



PATIENT INFORMATION

TODAY'S DATE: _____

Patient's Name: _____ Sex: Male Female

Date of Birth: _____ Age: _____ Marital Status: _____

Home Address _____ City _____ State _____ Zip _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Employer & Position: _____ Work Phone: (_____) _____

E-mail address for communications from our office: _____

Preferred method of contact: home work cell email SS# _____ - _____ - _____

How were you referred to my practice?: _____

RESPONSIBLE PARTY and SPOUSE'S INFORMATION

Person Responsible for payment: self spouse parent other _____

Responsible Party: _____ SS# _____ - _____ - _____ Date of Birth: _____

Home Address: _____

Home Phone: (_____) _____ Email address: _____

Employer: _____ Work Phone: (_____) _____

Spouse's Name: _____ Emergency Contact: _____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What are your goals in being here?

MEDICAL HISTORY

Please list current medications/supplements/vitamins/herbs: _____

Allergies/drug intolerances (describe): _____

Past medical problems/surgeries: _____

Primary Care Physician (Name/Phone): _____

Any history of head trauma, concussion or significant accidents?: _____

Ever any seizures or seizure like activity? _____

Prior hospitalizations (place, cause, date, outcome): _____

Are you pregnant? Yes No Planning to become pregnant? Yes No Currently nursing an infant? Yes No

Do you use birth control? Yes No What type? _____ Are you satisfied with your sex life? Yes No

Do you exercise? Yes No Type and frequency: _____ Present Height _____ Present Weight _____

PSYCHIATRIC HISTORY

Please list all medications/supplements taken alone and all medications taken in combination; including dosages, effectiveness and any side-effects.) *If you need more room, please attach another sheet.*

Date Taken	Medication <i>Individual or Combinations Dosage(s) and time(s) taken per day</i>	Effectiveness	Side-Effects/Problems

For prior psychotherapy, please provide dates seen, therapist name, and what was or was not helpful:

Please provide dates, location, and outcome of any psychiatric hospitalizations: _____

SOCIAL HISTORY

Current Life Stresses (include anything that is currently stressful for you, examples include relationships, job, school, finances, children) _____

Prenatal and birth events:

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc) _____

Any birth problems, trauma, forceps or complications? _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, trouble falling asleep or waking up? _____

School History: Last grade completed _____ Last school attended _____

Any behavior or learning problems in school? _____

Employment History: (summarize jobs you've had, list most favorite and least favorite)

Any work-related problems? _____

Ever Any Legal Problems/Criminal Charges? _____
Are you currently involved in any litigation? _____
Any history of suicide attempts/violent behavior? _____
Do you have access to firearms? Yes No

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mushrooms), PCP.

Do you or have you ever experienced withdrawal symptoms from alcohol or drugs? _____
Has anyone told you they thought you had a problem with drugs or alcohol? _____
Have you ever felt guilty about your drug or alcohol use? _____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____
Have you ever used drugs or alcohol first thing in the morning? _____
Caffeine use per day (include energy drinks) _____
Nicotine use per day (nicotine is in cigarettes, cigars, tobacco chew) _____
Have you been involved in any 12 step programs (AA, NA, etc)? _____

FAMILY HISTORY

Family Structure (who lives in your current household, please give ages and your relationship to each):

Significant Developmental Events (include marriages, separations, divorces, deaths, and any traumatic history) _____

Natural Mother's History: age _____ occupation _____
School: highest grade completed _____ Medical Problems _____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

Mother's alcohol/drug use history _____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

Natural Father's History: age _____ occupation _____
School: highest grade completed _____ Medical Problems _____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

Father's alcohol/drug use history _____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations?

(specify) _____

Siblings (names, ages, problems, strengths, relationship to patient) _____

Children (names, ages, problems, strengths) _____

Do you have any religious affiliation or spiritual practices?

Have any of your blood relatives experienced any of the following illnesses listed below? Please check the diseases and beside them, write which relative had the illness (i.e. mother, father, brother, sister, uncle, cousin, etc.).

Depression _____

Anxiety/nerves _____

Bipolar disorder/manic-depression _____

Epilepsy/seizures _____

Alcoholism/drug abuse _____

High blood pressure _____

Severe trauma _____

Diabetes _____

ADHD/learning disorders _____

Cancer _____

Attempted or completed suicide _____

Schizophrenia _____

Anorexia/bulimia _____

Alzheimer's or Parkinson's disease _____

Severe obesity _____

Psychiatric hospitalization _____

Please list any information you have about blood relatives who have taken psychiatric medications. In particular it is helpful to know if a given medication was helpful or if it was not tolerated well.



Authorization for the Release of Protected Health Information

1709 Legion Road, Suite 200-B
Chapel Hill, North Carolina 27517

www.kyleworshammd.com
(tel): 919-960-3133(fax): 919-960-3135

Patient Name

Date of Birth

Parent or Legal Guardian:

This form, when completed and signed by you, authorizes Kyle Worsham, M.D. to release and exchange health information from you or your child's clinical record.

