1370 Bedford Drive, Suite 106, Melbourne, FL 32940
Phone: (321) 253-8887 Fax: (321) 253-8878

Adult Intake Packet

March 30th, 2017

Dear Client,

Welcome, you have just taken a very positive step by deciding to seek counseling. I look forward to helping you overcome any current or past challenges, so that you can achieve positive growth and balance in your life. In addition, we offer support groups for women and male veterans (separated by gender) here at Baytree Behavioral Health. I currently do not participate in court appearances. Additionally, we ask your cooperation in filling out the following forms. This information is confidential and will assist myself, the psychologist in assessing your needs. We also need a copy of your driver's license and if you are paying with insurance, a copy of your insurance card.

Thank You,

Dr. Krista Puente Trefz
Licensed Florida Clinical Psychologist
PY7988

ADULT INTAKE:
FOR DR. KRISTA P. TREFZ

Counseling I am seeking: (-Individual -Couple –Family)_____

Date of Birth: ____/_____/_____
Name: _____
Address: _____
City: _____**Zip:** _____
Home #_____ **Cell #**_____ **Work #**_____
Other #_____ On what number may we leave a confidential message:
Home or Cell:_____
How did you hear about Dr. Krista P. Trefz? _____

I am: (Single, Married, Divorced, Widowed, Cohabitating):_____
How many people live in your household? _____
Do you have any pets or a service dog?_____

EMERGENCY CONTACT INFO:

Notify: _____**Phone:**_____
Relationship to client: _____

HEALTH AND MEDICAL :
Primary Care Physician:_____
Phone:_____ **Psychiatrist:**
_____ **Phone:**_____

What are the problem(s) for which you are seeking help?
1._____
2._____
3._____

If you had difficulties in the past, what have you done to cope? Was it helpful?
1._____
2. _____

What are your treatment goals?
1._____
2._____
3._____

Current Symptoms Checklist:

Symptoms:

Please check any symptoms or experiences that you have had in the last month:

- Difficulty falling asleep
- Difficulty staying asleep
- Difficulty getting out of bed
- Nightmares
- Flashbacks
- Night sweats/chills
- Waking up in a panic
- Not feeling rested in the morning
- Average hours of sleep per night:_____
- Persistent loss of interest in previously enjoyed activities
- Withdrawing from other people
- Spending increased time alone
- Depressed Mood Feeling Numb
- Rapid mood changes
- Irritability
- Anxiety Panic attacks
- Frequent feelings of guilt
- Avoiding people, places, activities or specific things
- Difficulty leaving your home
- Fear of certain objects or situations (i.e., flying, heights, bugs)
  Describe:_____
- Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- Outbursts of anger
- Worthlessness
- Hopelessness
- Sadness
- Helplessness
- Changes in eating/appetite
- Eating more Eating less
- Voluntary vomiting
- Use of laxatives
- Excessive exercise to avoid weight gain
- Binge eating
- Are you trying to lose weight?
- Weight gain: lbs
- Weight loss: lbs.
- Difficulty catching your breath
- Increase muscle tension
- Unusual sweating Easily started, feeling “jumpy”
- Increased energy Decreased energy

Current Symptoms Checklist Continued:

- Tremor/Dizziness
- Frequent worry
- Physical sensations others don't have
- Racing thoughts
- Intrusive memories
- Difficulty concentrating or thinking
- Large gaps in memory
- Thoughts about harming or killing yourself
- Thoughts about harming or killing someone else
- Feeling as if you were outside yourself, detached, observing what you are doing
- Feeling puzzled as to what is real and unreal
- Persistent, repetitive, intrusive thoughts, impulses, or images
- Unusual visual experiences such as flashes of light, shadows
- Hear voices when no one else is present
- Feeling that your thoughts are controlled or placed in your mind
- Feeling that the television or the radio is communicating with you
- Difficulty problem solving
- Difficulty meeting role expectations
- Dependency on others Manipulation of others to fulfill your own desires
- Inappropriate expression of anger
- Self-mutilation/cutting
- Difficulty or inability to say "no" to others
- Ineffective communication
- Sense of lack of control Decreased ability to handle stress
- Abusive relationship Difficulty expression emotions
- Concerns about your sexuality
- Sexual Orientation: (Heterosexual, Homosexual, Bisexual or I choose not to answer)_____

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? **( ) Yes ( ) No**. If YES, please answer the following. If **NO**, please skip to the next section.

Do you currently feel that you don't want to live? **( ) Yes ( ) No** How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way?

