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** ***Individual or Combinations*** ***Dosage(s) and time(s) taken per day***	**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.

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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 ____
- ☐ Bipolar disorder/manic-depression _______________________
- ☐ Alcoholism/drug abuse _________________________________
- ☐ Severe trauma _______________________________________
- ☐ ADHD/learning disorders ______________________________
- ☐ Attempted or completed suicide _________________________
- ☐ Anorexia/bulimia ______________________________________
- ☐ Severe obesity ____
- ☐ Anxiety/nerves __________________________________
- ☐ Epilepsy/seizures _______________________________
- ☐ High blood pressure_______________________________
- ☐ Diabetes _______________________________________
- ☐ Cancer ____
- ☐ Schizophrenia ___________________________________
- ☐ Alzheimer's or Parkinson's disease __________________
- ☐ 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.

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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:

- ☐ Copies of progress notes
- ☐ Treatment plan and summary (written and verbal)
- ☐ All of the Above
- ☐ Testing/lab results
- ☐ Other (Specify):

____

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 form 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

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General
- ❑ Being overweight
- ❑ Recent weight gain or weight loss
- ❑ Poor appetite
- ❑ Increased appetite
- ❑ Abnormal sensitivity to cold
- ❑ Cold sweats during the day
- ❑ Tired or worn out
- ❑ Hot or cold spells
- ❑ Abnormal sensitivity to heat
- ❑ Excessive sleeping
- ❑ Difficulty sleeping
- ❑ Lowered resistance to infection
- ❑ Flu-like or vague sick feeling
- ❑ Sweating excessively at night
- ❑ Urinating excessively
- ❑ Excessive daytime sweating
- ❑ Excessive thirst
- ❑ Other________________________

Neurological
- ❑ Pacing due to muscle restlessness
- ❑ Forgotten periods of time
- ❑ Dizziness
- ❑ Drowsiness
- ❑ Muscle spasms or tremors
- ❑ Impaired ability to remember
- ❑ "Tics"
- ❑ Numbness
- ❑ Convulsions / fits
- ❑ Slurred speech
- ❑ Speech problem (other)
- ❑ Weakness in muscles
- ❑ Other________________________

Respiratory
- ❑ Asthma, wheezing
- ❑ Cough
- ❑ Coughing up blood or sputum
- ❑ Shortness of breath
- ❑ Rapid breathing
- ❑ Repeated nose or chest colds
- ❑ Other________________________

Chest and Cardiovascular
- ❑ Ankle swelling
- ❑ Rapid / irregular pulse
- ❑ Breast tenderness
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Other__________________________

Head, Eye, Ear, Nose, & Throat
- ❑ Facial pain
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain or stiffness
- ❑ Frequent sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Overly sensitive to light
- ❑ See spots or shadows
- ❑ Hearing loss in both ears
- ❑ Ear ringing
- ❑ Disturbances in smell
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Sore tongue
- ❑ Other_________________________

Gastrointestinal and Hepatic
- ❑ Trouble swallowing
- ❑ Nausea or vomiting (throwing up)
- ❑ Abdominal (stomach / belly) pain
- ❑ Anal itching
- ❑ Painful bowel movements
- ❑ Infrequent bowel movements
- ❑ Liquid bowel movements
- ❑ Loss of bowel control
- ❑ Frequent belching or gas
- ❑ Vomiting blood
- ❑ Rectal bleeding (red or black blood)
- ❑ Jaundice (yellowing of skin)
- ❑ Other_________________________

Musculoskeletal
- ❑ Back pain or stiffness
- ❑ Bone pain
- ❑ Joint pain or stiffness
- ❑ Leg pain
- ❑ Muscle cramps or pain
- ❑ Other_________________________

Skin, Hair
- ❑ Dry hair or skin
- ❑ Itchy skin or scalp
- ❑ Easy bruising
- ❑ Hair loss
- ❑ Increased perspiration
- ❑ Sun sensitivity
- ❑ Other_________________________

Genitourinary
- ❑ Itchy privates or genitals
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Difficulty in starting urine
- ❑ Accidental wetting of self
- ❑ Pus or blood in urine
- ❑ Decreased sexual desire
- ❑ Other________________________

Females
- ❑ No menses
- ❑ Menstrual irregularity
- ❑ Painful or heavy periods
- ❑ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- ❑ Painful menstrual periods
- ❑ Painful intercourse or sex
- ❑ Sterility infertility
- ❑ Abnormal vaginal discharge

Other________________________

Males
- ❑ Impotence (weak male erection)
- ❑ Inability to ejaculate or orgasm
- ❑ Scrotal pain
- ❑ Abnormal penis discharge

Other________________________

Explanation

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