Chart No. _____

Revised Aug 2018

CAROLINA BEHAVIORAL CARE PATIENT REGISTRATION FORM

CAROLINA BEHAVIORAL CARE

ADULT PATIENT REGISTRATION FORM

Today's Date ____/_____/_____

Name _____ **Sex:** M F Identify as: _____

Date of Birth _____ **Age** _____ **Marital Status: S M W D** _____

Social Security Number _____

Driver's License Number _____

Mailing Address _____

City _____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

E-mail _____ *(**required** for Patient Web Portal use)*

Preferred method of communication for reminder calls: ____Calls ____Texts ____ E-mails

Patient's Employer & Address _____

Patient's Occupation _____

Primary Care Provider Name & Telephone May we communicate with your Primary Care Provider about your care? **YES NO**

Please list the names and contact information for any other health care providers you would like us to communicate with regarding your care at CBC: _____

_____

Emergency Contact/Person to notify, if necessary_____

Address_____ Phone _____ Relationship _____

Legal Competency Status [ ] Competent [ ] ****Incompetent** (if this box is checked, we MUST HAVE LEGAL DOCUMENTS ON FILE before we can treat the patient.)

****Name of Guardian**, *if applicable*: _____

Address_____ Phone _____ Relationship _____

Who can we thank for referring you to CBC? _____

Which Pharmacy do you use?_____ **Phone #** _____

Do you have health insurance coverage? Yes No

Do you have prescription insurance coverage? Yes No

GUARANTOR INFORMATION (person responsible for this account)

Name_____Relationship_____Date of Birth_____

Mailing Address_____

Social Security No. _____ Employer_____

Patient/Guardian/Guarantor SIGNATURE _____ Date: _____

Patient name_____ DOB: _____/_____/_____ Patient Chart No: _____

PATIENT HEALTH QUESTIONNAIRE – 9 (PHQ-9)

Over the LAST TWO WEEKS, how often have you been bothered by any of the following problems? (Circle your answer)	Not at All	Several Days	More than Half the Days *More than a week*	Nearly Every Day
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
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**
Thoughts that you would be better off dead or hurting yourself in some way	**0**	**1**	**2**	**3**
FOR OFFICE CODING	**0**	+ _____	+ _____	+ _____
				= Total Score: _____

If you checked off any problems above, 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
O	O	O	O

Patient name_____ DOB: _____/_____/_____ Patient Chart No: _____

PATIENT'S ALLERGIES

Do you have allergies to anything, including food, medications, etc.? Yes No

Circle all that apply. If your allergy is not listed, please write it in the Other section below.

Acetaminophen	Demerol	Pollen
Ampicillin	Eggs	Prednisone
Anesthesia	Ibuprofen	Salicylates
Antihistamines	MAOI's	SSRI's
ASA	Morphine	Sulfa drugs
Barbiturates	No known allergies	TCA's
Chocolate	No known drug allergies	Tetanus vaccine
Codeine	NSAID's	Other:
Dairy products	Penicillin	

PATIENT'S MEDICATIONS

Do you take prescribed or over-the-counter medications, supplements, or vitamins? **Yes No**

If yes, please list the name, daily dose, prescriber, status, and reason for each one below.

Current Medications, Vitamins, Supplements	**Daily Dose**	**Prescribed By**	**Active or Stopped** (circle one)	**Reason you take this medication (**name of illness, disease, etc.**)**
			Active Stopped	
			Active Stopped	
			Active Stopped	
			Active Stopped	
			Active Stopped	
			Active Stopped	
			Active Stopped	
			Active Stopped	

If you are having problems with any medications or have recently <u>stopped</u> taking any medications your doctor(s) prescribed, please <u>provide the medication name</u> and the <u>reason(s) you stopped taking each one</u>:

_____

Patient name_____ DOB: _____/_____/_____ Patient Chart No: _____

PATIENT'S PAST MEDICAL HISTORY

Please check all of the medical problems you have had or that you currently have.
Check all that apply. Mark • NONE beside any category in which you have had no problems.

