(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

Department of Psychiatry – Patient Demographic Information

Patient's Social Security #: _____ Patient's Date of Birth: _____

Patient's Full Legal Name: _____
first Middle Last Maiden

Permanent Address: _____
Street Apt #

_____
City State Zip Code Country

Home Phone: ( ) _____ Work Phone: ( ) _____ Message: ( ) _____

E-mail: _____ Cell Phone: ( ) _____ Other: ( ) _____

Please check the box next to acceptable methods of communication from this office:
☐ letter ☐ home phone ☐ work phone ☐ e-mail ☐ page ☐ cell phone ☐ other

Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-binary ☐ Other_____

Preferred Name: _____ Identified Pronouns: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership/Civil Union ☐ Involved with multiple partners
☐ Separated from spouse/partner ☐ Divorced/permanently separated from spouse/partner
☐ Widowed ☐ Other _____

Race/Ethnic Origin: _____ Religious Preference: _____

EMPLOYMENT INFORMATION:

Occupation: _____

Patient's Employer: _____ Date of Hire: _____

Employer Address: _____
Street City State Zip

Employer Phone: _____

Employment Status: ☐ full-time ☐ part-time ☐ disabled ☐ student ☐ self-employed ☐ retired, date: _____ ☐ unemployed

INSURANCE POLICY HOLDER: (if patient is not insured, please list guarantor information)

Name of Policy Holder: _____ Relationship to Patient: _____

Phone: ( ) _____ Address: _____

Social Security #: _____ Date of Birth: _____ Occupation: _____

Employer: _____ Phone: ( ) _____

Insurance Name: _____ Member/Subscriber ID: _____ Group Number: _____

Address: _____
Street City State zip

IN CASE OF EMERGENCY, we should notify: _____

Relationship to Patient: _____

Mobile Phone: ( ) _____ Work Phone: ( ) _____

_____ _____ _____
Signature Date Time

(Place MR Label Here)
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Patient's Date of Birth:

UAMS. | Psychiatric Research Institute

Admission/Consent Agreement

Patient Status: ☐ **Inpatient** ☐ **Outpatient**

1. **Consent for Medical Treatment:** I now voluntarily consent to inpatient and/or outpatient care and treatment by physician and all other health care providers at UAMS Medical Center Psychiatric Research Institute (PRI). UAMS is a teaching facility where medical students, residents and others in a training program will be involved in my care and treatment under the supervision of a qualified professional. I also consent to routine hospital services, diagnostic procedures, medical treatment, and other services and care as deemed necessary by the health care providers treating me. Except in emergency situations, it is the provider's responsibility to adequately inform me or my representative concerning proposed treatment and to obtain my or my representative's consent. I understand that the price of medicine is not an exact science and there is no guarantee that any particular treatment will be successful. I understand that I have the right to consent or refuse to consent to any proposed treatment and to discuss it with my health care provider. I understand and give authorization for my physician to access information from an online pharmacy data base about medications that I may be taking for the purpose of continued treatment.
2. **Inpatient Nursing Care:** UAMS PRI provides general duty nursing care unless additional care is required in special care units.
3. **Personal Information:** I certify that the information I have provided is true and accurate to the best of my knowledge. I understand this information is subject to verification with credit agencies, federal and/or state agencies and others as required. I authorize my employer to release to UAMS proof of my income. I consent to provide my cell phone number to UAMS, their designated collection agency, or attorney for them to contact me directly, by an automated dialing system or through a prerecorded messaging system to discuss payment of any unpaid financial obligation I have at UAMS PRI.
4. **Valuables:** I understand that UAMS PRI is not responsible for any valuables that I keep in my possession while in the hospital. I understand that valuables should be sent home with family / friends and those that cannot be sent home may be stored in the hospital safe.
5. **Assignment of Benefits:** In consideration of services rendered, I hereby assign any benefits due under my insurance coverage, benefits or inpatient/outpatient services to UAMS Medical Center/PRI and/or to physician services for my treating physicians. I understand I am financially responsible for all charges not covered including deductibles, co-pays, and co-insurance. After reasonable notice, accounts not paid may be turned over to a collection agency and/or attorney. Attorney fees, the cost of collection and court costs will be the patient's responsibility.
6. **Financial Disclosure:** I understand that my doctor and others that care for me at UAMS may have financial relationships (make money) with other companies. I understand that UAMS may have financial relationships with other companies in the health and medical field. If I want more information about this, I can ask my health care provider or call the UAMS Conflict of Interest office at (501) 686-6447.
7. **Text Messages:** By providing UAMS with my cell phone number and the cell phone numbers of any family and friends, I agree that UAMS can send text messages that may contain my health information. Text messages may include, but are not limited to, reminders of upcoming appointments, prescription refill reminders, my status during a surgery or Emergency Department visit, such as a text message that informs my family, friends and/or others who I choose that I am out of surgery and in a recovery room, treatment plans, and text messages for other similar purposes. UAMS does not guarantee information sent via a text message to a cell phone is secure and encrypted. There are security risks associated with texting information in an unsecure and unencrypted manner, including, but not limited to, an unauthorized person or entity accessing or using the information. I acknowledge and agree I have been warned of and accept such risks.

