	Med	Good/bad effects
Abilify		Haldol		Ritalin	
Ambien		Klonopin		Saphris	
Adderall		Invega		Serax	
Anafranil		Lamictal		Seroquel	
Antabuse		Latuda		Serzone	
Ascendin		Lexapro		Soma	
Atarax		Librium		Sonata	
Ativan		Lithium		Stelazine	
Buspar		Lunesta		Strattera	

Campral		Luvox		Suboxone/ subutex	
Celexa		Marplan		Symmetrel	
Chloral hydrate		Mellaril		Tegretol	
Clonidine		Methadone		Thorazine	
Clozaril		Miltown		Tofranil	
Cogentin		Nardil		Topomax	
Concerta		Norpramine		Traxene	
Cymbalta		Orap		Trazodone	
Dalmane		Pamelor		Trileptal	
Depakote		Parnate		Valium	
Dexedrine		Paxil		Vibryd	
Doral		Prosom		Vistraril	
Effexor		Pristiq		Vivitrol	
Elavil		Prolixin		Wellbutrin	
Fanapt		Remeron		Xanax	
Geodon		Restoril		Zoloft	
Halcion		Risperdal		Zyprexa	

Any other psychiatric medications you have taken?

_____

Past Medical Care

Do you have a primary care doctor? Name _____ Last seen? _____

What medical illnesses do you have?

_____

_____

_____

What surgeries have you had?

_____

_____

_____

Please list all medications you are currently taking, including over-the-counter medications, herbals, and supplements:

Medication	Dosage	# times per day	For what condition	Who prescribes it

Describe any allergies you have (e.g. medications, food):

_____

_____

Are you currently having or have you recently had any of these physical symptoms?

Fevers	Headache	Constipation	Hot/cold flashes
Chills	Chest pain	Acid reflux	Decreased sex drive
Night sweats	Shortness of breath	Joint pains	Problems reaching orgasm
Unexplained weight loss/gain	Heart palpitations	Muscle pains or tension	Easy bruising or bleeding
Weakness in arms/legs	Cough	Pain or difficulty urinating	Rashes
Numbness in arms/legs	Sore throat	Dental problems	
Episodes of passing out	Nausea or vomiting	Changes in vision	
Problems walking	Diarrhea	Changes in hearing	

For women -
Last menstrual period? _____ Usually regular? ❑ Yes ❑ No
Do you use any birth control? ❑ Yes ❑ No If yes, please list _____
Have you been pregnant before? ❑ Yes ❑ No If yes, how many times? _____
Miscarriages? ❑ Yes ❑ No
Elective abortions? ❑ Yes ❑ No
Any depression or unreal thoughts around pregnancies? ❑ Yes ❑ No

Substance Use History

How often have you used the following substances?

	Last time used?	Approximately how often (# of times per week, month or year)?	How much do you use in a sitting if/when you do use?
Tobacco			
Alcohol			
Marijuana or K2/"spice"			
Cocaine			
Opiates (e.g. Heroin, morphine, Percocet,			

oxycodone, Tylenol #3, Dilaudid/hydromorphone)			
Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)			
PCP or LSD			
Mushrooms			
Others			

Family History

Please list blood relatives who have been diagnosed with the following conditions:

Alcoholism _____
Anxiety disorder _____
Bipolar disorder _____
Cancer _____
Depression _____
Diabetes _____
Drug abuse _____
Heart disease/high blood pressure/arrhythmias _____
Osteoporosis _____
Seizures _____
Schizophrenia _____
Stroke _____
Suicide _____
Thyroid disease _____

Social History

Where do you live? _____
Who lives with you? _____

How far did you go in school/highest level of education? _____

What is your current job/occupation? _____
What jobs have you had in the past? _____
_____

Are you married? ☐ Yes ☐ No If so, for how long? _____

Have you been married in the past? ❑ Yes ❑ No # of times? _____
Do you have children? ❑ Yes ❑ No
If so, how many, what are their ages? _____

What do you do in your free time to relax?