_____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? ___

Would anything make it better?_____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

Past Medical History:

Allergies_____ **Current Weight** _____ **Height** _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name **Total Daily Dosage** **Estimated Start Date**

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements:

_____

_____

Current medical problems:

_____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ .
Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only: Date of last menstrual period _____
Are you currently pregnant or do you think you might be pregnant? **( ) Yes ( ) No.**
Are you planning to get pregnant in the near future? **( ) Yes ( ) No**
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____
Do you have any concerns about your physical health? **( ) Yes ( ) No**
Date and place of last physical exam:

_____

Personal and Family Medical History:

- Thyroid Disease
- Anemia
- Liver Disease
- Chronic Fatigue
- Kidney Disease
- Diabetes
- Asthma/respiratory problems
- Stomach or intestinal problems
- Cancer (type)

Personal and Family Medical History Continued:

- Fibromyalgia
- Heart Disease
- Epilepsy or seizures
- Chronic Pain
- High Cholesterol
- High blood pressure
- Head trauma
- Liver problems
- Family History
- Which Family Member? _____ _____ _____ _____ _____
- Other _____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History: Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment. Reason Dates Treated By Whom

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where. Reason Date, Hospitalized, Where:_____

_____

_____

Past Psychiatric Medications:

If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember). ***Please provide dates, dosage, and response.***

Antidepressants: Prozac (fluoxetine), Zoloft (sertraline),
Luvox (fluvoxamine), Paxil (paroxetine), Celexa (citalopram), Lexapro (escitalopram), Cymbalta (duloxetine), Wellbutrin (bupropion), Remeron (mirtazapine), Serzone (nefazodone), Anafranil (clomipramine), Pamelor (nortrptyline), Tofranil (imipramine), Elavil (amitriptyline)>,
Other: _____
Mood Stabilizers: <Tegretol (carbamazepine), Lithium, Depakote (valproate), Lamictal (lamotrigine), (carbamazepine),Topamax (topiramate), Other:_____ _____

Antipsychotics/Mood Stabilizers Dates Dosage Response/Side-Effects:
Seroquel (quetiapine), Zyprexa (olanzepine), Geodon (ziprasidone), Abilify (aripiprazole), Clozaril (clozapine), Haldol (haloperidol), Prolixin (fluphenazine), Risperdal (risperidone),
Other:_____

Past Psychiatric medications: (continued)

Sedative/Hypnotics:

Ambien (zolpidem), Sonata (zaleplon), Rozerem (ramelteon), Restoril (temazepam), Desyrel (trazodone), Other:_____

ADHD medications:

Adderall (amphetamine), Concerta (methylphenidate), Ritalin (methylphenidate), (atomoxetine), Other:

_____

Antianxiety medications: Xanax (alprazolam), Ativan (lorazepam), Klonopin (clonazepam), Valium (diazepam), Tranxene (clorazepate), Buspar (buspirone), Other

_____

Your Exercise Level: Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you prefer? _____

What are your hobbies/interests (e.g. reading, movies, gardening, etc.)?_____

What are your personal strengths? What do you like about yourself?_____ _____

Whom is your support system:_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder ( ) Yes ( ) *No* *Schizophrenia* ( ) Yes ( ) *No* *Depression* ( ) Yes ( ) No

Post-traumatic stress ( ) Yes ( ) No *Anxiety* ( ) Yes ( ) No *Alcohol abuse* ( ) Yes ( ) No

Anger challenges ( ) Yes ( ) No *Other substance abuse* ( ) Yes ( ) No *Suicide* ( ) Yes ( ) No

Violence ( ) Yes ( ) No If yes, who had each problem?

_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No If yes, for which substances?

_____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____ What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?

_____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Substance Use Continued:

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? Yes ( ) No If yes, which ones?

_____

Have you ever abused prescription medication? ( ) Yes ( ) No If yes, which ones and for how long?

_____

_____

Check if you have ever tried the following:
If yes, how long and when did you last use? _____
Methamphetamine ( )Yes, ( )No_____
Cocaine ( )Yes, ( )No_____
Stimulants( )Yes, ( )No_____
Opiates (pills) ( )Yes, ( )No_____
Heroin ( )Yes, ( )No_____
LSD or Hallucinogens ( )Yes, ( ) No_____
Marijuana ( )Yes, ( )No_____
Pain killers (not as prescribed) ( )Yes, ( )No_____
Methadone ( )Yes, ( )No_____
Tranquilizer/sleeping pills ( )Yes, ( )No_____
Alcohol ( )Yes, ( )No_____
Ecstasy ( )Yes, ( )No_____
Other _____
How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____
Tobacco History: How you ever smoked cigarettes? ( ) Yes ( ) No Currently? ( ) Yes ( ) No
How many packs per day on average? _____ How many years? _____ In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____ Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No What kind? _____
How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No
Where did you grow up? _____
List your siblings and their ages (are they living if so where):

_____

_____

Describe your relationship with your siblings?