(Place MR Label Here)
MR#:
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UAMS | Psychiatric Research Institute

8. **Release of Information:** I understand my information will be released in accordance with UAMS Notice of Privacy Practice.
9. **Discharge:** I agree to prompt discharge following my physician's order for discharge. If I leave against medical advice (AMA) or elope, I release the physician, or other health care providers, UAMS Medical Center/PRI and FGP, its employees, agents and assigns from any and all responsibility from any ill effects, sickness, disability, infirmity, damages, death and claims that may result.
10. **Tobacco Use:** UAMS is a TOBACCO FREE CAMPUS. I understand that I may no use any tobacco product on campus.
11. **Living Will:** In accordance with Arkansas Right of the Terminally Ill or Permanently Unconscious Act (Ark. Code Ann. Section 10-17-201 through 218, Supp. 1989). I acknowledge receipt of information regarding the living will and health care power of attorney.
12. **I understand that all patient rooms, hallways, and other areas of PRI are monitored by video recordings for security and safety reasons.**

I, or my legal representative, have read and agree to the above.

_____ _____ _____
Patient or Legal Representative Signature | Date | Time

_____ _____
Relationship of Legal Representative | Person Providing Verbal Consent

_____ _____ _____
Witness Signature | Date | Time

Inpatients only:
Please initial: ____ I have received a copy of the UAM Admission Packet which includes a copy of the Advanced Directives and a copy of the Patient's Rights and Responsibilities.

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS
PSYCHIATRIC RESEARCH INSTITUTE
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Acknowledgment of Receipt of Privacy Notice

By signing this form, you are only agreeing that you have received a copy of the UAMS PRI Notice of Privacy Practices.

_____ _____ _____
Patient Signature Date Time

_____ _____
Print Legal Representative's Name (if applicable) Legal Representative Signature

If Legal Representative, authority of Legal Representative _____
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

********** STAFF USE ONLY **********

We provided the Notice of Privacy Practices and attempted to obtain written acknowledgment but acknowledgment could not be obtained because:

[ ] Patient or Legal Representative declined to sign the Acknowledgment of Receipt.

[ ] Other (please specify) _____

_____

_____ _____ _____
Printed Name of Employee Completing Form Date Time

_____ _____
Signature of Employee Completing Form UAMS Location

(Place MR Label Here)
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Patient's Date of Birth:

UAMS
Medical Center

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a home health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing.**" This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS
Medical Center

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services (HHS), in coordination with the Department of the Treasury, Department of Labor and the Office of Personnel Management. The federal phone number for information and complaints is: 1-800-985-3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

Patient Signature	Date	Time

Trauma-Focused Screeners

These are some questionnaires that help Walker Family Clinic better identify some services you may benefit from her in the clinic.

Please add your name and date of birth to this packet.

Please complete the first screener prior to your appointment, and only complete the other questionnaires if you answer "Yes" to 3 out 5 questions on the PTSD-5.

If you are able to complete all three questionnaires, your clinician will review these with you in session. Please let them know if you have any questions or concerns.

If you are unable to fill out all three questionnaires before your session, please remain in the waiting room afterwards and complete. When done, please give to the front desk attendant.

Thank you for taking the time to fill these out.

ID # _____

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you...

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

   YES NO

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

   YES NO

3. been constantly on guard, watchful, or easily startled?