_____

Do you have any religious beliefs? ❑ Yes ❑ No
How important are your religious/spiritual beliefs to your life? _____

Have you had any legal issues (arrests, charges, time in jail)? If so, please describe:

_____
_____
_____

Have you ever been the victim of a violent crime? ❑ Yes ❑ No
Have you ever been a victim of physical abuse? Emotional? Sexual abuse or rape? If so, please explain:

_____
_____
_____
_____

Safety

Do you currently have thoughts of hurting yourself? ❑ Yes ❑ No Please explain:

_____

Have you tried to hurt yourself in the past? ❑ Yes ❑ No If so, please explain:

_____
_____
_____

Do you currently have thoughts of hurting anyone else? ❑ Yes ❑ No If so, please explain:

_____

Have you tried to hurt anyone in the past? ❑ Yes ❑ No If so, please explain:

_____
_____
_____

Do you own any guns or knives? _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name _____ **Date** _____

Provider _____ **Patient ID#** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?		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 in some way	0	1	2	3

add columns: _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL: _____

10	If you checked off any problems, 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** _____

KIRBY MEDICAL CENTER

What Is Telepsychiatry?

There is no question that telemedicine has become an essential service within healthcare in the United States. The lack of access to proper psychiatric care is one of the biggest struggles of the American public health system, and telepsychiatry has opened doors to obtaining quality care- despite geographical location.

Telepsychiatry is one of the most promising developments in the fight to provide more patient-centered, affordable, and effective interventions for individuals who need psychiatric care.

How It Works

If seen from the clinic, at the time of your appointment, you will be led into a private room by our Medical Assistant. The Medical Assistant will take your vitals, communicate them to your provider, and then leave the room (you may request her/him to stay) and your consultation with your provider will begin. If you are being seen from your home, you will be provided a link to access the virtual appointment with your provider.

These telepsychiatry sessions are private and confidential. Over time, patients and practitioners develop a strong relationship.

Learn More

We pride ourselves in being telepsychiatry experts. Check out our website at www.iristelehealth.com or follow us on social media for more!

- www.facebook.com/iristelehealth
- @IrisTelehealth
- Iris Telehealth

Meet Dr. Julie Baldinger, DO!

Dr. Julie Baldinger was born and raised in Northern Virginia, outside of Washington, D.C. She attended college at the University of Virginia where she was selected to be a member of Phi Beta Kappa, and she attended medical school at the Edward Via Virginia College of Osteopathic Medicine in Blacksburg, Virginia, graduating with Honors. In medical school, she spent time rotating through hospitals in Florida and South Carolina before returning to Virginia to complete a Psychiatry Internship at the University of Virginia, followed by an Adult Psychiatry Residency at Georgetown University. She then went on to attend the University of Virginia again for her Child/Adolescent Psychiatry Fellowship. Dr. Baldinger is a member of the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry.

Dr. Baldinger enjoys all realms of Psychiatry with a passion for children, young adults, as well as older adults dealing with depressive and anxiety-related disorders. While she has a breadth of experience in both inpatient as well as outpatient centers, she most enjoys the outpatient realm in which she can follow with her patients long-term. She focuses on treatment of the individualized patient and caters her pharmacological treatment to the individual. She provides care in an open and non-judgmental way, and she effortlessly seeks to destigmatize mental healthcare with the goal of greater access of care to all populations.

Outside of Medicine, Dr. Baldinger enjoys all things fitness-related, the outdoors and spending time with family/friends and her two rescue pups, a Great Dane and Terrier mix. With a passion for animals, she has a dream of one day opening a sanctuary for abandoned animals and integrating this into her care of patients.

Dr. Baldinger is excited to join the team at Kirby Medical Center!

KIRBY MEDICAL CENTER

MENTAL HEALTH RECORDS AUTHORIZATION

1. PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____ SS#: _____

City: _____ State: _____ Zip: _____ MR#: _____

Maiden/Other Names: _____ Phone #: (Home) _____ (work) _____

*The following persons are entitled upon request to inspect and copy a mental health record or any part thereof: 1) parent or guardian of a patient under 12 years of age; 2) the patient if 12 years or older; 3) the parent or guardian of a patient who is at least 12 but under 18 years, if the informed patient does not object or if the therapist does not find a compelling reason to deny access; 4) the guardian of a patient 18 years or older; 5) an attorney or guardian ad litem; 6) an agent appointed under patient's health care power of attorney; 7) an attorney-in-fact appointed under the Mental Health Treatment Preference Declaration Act; or 8) any person in whose care and custody the patient has been placed pursuant to Section 3-811 of the Mental Health and Developmental Disabilities Code.