_____

What was your father's occupation?

_____

Family Background and Childhood History Continued:

What was your mother's occupation?

_____

Did your parents' divorce? ( ) Yes ( ) No
If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?

_____

Describe your father and your relationship with him:

_____

_____

Describe your mother and your relationship with her:

_____

_____

Are you in contact with your parents? Do you visit or do they visit you?

_____

How old were you when you left home?

_____

Has anyone in your immediate family died?

_____

Who and when?

_____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom:

_____

Educational History: Highest Grade Completed? _____

Where? _____
Did you attend college? _____ Where? _____
Major? _____

What is your highest educational level or degree attained?

_____

How would you describe your college experience:

_____

Occupational History:

Are you currently:

( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

How do you get along with your work collegauges?_____

Military History:

Have you ever served in the military? _____

If so, what branch and when? _____

Honorable discharge ( ) Yes ( ) No Other type discharge _____

Can you briefly describe your military experience?_____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation? ( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual ( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____

How long? _____

Have there been any affairs in your marriage? ( ) Yes ( ) No (if yes, by who?

_____

Does anyone in your marriage have an addiction to pornography? ( ) Yes

( ) No_____

Relationship History Continued:

Is there any current or past verbal abuse in your marriage? ( ) Yes

()No_____

Is there any current or past physical violence in your marriage? ( ) Yes

()No_____

Have there been any restraining orders or arrests? ( ) Yes ( )

No_____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender:

_____

_____

Describe your relationship with your children: _____

_____

List everyone who currently lives with you:

_____

Legal History:

Have you ever been arrested? _____
Do you have any pending legal problems?

_____

Are you on probation? _____
Have the police been called to your home for any reason?_____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful Is there anything else that you would like us to know?

_____

_____

ADDITIONAL INFO:

Are you interested in attending group therapy in conjunction to your individual therapy?

_____

Do you wish for Dr. Trefz to have the ability to share any of your therapy progress with your medical physician, or psychiatrist?_____

If so, please be sure to request the forms necessary at the front office to complete the release of information form today before you leave (complete with the specific medical person , & their contact information.

Signature_____Date_____

Please print name as well_____

Emergency Contact _____ Telephone # _____

1370 Bedford Drive, Suite 106, Melbourne, FL 32940
Phone: (321) 253-8887 Fax: (321) 253-8878

Dr. Krista Puente Trefz

No-Show and Late Cancellation Policy:

Working with you and/or your family to help you achieve your therapy goals is very important to me. It is understandable that there may be scheduling conflicts that arise during treatment. Baytree Behavioral Health's administrative staff will work hard to try to accommodate any scheduling conflicts that may arise. The more advanced notice you can provide, the more accommodating we can be to try to find an alternative time that will meet your needs. Due to the high demand for psychological services, any no-shows or cancellations with less than 24-hour notice will be assessed a fee. We appreciate your cooperation with this matter and look forward to providing you and your family with mental health services. Effective immediately, all appointments that result in a no-show or late cancellation will be charged a $50 fee. Due to the high demand for afternoon appointments, those scheduled for 2:30 p.m. or later will be charged a $100 fee. This charge will be your responsibility and cannot be billed to your insurance company. Thank you for your cooperation-*Dr. Krista Puente Trefz*

I acknowledge that I have read and understand the no-show/cancellation policy as defined above.

_____

Printed Name of Client/Guardian

_____ _____

Signature of Client/Guardian *Date*

Baytree Behavioral Health
Orientation to Clinical Services

Following is an outline of items and issues which will be discussed in our first clinical meeting. These issues are discussed early in the therapeutic process to facilitate a clear understanding of the many factors which influence the clinical work we do together. They are established to ensure the highest quality of care. Any time you have questions regarding these policies and procedures, please feel free to discuss them in therapy. All of our administrative practices are in compliance with the Health Insurance Portability and Privacy Act (HIPPA).