   YES NO

4. felt numb or detached from people, activities, or your surroundings?

   YES NO

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

   YES NO

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem and then select one of the options to indicate how much you have been bothered by that problem in the past week. The options include not at all, a little bit, moderately, quite a bit, and extremely.

In the past week, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

(Place MR Label Here)
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UAMS Medical Center

Department of Psychiatry and Behavioral Sciences
Patient Questionnaire

Please bring this completed questionnaire to your first appointment.

Preferred Name: _____ Date: _____

What problem(s) are you seeking help for? _____

_____

What are you expectations for your care in this clinic? _____

_____

PRESENT STATE OF HEALTH

If you have been experiencing any of the following symptoms, please check or circle and describe:

Physical Pain: ☐ No Problems

☐ Yes, rate the level of pain on the following scale:

Low Moderate High

1 2 3 4 5 6 7 8 9 10

Eyes ☐ No Problems

☐ wear corrective lenses ☐ visual changes ☐ glaucoma ☐ other: _____

Ears, Nose, Mouth & Throat ☐ No Problems

☐ nose bleeds ☐ white patches in mouth ☐ hoarseness ☐ hearing difficulty ☐ sore throat

☐ other concerns: _____

Heart & Circulation (cardiovascular system): ☐ No Problems

☐ palpitations or fluttering sensation of heart ☐ chest pain ☐ tightness in chest with exertion

☐ other concerns: _____

Lungs & Breathing (respiratory system): ☐ No Problems

☐ coughing up phlegm or excretions ☐ shortness of breath ☐ asthma ☐ emphysema

☐ other concerns: _____

Stomach & Intestines (gastrointestinal system): ☐ No Problems

☐ stomach pain ☐ changes in diameter of stools (bowel movement)

☐ feel full quickly after eating small amounts of food ☐ abdominal pain

☐ diarrhea ☐ constipation ☐ dark tarry appearing stools or blood in stools

☐ changes in weight or appetite Other concerns: _____

Female / Male Reproductive & Urinary Systems (genitourinary system): ☐ No Problems

☐ Last menstrual period: ☐ No menstrual periods (never had / hysterectomy / menopause)

☐ infections (yeast / chlamydia / syphilis / HIV / genital warts / gonorrhea / other: _____)

☐ sexual symptom(s) (premature ejaculation / poor erections / no orgasm / pain with intercourse)

☐ difficulty with fertility ☐ loss of pregnancy / infant ☐ bladder infections ☐ kidney stones

☐ currently attempting to conceive ☐ birth control practices (the pill / condoms / diaphragm / other)

☐ change in desire for sexual activity ☐ blood in urine ☐ burning or difficulty urinating

☐ testicular lump ☐ other concerns : _____

Muscles & Bones (musculoskeletal system): ☐ No Problems

☐ muscle weakness ☐ arthritis or joint pain ☐ other concerns: _____

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Department of Psychiatry and Behavioral Sciences
Patient Questionnaire

Skin (Integumentary): ☐ No Problems

☐ rash ☐ breast lumps / discharge ☐ skin changes / growths ☐ chew or pick fingernails

☐ pull our hair ☐ other concerns: _____

Nervous System (neurologic system): ☐ No Problems

☐ numbness /tingling ☐ seizures ☐ poor coordination ☐ weakness or decreased energy

☐ head injury history ☐ tremor or muscle twitches ☐ sleep problems

☐ learning, reading, memory problems ☐ other concerns: _____

Endocrine / metabolic: ☐ No Problems

☐ cold / heat intolerance ☐ vitamin deficiency (B12) ☐ parathyroid problem ☐ thyroid problem

☐ pancreatitis ☐ diabetes ☐ Addison's disease ☐ kidney disease ☐ liver disease

☐ other concerns: _____

Hematologic / Lymphatic (blood flow system): ☐ No Problems

☐ anemia ☐ enlarged lymph nodes ☐ fever ☐ other concerns; _____

Allergic / Immunologic: ☐ No Problems

☐ NO KNOWN DRUG ALLERGIES ☐ medication allergies : _____

☐ allergies to foods, insects, environmental: _____

☐ autoimmune diseases ☐ other concerns: _____

PAST MEDICAL HISTORY:

Date of last physical exam: _____ Physician's Name: _____

1. List all past hospitalizations, emergency room visits, outpatient surgeries (include reason and date):

   _____

   _____

   _____

2. List all current medical problems: _____

   _____

   _____

3. Family Medical History: List any mental and medical illnesses (i.e. history of bipolar/schizophrenia, substance abuse, suicide attempt or completion) among your biological relatives (parents, siblings, grandparents, aunts, uncles):

   _____

   _____

   _____

4. Abuse History: Have you ever been abused (emotional, physical, sexual), a victim of a crime or experienced trauma? ☐ no ☐ yes, _____

   Risk of Exploitation? ☐ no ☐ yes, _____

5. Do you have a Psychiatric Advanced Directive? ☐ no ☐ yes, _____

(Place MR Label Here)
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UAMS Medical Center

Department of Psychiatry and Behavioral Sciences
Patient Questionnaire

MENTAL HEALTH HISTORY

List all previous mental health and substance abuse treatments (include reason and date):

Circle any types of medications that you have or are currently taking: ☐ never taken medication

Antidepressants: Prozac / Zoloft / Celexa / Paxil / Luvox / Elavil / Wellbutrin / Effexor / Serzone / Tofranil / Anaframil / Pamelor / Sinequan / Nardil / Remeron / Other: _____

Nerve pills: Xanax / Valium / Klonopin / Buspar / Ativan / Other: _____

Sleeping pills: Ambien / Restoril / Daimane / Other: _____

Mood stabilizers: Tegretol / Lithium / Lamictal / Depakote / Neurontin / Other: _____

Antipsychotics: Risperdal / Haldol / Proixin / Stelazine / Clozaril / Geodon / Seroquel / Zyprexa Other: _____

Other: Vistaril / Benadryl / Cogentin / Artane / Ritalin / Adderall / other: _____

HABITS:

Do you currently smoke cigarettes? ☐ no ☐ yes, packs per day: _____ Years smoked: _____

Do you use other tobacco products? ☐ no ☐ yes

If you drink alcohol at least once a month, please estimate how much: _____

Have you ever used or currently use recreational drugs? ☐ no ☐ yes, please circle types:

Marijuana / Cocaine / Methamphetamine / Hallucinogenics / Other: _____

_____

Recreational / Social Activities (please list): _____

_____

Sexuality:

Do you have any sexual concerns you wish to discuss? ☐ no ☐ yes, _____

Spirituality:

Do you have any spiritual concerns you wish to discuss? ☐ no ☐ yes, _____

(Place MR Label Here)
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UAMS Medical Center

Department of Psychiatry and Behavioral Sciences
Patient Questionnaire

Nutrition Screening

Please indicate all that apply – refer to dietitian or Primary Care Provider if YES to any of the following and patient is not being currently followed for the problem(s).

		Staff Use Only. For "yes" answers, please check as appropriate.			
	Please Circle	Addressed	Refer	Not Addressed	See intake
Have you had an unintentional weight loss of over 10lbs in the last month?	Yes / No				
Have you had an unintentional weight gain of over 10 lbs in the last 10 months?	Yes / No				
Do you have difficulty chewing / swallowing?	Yes / No				
Do you suffer from chronic nausea / vomiting / constipation / diarrhea?	Yes / No				
Are you pregnant or nursing?	Yes / No				
Do you have a history of an eating disorder?	Yes / No				
Are you currently being followed for any of the nutrition problems noted above?	Yes / No				
Do you have dental problems?	Yes / No				

Patient Signature: _____ Date: _____ Time: _____

Staff Member Signature: _____ Date: _____ Time: _____

Staff Member Printed Name: _____

(Place MR Label Here)
MR#:
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Patient's Date of Birth:

UAMS
Medical Center

UAMS Department of Psychiatry Medication Tracking Sheet *

Print Name: _____

Please help us care for you better by listing ALL prescription and over-the-counter medications you take.

Note any Medication Allergies: _____

_____

Prescriptions:			
Name of Medicine	**Dosage**	**How many times/day?**	**MD who prescribed?**

☐ check here if your medication list is continued on the back of this page

Please list over-the-counter medications, including herbal remedies and vitamins:			
Name of medicine		**How often do you take it?**	

_____ _____ _____

Signature Date Time

**You may be asked to complete this: upon program entry, upon transfer to another program and/or discharge.*