

DuPage Medical Group

WE CARE FOR YOU

PSYCHOLOGY DEPARTMENT
24020 W. Riverwalk Court, Suite 102
Plainfield, IL 60544
Phone: 630-510-2607 Fax: 815-676-2574

We are on Route 59 and Riverwalk Ct.
One block south of 143rd St. on Route 59 on the
west side of the street. (Across the street from
the Plainfield Animal Clinic).

Thank you for choosing DuPage Medical Group Psychology Department. We look forward to providing services to you.

***We do not evaluate for Worker's Comp, Court cases or any injury or illness caused by an external source that will lead into a court case. ***

In order to make the most of your first appointment, please come at least 15 minutes prior to your scheduled time. It is important that you bring the following items with you:

1) Completed paperwork

In order for us to provide the highest quality service, it is important for us to obtain a detailed personal and family history. Also, information about medical conditions and current medications can be very important, so please include this information on the forms to the best of your ability. If you have a typed list of your current medications, you may bring that in rather than fill out the current medication form.

2) Your insurance Card(s)

We will be scanning your card(s) into our system. Please contact your insurance company to verify your outpatient behavioral health benefits and secure any preauthorization requirements. If a required authorization is not obtained, you will be responsible for payment of services.

3) A picture I.D.

We will be scanning your driver's license or picture I.D. into our system for verification of your identity and to protect you from medical identity theft.

4) Copayment and/or Deductible (amount not covered by insurance)

Insurance co-payments and deductibles are payable at the time of service. Most insurance companies do not cover 100% of charges.

Please do not bring children with you to this appointment. Children cannot be left unattended.

As a reminder, please give at least 24-hour notification for broken or canceled appointments. If you have any questions, please call our office at (630) 510-2607.

PLEASE NOTE: IT IS MOST IMPORTANT THAT YOU BRING THIS COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTMENT IN ORDER TO AVOID HAVING YOUR APPOINTMENT RESCHEDULED.

**YOUR APPOINTMENT IS SCHEDULED FOR:
PLEASE ARRIVE 15 MINUTES EARLY**

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OUTPATIENT TREATMENT EXPECTATIONS

24020 W. Riverwalk Court, Suite 102
Plainfield, IL 60544
PH: (630) 510-2607
Fax: (815) 676 2574

Patient Name: _____ GE #: _____

DuPage Medical Group's Mission: To enhance the physical well being of the patients we serve by continuing to provide the highest quality medical care.

Thank you for selecting DuPage Medical Group for your behavioral health needs. We look forward to serving you.

Confidentiality: DuPage Medical Group is careful to follow all confidentiality laws and policies.

- No patient information is released without your written permission except for a situation in which you or another person is in immediate danger.
- Please note that when you sign our Consent for Treatment Form it allows DuPage Medical Group to share pertinent information regarding your treatment with your insurance company.
- Please be aware that employees of DuPage Medical Group psychology department will have access to confidential information on a "need to know" basis. These employees are bound by confidentiality laws and will not release this information without proper authorization.
- E-mail is not a secure (confidential) form of communication, and should not be used to communicate with your clinician.

Phone Calls and Messages: Your care is important to us. Every possible effort to return your call or respond to a message will be made in a timely manner. If your situation is an emergency, call 911. Linden Oaks is part of Edward Hospital and has 24 hour assessments if your situation is not a life-threatening emergency. That phone number is 888-969-7874.

Medication Refill Requests: If you are receiving a prescription from one of our medical providers, please be aware that you must allow a minimum of 3 business days for your refill request to be processed.

Smoking Policy: All DuPage Medical Group locations are *non-smoking*. There are NO designated smoking areas.

Attendance and Missed Appointments:

- Please arrive ten minutes prior to the start of your appointment and check in at the reception desk.
- If you arrive late, (generally 15 minutes) you may be asked to reschedule your appointment.
- We have reserved this time for you and require proper notification if you are unable to make your appointment. If you need to cancel an appointment, you must call at least **24 hours prior to the appointment** so that we can fill this appointment slot. **Late cancellations or no-shows for appointments are subject to charges.** If charged, this fee will be your responsibility as insurance companies do not pay for appointments you do not keep.
- If you have 3 or more broken appointments, your case will be reviewed to determine your ability to continue in treatment at DuPage Medical Group.

Account Balances:

- Most insurance companies do not cover 100% of charges.
- You are expected to pay your co-pay and/or deductible at the time of each service.
- If you find it difficult to make your payment, you must notify our customer service department @ 630-942-7997.