Please list names of provider(s), person(s), agency(s) phone and/or fax number below:

1. _____

2. _____

3. _____

4. _____

5. _____

This information will include:

- | | |
|--|--|
| <input type="checkbox"/> Copies of progress notes | <input type="checkbox"/> Testing/lab results |
| <input type="checkbox"/> Treatment plan and summary (written and verbal) | <input type="checkbox"/> Other (Specify): |
| <input type="checkbox"/> All of the Above | |

This authorization shall remain in effect for: 1 year or until the end of treatment

I understand that I have no obligation to disclose the above information and that I may revoke this consent at any time by notifying this office in writing at the address below. Such revocation will not extend to prior release of information on the basis of this authorization. I further understand that this office has no control over information once it has been released and in consideration of this consent, I release Dr. Kyle A. Worsham from any and all liability arising therefrom.

Signature of Patient / Parent or Legal Guardian

Date

Witness



PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. The terms of this Privacy Notice apply to the medical practice of **Kyle A. Worsham, MD**, and is effective April 14, 2003.

In the course of evaluating and treating you, I may obtain Protected Health Information (PHI) from you and from other medical and non-medical informants. With your signed Treatment Consent, I may use and disclose the **minimum necessary** information for purposes of **Treatment, Payment, and Healthcare Operations (TPO)**. Examples of **treatment purposes** include sharing information with other professionals, relatives, or friends involved in your care; arranging a hospitalization; placing diagnoses on order forms for laboratory or other tests; telephoning prescriptions or providing information to third parties necessary to obtain insurance coverage for prescription drugs; etc. Examples of **payment purposes** include submitting information electronically or on paper to a third-party payer such as Blue Cross Blue Shield, to a utilization review professional to have services authorized for payment, and to a collection agency. Examples of **healthcare operations** include quality assurance activities. (I do not disclose patient names to anyone for marketing purposes.) An appointment reminder message may be left on your voice mail or email account.

I am legally required or permitted to release PHI, without your consent or authorization; to the Department of Health and Human Services (HHS), upon its request to state or local agencies in cases of suspected child or elder abuse, domestic violence, certain infectious diseases, injury, death, or other public health purposes; to the Food and Drug Administration in case of adverse events or product recalls; in legal proceedings, if your mental condition becomes an issue. If I believe you pose an imminent danger to yourself or others, I must disclose PHI to those necessary to prevent injury to yourself or another.

Other uses and disclosures of PHI will be made *only with your written authorization*, which you may revoke in writing at any time except to the extent that action has been taken in reliance thereon.

You have the right to receive confidential communication of PHI. You have the right to inspect and receive copies of PHI. (Exceptions include separate psychotherapy notes, if any information compiled for civil criminal or administrative proceedings; information obtained from a non-healthcare professional under a promise of confidentiality where access would reveal the source, if release is likely to endanger the life or physical safety of, or cause substantial harm to, you or another person; etc.) You agree to accept a summary of the PHI instead of copies, if I believe this is appropriate, and you may be charged for copying or for preparation of a summary. You have the right to request, in writing and including supporting reasons, that your PHI be amended; I may accept or deny the request, in which case you may submit a written statement of disagreement, to which I may prepare a rebuttal. You have the right to receive an accounting of disclosures of your PHI made by me after April 14, 2003. You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to your requested restrictions and may refuse to treat you if I do not agree to such a request.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of the notice currently in effect. I may review the terms of this Privacy Notice and make new provisions effective for all the PHI maintained. The revised Notice will be posted in my reception area and written copies will be made available on request.

You may complain in writing to myself and to the Secretary of Health and Human Services in Washington, DC if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint. The contact person is myself at the phone number and address below;

Kyle Worsham, MD
1709 Legion Road
Suite 200B
Chapel Hill, NC 27517
(919) 960-3133

revised 1/20/2011

General Symptom Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner, or parent) rate you as well. List the other person _____. Please place a star by your most concerning symptoms.

