DEER VALLEY COUNSELING, INC

PREPSYCHIATRIC VISIT HISTORY

NAME:____ DATE:__________________,20___
(Last) (First) (Middle)
MEDICAL RECORD #:_________________________________ DOB:________________________
HOME PHONE:_______________________________________ MOBILE PHONE:________________
MAY I LEAVE A VOICEMAIL MESSAGE: YES OR NO (circle one)
OCCUPATION:____
EDUCATION COMPLETED: GRADE SCHOOL HIGH SCHOOL COLLEGE GRAD SCHOOL
YEARS OF EDUCATION _____________
MARITAL STATUS: SINGLE M Sep D W Co-Habiting Engaged Other______
SPOUSE/PARTNER'S NAME:_________________________________ NUMBER OF CHILDREN:________
WHO LIVES AT HOME WITH YOU?________________ PRIMARY SUPPORT?______________________

MEDICAL CARE

PRIMARY CARE PROVIDER:______________________________ PCP PHONE NUMBER________________
DATE OF LAST PHYSICAL EXAM:_____________________ DATE OF MOST RECENT LABS___________
DATE OF MOST RECENT DR VISIT____________________
HOW WOULD YOU RATE YOUR GENERAL HEALTH? Excellent Good Fair Poor

PREVENTIVE CARE

WHEN WERE YOUR MOST RECENT:
Hepatitis A shot________ Hepatitis B shot________ Influenza (flu) shot________ Measles shot___________
Pneumovax shot________ Rubella shot___________ Tetanus (Td) shot ________ Chicken pos shot_______
Tuberculosis skin test______ Dental Exam________

LIFESTYLE INFORMATION

Do you smoke? If yes, how much do you smoke per day? Yes No Explain__________________
Do you drink alcohol? If yes, how much do you drink per week? Yes No Explain__________________
Are you taking Over The Counter supplements? If yes, list name and quantity per day/week. Yes No
Explain____
Do you exercise regularly? If yes, describe your exercise routine below. Yes No
Explain____
Do you use mood altering substances? If yes, list name and quantity used per day/week. Yes No
Explain____
Do you use pain medication? If yes, list name and quantity per day/week. Yes No
Explain____
Do you wear a seat belt when in a vehicle? Yes No
Are you sexually active? Yes No Not currently Current sex partners is/are Male Female
Birth control method_______________________ none needed_________________
If sexually active, do you practice safe sex? Yes No N/A
Have you ever had any sexually transmitted diseases? Yes No If yes, please list disease and
dates____

072010
LMH

NAME:______________________________________ DATE:_______________,20___
(Last) (First) (Middle)

DISEASE HISTORY

Do you currently have or ever had any of the following? If yes, please explain below:

Choose yes or no for each		
Any known deficiency including minerals and electrolytes	Yes	No
Blood disorders	Yes	No
Cancer	Yes	No
Carpal Tunnel Syndrome	Yes	No
Orthopedic or muscle disorder including fracture or joint disorder	Yes	No
Allergies to medications	Yes	No
Edema/excess fluid retention	Yes	No
Emotional disorders/depression	Yes	No
Genital/urinary disorder	Yes	No
Hyperlipidemia	Yes	No
Neurological disorders	Yes	No
Endocrine disorder including insulin resistance or diabetes	Yes	No

Choose yes or no for each	Yes	No
Use of medications:	Yes	No
If yes, list medications below		
Immune disorders	Yes	No
Chemical dependency	Yes	No
Lung disorder	Yes	No
Heart disease including atherosclerosis, angina, heart failure, heart attack	Yes	No
Upper respiratory	Yes	No
Poor wound healing	Yes	No
Renal disease	Yes	No
Hypertension	Yes	No
Liver disease/hepatitis	Yes	No
Thyroid condition	Yes	No
Other Illnesses	Yes	No

Please explain below any YES answers for surgeries, hospitalizations, disease, or any additional information:____

____

Please list all medications, vitamins, herbs, and supplements that you take:

Name	Dosage (for example, mg/pill)	How many times per day	When started

Allergies/reactions to medicines or vaccinations:

____

____

____

____

____

____

____

____

072010
LMH

NAME:______________________________________ DATE:__________________,20______
(Last) (First) (Middle)

FAMILY MEDICAL HISTORY

Medical condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Anxiety								
Alcoholism								
ADD Attention Deficit Disorder								
Bleeding Problems								
Cancer, breast								
Cancer, colon								
Cancer, melanoma								
Cancer, ovary								
Cancer, prostate								
Cancer, other								
Heart attack, heart disease								
Depression								
Diabetes, on insulin								
Diabetes, not on insulin								
High cholesterol								
High blood pressure								
Learning disability								
Migraine headaches								
Psychiatric problems								
Scoliosis								
Seizures								
Stroke								
Substance abuse								
Sudden death								
Thyroid disorders								
Other, please specify								