Cancer: □ NONE
□ Type_____

Cardiovascular □ NONE
□ Hypertension
□ CHF
□ Mitral Valve Prolapse
□ Peripheral vascular disease
□ Arrhythmia

Dermatology □ NONE
□ Herpes
□ Lupus
□ Melanoma
□ Shingles
□ Skin cancer
□ Ulcers

Endocrine □ NONE
□ Diabetes
□ Hypothyroid
□ Hyperthyroid
□ Goiter

Gastrointestinal □ NONE
□ Cirrhosis
□ Colitis
□ Gastritis
□ Hepatitis
□ Ulcer

Female GU □ NONE
□ Abnormal pap
□ Birth control pills
□ Cancer
□ Dysmenorrhea
□ Infertility
□ Postpartum depression
□ Pregnancy

Male GU □ NONE
□ BPH
□ Erectile dysfunction
□ Prostate problems

Renal □ NONE
□ Dialysis
□ Incontinence
□ CRF
□ UTI

HEENT □ NONE
□ Cataract
□ Glaucoma
□ Visual Loss

Hematologic □ NONE
□ Anemia
□ Low iron
□ Hodgkin's disease

Immunological □ NONE
□ Chemotherapy
□ HIV
□ AIDS
□ Lupus
□ TB

Musculoskeletal □ NONE
□ Arthritis
□ Disc disease
□ Osteoarthritis
□ Scoliosis

Neurology □ NONE
□ Alzheimer's disease
□ Headache
□ Migraine
□ MS
□ Stroke
□ Seizures
□ Tumor

Psychiatric □ NONE
□ Bipolar
□ Depression
□ Dementia
□ MR
□ Schizophrenia

Respiratory □ NONE
□ Asthma

□ **Other:** _____

_____

_____

Patient name_____ DOB: _____/_____/_____ Patient Chart No: _____

PATIENT'S REVIEW OF SYSTEMS

Please check all that of the problems or symptoms you have today. *Check all that apply*. If none, mark □ **None.**

ALLERGIC CONDITIONS □ None
□ Food Allergies
□ Hay Fever
□ Medication Allergies

CANCER □ None
□ Breast
□ Cervical
□ Colon
□ Lung
□ Prostate
□ Radiation Therapy
□ Uterus

CARDIOVASCULAR □ None
□ Arrhythmia/Palpitation
□ Blood clots/Phlebitis
□ Edema/Swelling
□ Fainting/Dizziness
□ Heart Attack/Chest pain/Catheter
□ Hemophilia
□ High blood pressure
□ High cholesterol
□ Sickle Cell Disease (not trait)

COMMUNICABLE DISEASE □ None
□ Aids/HIV
□ Blood transfusions
□ Hepatitis
□ Herpes
□ Sexually transmitted disease
□ Syphilis
□ Tuberculosis, positive skin test

CONSTITUTIONAL SYMPTOMS
□ **None**
□ Fever, headache, nausea, dizziness
□ Anorexia
□ Insomnia
□ Sedation

EARS, NOSE, MOUTH, THROAT
□ **None**
□ Deafness
□ Dental Problems
□ Ear infections
□ Speech problems

ENDOCRINE □ None
□ Adrenal
□ Diabetes
□ Osteoporosis
□ Pituitary disorders
□ Major birth defect(s)
□ Thyroid disorders
□ Weight changes

EYES □ None
□ Blindness
□ Eye problems
□ Glaucoma

GASTROINTESTINAL □ None
□ Cirrhosis liver
□ Colon/Rectal polyps
□ Hiatal Hernia reflux
□ Loss of appetite
□ Nausea/vomiting
□ Pancreatitis
□ Rectal bleed
□ Ulcerative colitis
□ Ulcers/stomach pain
□ Diarrhea

GENITOURINARY □ None
□ Abnormal mammogram
□ Abnormal pap
□ Blood in urine
□ Breast lumps/cysts
□ Incontinence
□ Kidney or urinary problems
□ Menstrual irregularity
□ Painful periods
□ Pain during intercourse
□ Premenstrual Syndrome
□ Premenstrual Syndrome
□ Sexual problems

HEMATOLOGIC/LYMPHATIC
□ **None**
□ Anemia
□ B12 Deficiency
□ Easy bruising
□ Hemophilia
□ Iron Deficiency
□ Sickle Cell

INTEGUMENTARY □ None
□ Eczema
□ Acne
□ Change in mole
□ Psoriasis
□ Sores that won't heal or reoccur

MUSCULOSKELETAL □ None
□ Acute Pain
□ Chronic Pain
□ Osteoporosis

NEUROLOGICAL □ None
□ Balance disorder
□ Dizziness
□ Headaches
□ Loss of consciousness
□ Multiple sclerosis
□ Neuropathy/numbness/tingling
□ Paralysis/weakness of limb(s)
□ Seizures/convulsions
□ Seizures/convulsions
□ Spinal cord injury
□ Stroke
□ Tics
□ Tremor

RESPIRATORY □ None
□ Asthma
□ Asthma with frequent hospitalizations
□ COPD
□ Emphysema
□ Pneumonia
□ Shortness of breath
□ Sleep Apnea
□ Snoring
□