1. CONFIDENTIALITY: Some exceptions to maintaining confidentiality include:
   - Insurance processing (limited information necessary to process claim)
   - Discussions with other clinical professionals in private anonymous consultation
   - In the case of child abuse
   - Suicidal or homicidal plan, action, or intent
   - Disclosure of violent crimes or of threat or intent to harm others
   - Other individuals, only with your written consent

2. EMERGENCIES:
   - Contact the clinic during normal business hours
   - The clinic or answering service will contact your therapist. After-hours emergency phone sessions will be charged private pay in increments of 15 minutes. Price depends on the provider.
   - Go to the nearest Emergency Room

3. APPOINTMENTS:
   A clinical therapy appointment can be expected to be 45 minutes in length and I make every attempt to start the appointment on time. From time to time, clinical needs may dictate adjustments, but every effort will be made to avoid delays.

4. CANCELLATIONS:
   Many times there are patients on a waiting list to see a therapist. Subsequently, there is a $50 charge for appointments missed or appointments not canceled within 24 hours of the appointed time. This fee cannot be charged to insurance and is the responsibility of the patient.

5. INSURANCE:
   If financial conditions make it necessary to adjust service fees or co-pays, the insurance company must be notified of such an adjustment. It is unethical and constitutes insurance fraud if a co-pay is waived without the insurance company's awareness. Patients are responsible for the payment of their co-pays and deductibles at the time the service is rendered. If the insurance company refuses to pay, the patient is responsible for the cost related to the services. Baytree Behavioral Health will not bill tertiary insurance for patients. Costs not covered by primary/second insurance will be the patient's responsibility.

6. TRAINING INSTITUTE:
   Periodically, we may supervise mental health professionals in training who may be involved in various aspects of the therapeutic process. Their clinical participation is critical to the development of quality clinicians. They, of course, follow the same rigorous rules regarding confidentiality and your permission is always requested.

Please read and sign:

I hereby fully understand that I enter into treatment having discussed the nature of the therapeutic relationship, the therapeutic course, and techniques to be used, to include therapeutic risks and benefits. I am aware of issues relating to confidentiality and its exceptions, patient's rights and responsibilities, the established fees, insurance company requirements, and policies related to “no shows” and cancellations. I have had the opportunity to review the Privacy Act Policies of the clinic and I am also aware that I may discuss these issues at any time.

_____ _____

(Patient Signature) (Date) (Print Name)

Baytree Behavioral Health Notices of Privacy Practices

I have read and understand Baytree Behavioral Health HIPAA Practices and my rights and responsibilities as they pertain to my treatment record at Baytree Behavioral Health. I am also aware that upon request I may receive a hardcopy of this Privacy Notice.

Patient Signature:

Patient Representative:

Witness:

Date:

Date: _____

Patient Name: _____

I have been provided information on the following:

Patient Privacy Statement (HIPAA)

I Accept _____
(Patient Signature)

Benefits & Release: I authorize the billing of my insurance company for services provided.
*(For Medicare/Tricare patients: Your plans are **almost always secondary to any other commercial insurance**. Failure to disclose other insurance is illegal and could result in charges not being covered by either insurance, becoming patient responsibility.)*

I Accept _____
(Patient Signature)

Patient Financial Policy

Note: No-shows or cancellations with less than 24 hours notice are subject to a $50 fee

I Accept _____
(Patient Signature)

For Tricare Patients Only

Baytree Behavioral Health
Office: 321-253-8887 / Fax: 321-253-8878
CONSENT TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

I, _____ (DOB_____), hereby authorize
Baytree Behavioral Health, located at 1370 Bedford Dr., Suite 106, Melbourne, Florida 32940,
_____ **to release to** _____**to receive from** (check appropriate line)

Person/facility/agency: **45th Medical Group Patrick AFB**
Fax/Phone: **P: 321-494-7599 F: 321-494-8334**
Address if known: _____
The specific information indicated below with regard to the services provided to me for the period of treatment from _____(all dates included)_____ for the following purposes:
____For coordination of care
____For treatment at this facility
____For processing of my insurance claim
____For peer review/third party payer
____Other (specify): _____
Information to be furnished (this section must be completed)
Check/Initials

_____Progress reports throughout treatment
_____Report of psychological/psychiatric evaluation
_____History and Physical
_____Medical Discharge Summary
_____Psychosocial Assessment
_____Continuing Care Plan
_____Progress Notes
_____Neuropsychological Assessment
_____Lab and Radiographic results
_____Consultations
_____Legal
_____Other: Specify_____

I understand that the above consent is subject to revocation by me at any time except to the extent that action has been taken in reliance on this consent prior to revocation. The Federal Regulations regarding the confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR part 2) have been explained to me as applicable.

_____ or _____
Patient Signature Parent/Legal Guardian

_____ _____
Witness Date

****

I do not want my records released to Patrick Airforce Base.

_____ or _____
Patient Signature Parent/Legal Guardian

_____ _____
Witness Date