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable

Other Self

- | | | |
|-------|-------|--|
| _____ | _____ | 1. Feeling depressed or being in a sad mood |
| _____ | _____ | 2. Having a decreased interest in things that are usually fun |
| _____ | _____ | 3. Experiencing a significant change in weight or appetite, increased or decreased |
| _____ | _____ | 4. Having recurrent thoughts of death or suicide |
| _____ | _____ | 5. Experiencing sleep changes, such as a lack of sleep or a marked increase in sleep |
| _____ | _____ | 6. Feeling physically agitated or easily irritated |
| _____ | _____ | 7. Having feelings of low energy or tiredness |
| _____ | _____ | 8. Having feelings of worthlessness, helplessness, hopelessness or guilt |
| _____ | _____ | 9. Experiencing decreased concentration or memory |
| _____ | _____ | 10. Having periods of an elevated, high or irritable mood |
| _____ | _____ | 11. Having periods of a very high self-esteem or grandiose thinking |
| _____ | _____ | 12. Having periods of decreased need for sleep without feeling tired |
| _____ | _____ | 13. Being more talkative than usual or feeling pressure to keep talking |
| _____ | _____ | 14. Having racing thoughts or frequently jumping from one subject to another |
| _____ | _____ | 15. Being easily distracted by irrelevant things |
| _____ | _____ | 16. Having a marked increase in activity level |
| _____ | _____ | 17. Excessive involvement in pleasurable activities that have the potential for painful consequences (e.g., spending money, sexual indiscretions, gambling, foolish business ventures) |
| _____ | _____ | 18. Experiencing panic attacks, which are periods of intense, unexpected fear |
| _____ | _____ | 19. Having periods of trouble breathing or feeling smothered |
| _____ | _____ | 20. Having periods of feeling dizzy, faint or unsteady on your feet |
| _____ | _____ | 21. Having periods of heart pounding or rapid heart rate |
| _____ | _____ | 22. Having periods of trembling or shaking |
| _____ | _____ | 23. Having periods of sweating |
| _____ | _____ | 24. Having periods of nausea or abdominal discomfort/trouble |
| _____ | _____ | 25. Having feelings of a situation "not being real" or feeling as if you are in a movie |
| _____ | _____ | 26. Experiencing numbness or tingling sensations |
| _____ | _____ | 27. Experiencing hot or cold flashes |
| _____ | _____ | 28. Having periods of chest pain or discomfort |
| _____ | _____ | 29. Fearing death |
| _____ | _____ | 30. Fearing going crazy or doing something out-of-control |
| _____ | _____ | 31. Avoiding everyday places for 1) fear of having a panic attack or 2) needing to go with other people in order to feel comfortable |
| _____ | _____ | 32. Excessive fear of being judged by others, which causes you to avoid or get anxious in situations |
| _____ | _____ | 33. Experiencing persistent, excessive phobia (heights, closed spaces, specific animals, etc.) |
| _____ | _____ | 34. Having recurrent bothersome thoughts, ideas, or images that you try to ignore |
| _____ | _____ | 35. Having trouble getting "stuck" on certain thoughts, or having the same thought over and over |
| _____ | _____ | 36. Experiencing excessive worrying which feel irrational |
| _____ | _____ | 37. Others complaining that you worry too much or get "stuck" on the same thoughts |
| _____ | _____ | 38. Having compulsive behaviors that you must do or else you feel very anxious, such as excessive hand washing, checking locks, or counting or spelling |
| _____ | _____ | 39. Needing to have things done a certain way or else you become very upset |

- ___ 40. Others complaining that you do the same thing over and over to an excessive degree
- ___ 41. Experiencing recurrent and upsetting thoughts of a past traumatic event
- ___ 42. Experiencing recurrent distressing dreams of a past upsetting event
- ___ 43. Feeling detached or distant from others
- ___ 44. Feeling numb or restricted in your feelings
- ___ 45. Feeling that your future is shortened
- ___ 46. Being quick to startle
- ___ 47. Feeling like you're always watching for bad things to happen
- ___ 48. Being markedly more irritable or experiencing anger outbursts
- ___ 49. Having unrealistic or excessive worry in at least a couple areas of your life
- ___ 50. Trembling, twitching, or feeling shaky
- ___ 51. Experiencing muscle tension, aches, or soreness
- ___ 52. Having trouble sustaining attention or being easily distracted
- ___ 53. Experiencing difficulty completing or initiating projects
- ___ 54. Feeling overwhelmed by the tasks of everyday living
- ___ 55. Having trouble maintaining an organized work or living area
- ___ 56. Being inconsistent in work performance
- ___ 57. Lacking in attention to detail
- ___ 58. Making decisions impulsively
- ___ 59. Having difficulty delaying what you want, having to have your needs met immediately
- ___ 60. Feeling restless and/or fidgety
- ___ 61. Making comments to others without considering their impact
- ___ 62. Being impatient and/or easily frustrated
- ___ 63. Experiencing frequent traffic violations or near accidents
- ___ 64. Refusing to maintain body weight above a level that most people consider healthy
- ___ 65. Intensely fearing gaining weight or becoming fat even though underweight
- ___ 66. Feeling of lack of control over eating behavior
- ___ 67. Being overly concerned with body shape and/or weight
- ___ 68. Experiencing involuntary physical movements and/or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking).
- ___ 69. Having delusional or bizarre thoughts (thoughts you know others would think are false)
- ___ 70. Seeing objects, shadows or movements that are not real
- ___ 71. Hearing voices or sounds that are not real
- ___ 72. Experiencing periods of time where your thoughts or speech were disjointed or didn't make sense to you or others
- ___ 73. Feeling socially isolated or withdrawn
- ___ 74. Having a severely impaired ability to function at home or at work
- ___ 75. Lacking personal hygiene or grooming
- ___ 76. Having a marked lack of initiative
- ___ 77. Having frequent feelings that someone or something is out to hurt you or discredit you
- ___ 78. Snoring loudly (or others complaining about your snoring)
- ___ 79. Others saying that you stop breathing when you sleep