I authorize the use/disclosure of my, or as legal representative or guardian of patient's, mental health records and/or information as follows:

2. PARTY WHO HAS MY MENTAL HEALTH RECORDS AND / OR INFORMATION TO USE / DISCLOSE:

☐ Kirby Medical Group (KMG) ☐ Kirby Medical Center (KMC)

☐ Other: _____

3. PARTY OR PARTIES WHO I WANT TO RECEIVE MY MENTAL HEALTH RECORDS AND / OR INFORMATION:

Name: Kirby Medical Center, HIM Dept

Address: 1000 Medical Center Drive City: Monticello

State: IL Zip: 61856 Phone #: (217) 762-1860

4. PURPOSE OF USE / DISCLOSURE OF MY MENTAL HEALTH RECORDS AND / OR INFORMATION:

☐ Medical treatment ☐ Employment reasons ☐ Underwriting (insurance)

☐ Legal ☐ Patient request

☐ Involvement in my care

☐ Other: _____

5. THE DATES OF RECORDS AND / OR INFORMATION TO BE USED OR DISCLOSED:

☐ Records or information from: _____ to _____

(Beginning Date) (End Date)

6. DESCRIPTION OF MY MENTAL HEALTH RECORDS AND / OR INFORMATION TO BE USED AND DISCLOSED:

☐ Psychiatry / psychology initial evaluation ☐ Independent medical / psychological exam

☐ Psychiatry / psychology consultation ☐ Billing records

☐ Psychiatry / psychology progress notes ☐ Consent forms

☐ Appointment information ☐ Other: _____

_____

7. EXPIRATION

This authorization will expire 6 months from the date this release is received by our office. If I want it to expire on a different date, then that date is: _____

8. CANCELING THIS AUTHORIZATION

I understand that I may cancel this authorization at any time. Canceling this authorization must be done by sending a signed and dated letter, and having a person who can identify me sign it as my witness. The letter must be delivered to Kirby Medical Center Health Information Management at the address shown at the bottom of this page. The cancellation will take effect when Kirby receives the letter. I understand the letter will not apply to the uses/disclosures of my health information that were made in reliance on the authorization before Kirby received my letter.

[Please turn to the back of this page]

9. RE-DISCLOSURE OF MY HEALTH RECORDS AND / OR INFORMATION:

I understand that the person who receives my mental health information may NOT disclose it to someone else without my permission, unless permitted by law.

10. EFFECT OF NOT SIGNING THIS AUTHORIZATION:

I am not required to sign this authorization in order to receive most health care services at KMG/KMC. However, I understand that if the ONLY reason I am seeing a Kirby provider is to create health information for someone else's use (such as my employer), Kirby may refuse to see me if I do not sign this authorization. For example, if I am here for pre-employment testing, then I must sign this authorization in order for Kirby to perform the pre-employment test.

11. FEES:

I may be charged a processing fee for this request to disclose my health information. I may ask Kirby for a fee estimate. If I receive a bill for processing this request, the bill may come from a company that processes health information requests for Kirby.

12. RIGHT TO INSPECT & COPY:

I understand that I have a right to inspect and receive a copy of the records to be disclosed pursuant to this authorization.

13. MY AUTHORIZATION:

_____ _____
(Signature of Patient) (Date Signed)

_____ _____
(Signature of Legal Representative or Guardian) (Date Signed)

_____ _____
(Printed Name of Legal Representative or Guardian) (Relationship to Patient if signed by Representative or Guardian)

_____ _____
(Signature of Witness) (Date Signed)

14. INSTRUCTIONS FOR RECORD COPY REQUESTS ONLY (CHECK ONE IF APPLICABLE):

☒ Mail record copies out to party or parties I named in #3

☐ I will pick up records

15. RETURN THIS COMPLETED FORM TO:

Kirby Medical Center
Health Information Management Department
1000 Medical Center Drive
Monticello, IL 61856

Phone (217) 762-1865
Fax (217) 762-1862

16. PROVIDER RELEASE NOTIFICATION:

☐ _____ has been notified of this release _____(initials/date)

☐ _____ has been notified of this release _____(initials/date)

☐ _____ has been notified of this release _____(initials/date)

☐ _____ has denied this release _____(initials/date)

PROVIDE COPY OF SIGNED FORM TO PATIENT