NAME:____ DATE:__________________,20___
(Last) (First) (Middle)

PSYCHIATRIC HISTORY

Have you been diagnosed with and treated for a mental health issue? YES NO
Have you been prescribed psychotropic medications in the past? If yes, please list the medications, dosages, and dates used. YES NO

____

Have you ever been hospitalized for psychiatric reasons? If yes, please list the dates and reasons for the hospitalizations. YES NO

____

Have you ever been hospitalized for substance abuse issues? If yes, when and why? YES NO

____

Have you felt suicidal or homicidal in the past? YES NO
If you felt suicidal or homicidal have you ever acted on those Feelings? If yes, when and how? What was the outcome? YES NO

____

Have you ever experienced physical abuse? If yes, to what extent When and who was the perpetrator? ______________ YES NO

____

Have you ever been the victim of sexual abuse? If yes, when and what type? YES NO

____

Have you ever experienced emotional abuse? If yes, when and to what extent?______________ YES NO

____

Have you had impulse control problems? If yes, describe. YES NO

____

Do you now, or have you ever, experienced:

Racing thoughts	Yes	No	Voices	Yes	No	Mistrust	Yes	No
Periods of increased activity	Yes	No	Impulsiveness	Yes	No	Sleep Disturbance	Yes	No
Fearful or anxious	Yes	No	Social Withdrawal	Yes	No	Decreased concentration	Yes	No
Repetitive Thoughts	Yes	No	Repetitive Behaviors	Yes	No	Rapid Speech	Yes	No
Difficulty leaving your home	Yes	No				Depressed Mood with Melancholia	Yes	No
Cutting, burning or other self harm behaviors	Yes	No						

NAME_______________________________________ DATE:__________________,20__________
(Last) (First) (Middle)

CURRENT SYMPTOMS/CONCERNS

Review of Systems: Please check ( ) any current problems you have on the list below:

Constitutional
____Fevers/chills/sweats
____Unexplained weight loss/gain
____Fatigue/weakness
____Excessive thirst or urination
Eyes
____Change in vision
Ear/Nose/Throat/Mouth
____Difficult hearing/ringing in ears

____Problems with teeth/gums
____Hay fever/allergies
Cardiovascular
____Chest pain/discomfort
____Leg pain with exercise
____Palpitations

Chest(breast)
____Breast lump/discharge
Respiratory
____Cough/wheeze
____Difficulty breathing
Gastrointestinal
____Abdominal Pain
____Blood in bowel movement
____Nausea/vomiting/diarrhea
Genitourinary
____Nighttime urination
____Leaking urine
____Unusual vaginal bleeding
____Discharge: penis or vagina
____Sexual function problems
Musculo-skeletal
____Muscle/joint pain

Skin
____Rash or mole change
Neurological
____Headaches
____Dizziness/light-headed
____Numbness
____Memory loss
____Loss of coordination
Psychiatric
____Anxiety/Stress
____Problems with sleep
____Depression
Blood/Lymphatic
____Unexplained lumps
____Easy bruising/bleeding
Other (please specify) ______
____

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost interest or pleasure in things you usually cared about or enjoyed? Yes No

Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?
Yes No

Have you felt depressed or sad much of the time in the past year?
Yes No

NAME:____ DATE:__________________,20______

(Last) (First) (Middle)

PSYCHIATRIC SYMPTOMS

Please check all items that are of a current concern to you:

_____Antsy/Can't sit still
_____Anxious
_____Angry
_____Difficulty sleeping
_____Sleeping too much
_____Cutting or burning
_____Impulsiveness
_____Loss of appetite
_____Overeating
_____Bingeing
_____Purging
_____Over-using laxatives
_____Losing weight
_____Weight gain
_____Sad
_____Morbid thoughts
_____Crying
_____Loss of energy
_____Feel people are against me
_____Restless
_____Irritable
_____Racing heart
_____Guilt
_____Thoughts of dying
_____Disinhibition

_____Trouble making decisions
_____Feeling worthless
_____Poor libido
_____Want to die
_____Difficulty concentrating
_____Rapid speech
_____Racing thoughts
_____Constant worry
_____Hearing voices
_____Elevated mood
_____No pleasure in things
_____Excess energy
_____Nightmares
_____Flashbacks
_____Poor self care
_____Want to hurt someone
_____Mood swings
_____Disorganized
_____Fear of dying
_____Panic attacks
_____Hoarding
_____Counting
_____Excessive hand washing
_____Trouble leaving home
_____Relationship problems

_____Use of alcohol
_____Unable to meet obligations
_____Feeling hopeless
_____People talk about me
_____Problems at work
_____Sexual problems
_____Can't get along with others
_____Taking too many risks
_____Memory loss
_____Using drugs
_____Increased smoking
_____Isolating
_____Aggressiveness
_____Suicidal thoughts
_____Avoiding social activities
_____Get upset over little things
_____Problems with the law
_____Making careless mistakes
_____Argumentative
_____Repetitive thoughts
_____Repetitive behaviors
_____Too ritualistic
_____Everything must be in its place
_____Can't face daily tasks

What are your primary concerns/needs and what are you hoping to get help to change?

