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Psychiatry
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Medication Management Health Intake Form

Please complete to the best of your ability and email back to drgonyweiss@gmail.com prior to your first appointment. Thank you!

Name: ____

Who can we thank for referring you to us: ______________________________

Date of Birth: ___________________________ **Age:** ____________________________

Address: ____

Phone Number: ____

Email: ____

Current Pharmacy: ____

Current Therapist: ____

Insurance Carrier: _______________ **ID #:** _______________ **Group #** ________________

Primary Subscriber: ___________________ **Date of Birth:** _________________________

***I am considered out of network for all insurances aside from Aetna and**

United.

Are you currently employed? ____

If you are, what is your line of work? ____

Current Living Situation: ____

What would you like me to help and support you with?

What is the reason for making your appointment at this time in your life?

What are your biggest stressors?

What helps you feel better?

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?

Do you feel hopeless and/or worthless?

Have you ever tried to kill or harm yourself?

Past Medical History:

Current Weight ____________ Height ____________

Allergies____

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

Medication Name, Total Daily Dosage, Estimated Start Date:

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Current over-the-counter medications or supplements:

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Current and Past Medical Problems:
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Have you ever had an EKG? ( ) Yes ( ) No
If yes, when _________
Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

Have you had routine bloodwork done recently? If yes, when?
____
Was the bloodwork ( ) 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? _______________

Personal and Family Medical History:
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Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No

If yes, please describe when, by whom, and nature of treatment: reason, dates treated, and by whom:

Past Psychiatric Hospitalizations ( ) Yes

( ) No If yes, describe for what reason, when and where.

Past Psychiatric Medications:

Please indicate date, dosage, response, side effects.

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No How many days a week do you getexercise

How much time each day do you exercise?

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What kind of exercise do you do?
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Family Psychiatric History:

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Substance Use History:

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 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?

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Legal History:
Have you ever been arrested? ________
Do you have any pending legal problems? ________________

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?

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Signature____
Date______________________

Emergency Contact ________________________________ Telephone # ______________

OFFICE POLICIES: KINDLY INITIAL BELOW

______ PRESCRIPTIONS: Prescriptions are sent during appointments only. If an appointment is not possible, the fee for sending in a refill is $250.00.

______ FOR PATIENTS NOT USING INSURANCE: Payment is due prior to the appointment. Payment can be submitted via VENMO or ZELLE: @Gony_Weiss, 203-727-8969. Once payment is made, appointment will start, and you will receive an invoice to provide your insurance. Your insurance will then reimburse you for the appointment.

______FOR PATIENTS NOT USING INSURANCE:
Appointment Fee: $300

_____ NO SHOW/LATE CANCELLATION: There will be $250 LATE FEE, if 24 hours notice is not given.

_____ HIPAA: I understand that my records will be kept safe and confidential. My records will not be released without my written consent, unless I am hospitalized or need some type of urgent care.

_____ IN CASE OF EMERGENCY: If I am experiencing a MEDICAL EMERGENCY, then I agree and understand that I MUST GO TO THE EMERGENCY DEPARTMENT OR CALL 911. I will NOT call the office. Emergencies are serious and must be treated immediately by the hospital.

By signing below, I acknowledge and agree that I have read and fully understand the office policies listed

Signature:___________________________________.

Date:_______________________________________

Credit Card Payment Authorization Form

Sign and complete this form to authorize __________________ (your "Provider") to make charges to your credit card listed below for any appointment fees, including co-payments, or for any missed appointments that were not cancelled before the applicable cancelation timeframe.

By signing this form you give us permission to charge your card for amounts previously agreed upon in your Provider's Patient Services Agreement.

Please complete the information below:

I ____________________________ authorize my Provider to charge my credit card
(full name)
on or after ___________________ for any appointments, attended or missed, or any

(today's date)
associated costs owed to my Provider.

Billing Address ____________________________ Phone # ________________________

City, State, Zip _______________________________ Email ________________________

Account Type: Visa MasterCard AMEX Discover
Cardholder Name ____
Account Number ____
Expiration Date ____________
CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) ______

SIGNATURE ____________________________________ DATE ______

I authorize my Provider to charge the credit card indicated in this authorization form. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.