OTHER
□ _____
□ _____
□_____
□_____
□ _____

Patient name_____ DOB: _____/_____/_____ Patient Chart No: _____

PATIENT'S SURGERY HISTORY

Have you ever had surgery? YES NO If yes, please circle all the surgeries you have ever had and state the year each surgery was performed. *Circle all that apply.*

Surgery	Year	Surgery	Year
Bariatric Surgery		Lung Cancer	
Brain Cancer		Lumbosacral Surgery	
Breast Cancer		Ovarian Surgery	
CABG		Parathyroid tumor	
Cerebral Aneurysm		Pituitary tumor	
Cervical Cancer		Prostate cancer	
Colon Cancer		Rectal cancer	
Diverticulitis		Scoliosis surgery	
Gastric ulcer		Skin cancer	
Gallbladder		Subdural hematoma	
Glaucoma		Thyroid surgery	
Hernia Repair		Ulcerative Colitis	
Hysterectomy		Valvular heart disease	
Kidney Transplant		Other:	

PATIENT'S FAMILY HISTORY:

Please circle any current problems or past problems you, your children, your siblings, your parents, or your grandparents have had. State who had each problem. *Circle all that apply.*

	WHO?		WHO?		WHO?
Alcoholism		Dementia		Learning disability	
Alzheimer's		Diabetes Mellitus		Mental retardation	
Anemia		Depression		Schizophrenia	
Anxiety disorder		Down's syndrome		Stroke	
ADD		Endocrine disease		Substance Abuse	
Autism		Enuresis		Suicidal attempts	
Bipolar disorder		Headaches		Thyroid disease	
Cardiac Arrhythmia		High cholesterol/lipids		Ulcerative colitis	
Cardiac disease		Jail or Prison		Other:	

Other comments or information you would like us to know about you (please print)**:**

_____

_____

_____

_____

Patient name_____ DOB: _____/_____/_____ Patient Chart No: _____

CAROLINA BEHAVIORAL CARE

Authorization to Use or Disclose Protected Health Information *updated Feb2018*

This authorization form implements the requirements for client authorization to use and disclose health information protected by federal health privacy law (45 C.F.R. Parts 160,164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122 CC-52 through 122C-56) as well as the HIV/AIDS information (NC General Statute 130A-143) and Substance Abuse information (42CFR Part 2).

Specific Dates of Treatment: *Month _____/ Year_____* **All Dates of Treatment** (*Initial Here*):_____

INFORMATION TO BE RELEASED

*Please **check one:*** TO_____ FROM_____

_____
Name of Contact Person

_____
Business Name

_____
Mailing Address

_____
City, State, Zip

_____
Telephone Number

_____
Fax Number

INFORMATION TO BE RELEASED

*Please **check one:*** TO_____ FROM _____

For All CBC Locations, Use

Carolina Behavioral Care
P O Box 1630
Pinehurst, NC 28374
Fax Number: 877-256-8588
Tele Number: 844-534-7208

*****IF REQUESTING RECORDS FROM CBC,**
PLEASE FAX YOUR REQUEST TO 1-877-256-8588, ATTENTION: MEDICAL RECORDS***

***Purpose of Release:* Client must initial beside the purpose(s) of this release:**

____Continuity of Care ____Insurance ____Other
____Legal Representation ____Request of the individual

Information to be Released: Client must initial beside each record to be released.

____Assessments ____Psychosocial Assessment ____Psychotherapy Notes
____Psychiatric Evaluations ____Medication Records ____HIV/AIDS Information
____Psychological Evaluations ____Progress Update/Verbal ____Substance Abuse/Treatment
____Financial ____Other:_____

I understand that I may revoke or terminate this authorization at any time by submitting a written revocation to Carolina Behavioral Care, except to the extent that action has already been taken in reliance there on. If not previously revoked, this authorization will expire one year from the date of signature.

I understand that information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand that I may inspect or request a copy of information that is used or disclosed under this authorization and I may refuse to sign this authorization. If I refuse to sign this authorization Carolina Behavioral Care will not deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

_____ _____ _____ _____
Signature of Patient Date Signature of Witness Date

_____ _____ _____
Signature of legally-responsible person Date Relationship to Patient

Patient name_____ DOB: _____/_____/_____ Patient Chart No: _____

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Specific Dates of Treatment: *Month _____/ Year_____* **All Dates of Treatment** (*Initial Here*):_____

INFORMATION TO BE RELEASED

*Please **check one:*** TO_____ FROM_____

_____
Name of Contact Person

_____
Business Name

_____
Mailing Address

_____
City, State, Zip

_____
Telephone Number

_____
Fax Number

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_____ _____ _____ _____
Signature of Patient Date Signature of Witness Date

_____ _____ _____
Signature of legally-responsible person Date Relationship to Patient