Letters/Forms/other Correspondence: If you request a letter, form or other type of correspondence (SSI paperwork, medical leave, attorney letter, etc.) to be completed on your behalf, you will need to provide information as requested by the clinician or letter recipient. In addition, a release of information is required. Charges for the clinical time to address such correspondence will apply.

Patient/Parent Signature

Date

Clinician Signature

Date

**Outpatient Initial Assessment
Adult Patient Information (Part 1)**

INSTRUCTIONS: To assist us in understanding and helping you, please fill out this form as completely as possible. This information is confidential and only released with your permission.

IDENTIFICATION:

Patient's legal name _____ Date of Birth: _____ Age: _____
Best number to reach you: _____ Time of day to reach _____
Ethnic Background: __ American Indian/ Alaska Native __ Asian
 __ Hispanic/Latino __ Black/ African America
 __ Caucasian/White __ Other
Form Completed by (if other than patient) _____ Relationship to patient: _____

PRESENTING PROBLEM:

What is your reason for seeking treatment? _____

Who referred you to DuPage Medical Group: _____

What are your expectations for treatment? _____

SIGNS/SYMPTOMS: (check those that are problematic to you)

<input type="checkbox"/> Alcohol/Drug use	<input type="checkbox"/> Fear	<input type="checkbox"/> Memory problems	<input type="checkbox"/> Sexual problem
<input type="checkbox"/> Angry outbursts	<input type="checkbox"/> Gambling	<input type="checkbox"/> Money management	<input type="checkbox"/> Sleep problem
<input type="checkbox"/> Anxious feelings	<input type="checkbox"/> Grief/Loss issues	<input type="checkbox"/> Mood shifts	<input type="checkbox"/> Unable to experience forgiveness
<input type="checkbox"/> Appetite change	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Not enjoying things	<input type="checkbox"/> Unable to pray
<input type="checkbox"/> Concentration difficulties	<input type="checkbox"/> Health worries	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Withdrawing
<input type="checkbox"/> Crying spells	<input type="checkbox"/> Hopeless/Helpless	<input type="checkbox"/> Recurring behaviors	<input type="checkbox"/> Worrying excessively
<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Impulsive behaviors	<input type="checkbox"/> Recurring thoughts	
<input type="checkbox"/> Disorganized thoughts	<input type="checkbox"/> Irritable	<input type="checkbox"/> Recurring pain	
<input type="checkbox"/> Energy level changes	<input type="checkbox"/> Life changes	<input type="checkbox"/> Relationship issues	
<input type="checkbox"/> Excessive guilt	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Other (specify): _____	

How do the symptoms you checked affect your daily functioning? _____

Do you currently have thoughts of harming yourself or others? _____

Have you had these thoughts in the past? _____

How strongly do you feel about acting on these thoughts? _____

Do you have a plan to harm yourself? _____

MEDICAL HISTORY:

Have you had any past surgical procedures? __no __yes If yes, list: _____

Have you been exposed to any contagious diseases such as Tuberculosis? __no __yes If yes, what were you exposed to and when did that exposure take place? _____

Are you immunizations up to date? __no __yes

Any functional impairments? __no __yes If yes, what type of impairment and have you had any rehab services for this? _____

Any current pain? __no __yes If yes, type and duration: _____

Pain severity? (rate 1 to 10 with 1 being the least amount): _____

Has pain been an issue in the past? __no __yes If yes, type and duration: _____

Do you have any problems with amount or quality of sleep? __no __yes If yes, please explain: _____

MEDICAL HISTORY CONTINUED...

Have you experienced weight **loss** greater than 10 pounds in one month? no yes If yes, when?: _____

- Was the weight loss due to dieting? no yes
- Was the weight loss due to exercise? no yes
- Was the weight loss due to a lack of eating? no yes
- Did you engage in bingeing? no yes
- Did you engage in purging? no yes
- Was the weight loss due to a new medication? no yes

If yes, what medications? _____

Have you **gained** more than 15 pounds in one month? no yes If yes, When?: _____

- Was the weight gain due to poor exercise habits? no yes
- Was the weight gain due to poor eating habits? no yes
- Did you engage in bingeing? no yes
- Did you engage in purging? no yes
- Was the weight gain due to a new medication? no yes

If yes, what medications? _____

Are you following any special diet and desire more information about your special diet? no yes

Female patients: Do you have any reproductive health medical issues/concerns you wish to discuss? no yes

TRAUMA HISTORY:

Have you had a history of trauma or abuse? no yes

If yes, what type of abuse or trauma occurred? Physical Sexual Emotional Neglect

Please explain the event: _____

When did this trauma or abuse occur? _____

What was the duration of time for the abuse/traumatic event? _____

SUBSTANCE USE HISTORY:

Have you used alcohol or drugs in the past no yes If yes, what was your substance of preference? _____

Do you currently use alcohol? no yes If yes, what is your drink of choice? _____

What is your current amount of intake? _____

Do you see your use as a problem? no yes

If yes, how motivated are you to make changes? Unsure Somewhat Very

If very, what motivated you to change? _____

Do you currently use drugs? no yes If yes, what is your substance of preference? _____

what is your current amount of intake? _____

Do you see your use as a problem? no yes

If yes, how motivated are you to make changes? Unsure Somewhat Very

If very, what motivated you to change? _____

Is your current living situation and/or family helpful in supporting any changes? (please explain)

Have you received inpatient or outpatient treatment or educational programs for alcohol or drug use?

Where & With Whom	Type of Treatment	Dates	Was it helpful?
_____	_____	_____	_____
_____	_____	_____	_____

If treatment was **not helpful**, why not? _____

SUBSTANCE USE HISTORY CONTINUED...

Have you experienced any of the following symptoms in relation to your alcohol or drug use?

- Anxiety Increased tolerance Preoccupied with substance
- Depression Loss of control Stomach problems
- Hallucinations Memory Loss Tremors
- Inability to abstain Overdoses Withdrawal symptoms
- Other adverse reactions (Please explain): _____

Do you currently smoke? no yes If yes, how much and how often? _____

PERSONAL PSYCHIATRIC COUNSELING/TREATMENT HISTORY (Please provide past and present information)

	No	Yes	When	Purpose	Result
Counseling/Therapy	___	___	_____	_____	_____
Drug/Alcohol Treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Self-help Groups	___	___	_____	_____	_____

If any of the services were **not helpful**, why? _____

Please list any current or past psychiatric diagnoses:

Diagnosis	Current?	When?	Currently having symptoms?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL/CULTURAL/SPIRITUAL INFORMATION:

In your experience, how important are spiritual matters? _____

What is your present religious affiliation? _____

Do you have spiritual concerns that you would like to address in the therapy process?

no yes Not sure

Describe: _____

Do you have concerns that you would like to address related to cultural or ethnic issues?

no yes

If yes, explain: _____

PERSONAL INFORMATION:

What are your greatest strengths? _____

What are your greatest weaknesses? _____

Currently living with you:

Name	Age	Relationship	Quality of relationship
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
_____	_____	_____	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Family History of Psychiatric Disorders:

Diagnosis	Relationship	When?	Currently having symptoms?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social Relationships:

How do you usually get along with people?

Avoidant Shy Leader Outgoing Assertive Follower Irritable

Has there been any recent change in your attitude/relationships with others? no yes

If yes, describe that change _____

Optional: What is your sexual orientation? Heterosexual Bisexual Homosexual

Legal History: (if applicable)

Are you currently involved with the legal system? no yes If yes, explain _____

Have you been involved with the legal system in the past? no yes If yes, explain _____

Do you currently have a probation or parole officer? no yes If yes, name _____

Educational History: (check all that apply)

Currently in school no yes

High School Grad/GED no yes

Vocational Graduated no yes Major: _____

College Graduated no yes Major: _____

Graduate School Graduated no yes Major: _____

Did you experience any of the following problems in school?

Learning Emotional Discipline Social

If yes, explain: _____

Do you currently experience any of the following learning barriers?

Learning disability Vision impairment Hearing impairment Language

If yes, explain: _____

I learn best through: (check all that apply) Discussion Written materials Videos Tapes

What is your primary language? English Spanish Sign Other

Employment History: (complete those that apply)

List job history beginning with most recent job

Employer	Dates	Job Title	Reason for Leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Status: Full-time Part-time Disabled Laid off Retired

Student Homemaker Other _____

Current Stressors due to work environment:

Attendance problems Performance problems Work load Medical leave

Employer concerns Potential for lay off Dislike job

Relationship problems with coworkers Other _____

Financial Status:

(circle one) Stable Unstable Comments _____

Military History:

Military experience __no __yes If yes, specify branch and dates of service.