____
____
____
____
____
____
____
____
____

"Skills for Better Living"

Dear Client:

As the Psychiatric Provider at Deer Valley Counseling, I would like to take this opportunity to welcome you. We are glad that you have decided to obtain your psychiatric services at our agency. The treatment that you receive here is based on a comprehensive assessment and designed to address your unique issues and needs. The service will be thorough, compassionate and provided with respect to you as an individual.

I recognize that your time is as valuable as mine, so my appointments begin and end on time. Please try to be here a few minutes prior to each appointment to complete a brief progress review form. It will only take a few minutes but will assist me to understand your progress and current clinical needs and will allow us to more effectively use our time together. Please call the office if you are running late and please understand that you will be charged the full fee even if your arrive late and your appointment is shortened or rescheduled.

As you know, I am at Deer Valley Counseling on a part-time basis. You may call and leave a non-urgent message but it will not be answered until I return to the office- which might be as long as seven days. In addition, there is no on-call or after hours service available at this time. Therefore, if you experience a psychiatric medication issue that cannot wait until I return to the office, develop a marked increase in symptoms, have a reaction/side effect to a medication or feel unsafe in any way it is imperative that you seek help from other available crisis services such as: EMPACT: 480.784.1500, the Crisis Line: 602.222.9444, see your primary care provider, urgent care or go to the nearest hospital emergency room.

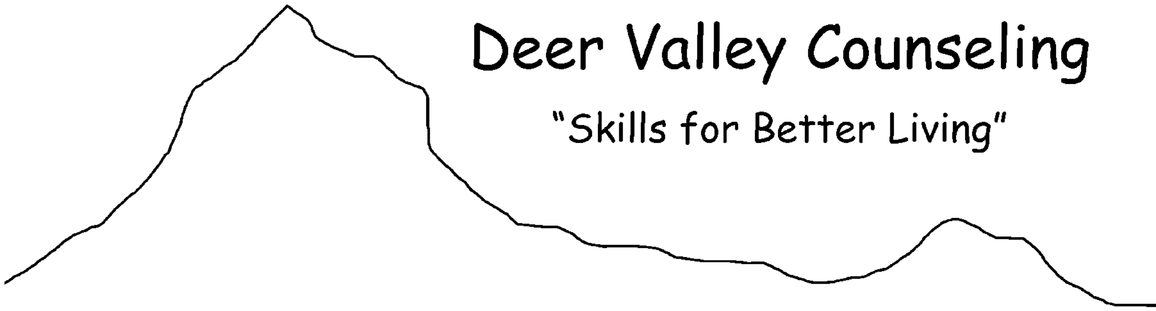
Psychiatric emergencies are very rare, and you and I will be developing a treatment plan designed to treat your target symptoms without creating side effects. But it is necessary that you understand the importance of seeking medical assistance if such an emergency should occur.

I encourage you to be open about your thoughts, feelings, beliefs and concerns regarding psychotropic medication and look forward to working with you to develop the best plan to meet your needs.

Sincerely,

Dr. Lynnette Hjalmervik DNP
Psychiatric Nurse Practitioner

Deer Valley Counseling, 2301 W Dunlap Ave, Suite 206, Phoenix AZ 85021
Phone: 602.750.8051, Fax: 602.674.5701, www.deerval.com



Medication Management Policies

I hereby acknowledge that I have received, read and understand the following Deer Valley Counseling medication management policies:

- Deer Valley Counseling does **not** provide emergency or urgent psychiatric services.
    1. If you experience a medical emergency, call 911.
    2. If you experience an urgent situation that is not life-threatening, go to an urgent care facility or call your primary care physician.
    3. If you experience a mental health crisis, call the crisis hotline at 602-222-9444.
- Dr. Lynnette Hjalmervik, DNP, is in the office and has access to your file on Fridays only. In addition, she is not in the office every Friday. If you have a question, you can leave a message, but be aware that most questions will either need to wait until Dr. Hjalmervik is in the office or until your next office visit. If you are in crisis, call 911, go to an urgent care facility, or call the hotline at 602-222-9444.
- In general, Dr. Hjalmervik does not provide call-in refills. If she only gave you a one-month supply, or a three-month supply, she **must** see you again before refilling your prescription. You are responsible for ensuring that you see Dr. Hjalmervik again **before** you run out of your medication. If you run out early, you must see Dr. Hjalmervik to discuss why you are not taking your medication as prescribed.

Name of Client	Signature of Client	Date Signed
Person Authorized to Sign for Client	Signature of Person Authorized to Sign	Date Signed

Reason person may sign for client: ☐ Parent ☐ Guardian ☐ Other: ________________