_____	_____	_____
Branch	Date enlisted	Date Discharged

Leisure/Recreational:

Hobbies/Interests	Recent change in frequency?		
_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency
_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency
_____	<input type="checkbox"/> No change	<input type="checkbox"/> Decreased frequency	<input type="checkbox"/> Increased frequency

Signature: _____

Date: _____

THANK YOU!

DuPage Medical Group

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Name: _____

MR#: _____
(office use only)

Pre-Treatment Medication Checklist

Please indicate all the medications you have ever been prescribed, include comments on effectiveness and reasons for discontinuing the medication.

ANTIDEPRESSANTS

- Anafranil (Clomipramine) _____
- Celexa (Citalopram) _____
- Cymbalta (Duloxetine) _____
- Desyrel (Trazodone) _____
- Effexor, (Venlafaxine) _____
- Elavil (Amitriptyline) _____
- ENSAM Transdermal Patch (Selegiline) _____
- Lexapro (Escitalopram) _____
- Luvox, (Fluvoxamine) _____
- Nardil (Phenelzine) _____
- Norpramin (Desipramine) _____
- Pamelor (Nortriptyline) _____
- Parnate (Tranylcypromine) _____
- Paxil, (Paroxetine) _____
- Pristiq (Desvenlafaxine) _____
- Prozac; Sarafem (Fluoxetine) _____
- Remeron, (Mirtazapine) _____
- Serzone (Nefazodone) _____
- Sinequan (Doxepin) _____
- Surmontil (Trimipramine) _____
- Tofranil (Imipramine) _____
- Vivactil (Protriptyline) _____
- Wellbutrin, (Bupropion)/Zyban _____
- Zoloft (Sertraline) _____

ANTI-ANXIETY and INSOMNIA MEDICATIONS

- Ambien, (Zolpidem) _____
- Ativan (Lorazepam) _____
- Benadryl (Diphenhydramine) _____
- BuSpar (Buspirone) _____
- Dalmane (Flurazepam) _____
- Halcion (Triazolam) _____
- Klonopin (Clonazepam) _____
- Librium (Chlordiazepoxide) _____
- Lunesta (Eszopiclone) _____
- Noctec (Chloral hydrate) _____
- ProSom (Estazolam) _____
- Restoril (Temazepam) _____
- Rozerem (Ramelteon) _____
- Serax (Oxazepam) _____
- Sonata (Zaleplon) _____
- Tranxene (Clorazepate) _____
- Unisom (Doxylamine) _____
- Valium (Diazepam) _____
- Vistaril, Atarax (Hydroxyzine) _____
- Xanax (Alprazolam) _____

OTHER MEDICATIONS NOT LISTED ABOVE

STIMULANT MEDICATIONS

- Adderall _____
- Concerta, Daytrana TD Patch, Metadate, Ritalin (Methylphenidate) _____
- Dexedrine (Dextroamphetamine) _____
- Focalin (Dexmethylphenidate) _____
- Provigil _____
- Strattera (Atomoxetine) _____
- Tenex (Guanfacine) _____
- Vyvanse (Lisdexamfetamine) _____

MEDICATIONS FOR SIDE EFFECTS

- Artane (Trihexyphenidyl) _____
- Benadryl (Diphenhydramine) _____
- Cogentin (Benztropine) _____
- Inderal (Propranolol) _____
- Parlodel (Bromocriptine) _____

MOOD STABILIZERS

- Carbatrol, Equetro, Tegretol (Carbamazepine) _____
- Depakote, (Divalproic Acid) _____
- Eskalith, Lithobid (Lithium) _____
- Lamictal (Lamotrigine) _____
- Topamax (Topiramate) _____
- Trileptal (Oxcarbazepine) _____

ANTIPSYCHOTICS

- Abilify, (Aripiprazole) _____
- Clozaril, Fazaclo (Clozapine) _____
- Geodon, (Ziprasidone) _____
- Haldol (Haloperidol) _____
- Invega (Paliperidone) _____
- Loxitane (Loxapine) _____
- Mellaril (Thioridazine) _____
- Moban (Molindone) _____
- Navane (Thiothixene) _____
- Prolixin (Fluphenazine) _____
- Risperdal, (Risperidone) _____
- Serentil (Mesoridazine) _____
- Seroquel, (Quetiapine) _____
- Stelazine (Trifluoperazine) _____
- Thorazine (Chlorpromazine) _____
- Trilafon (Perphenazine) _____
- Zyprexa, (Olanzapine) _____

MEMORY

- Aricept (Donepezil) _____
- Exelon (Rivastigmine) _____
- Namenda (Memantine) _____
- Reminyl (Galantamine) _____