WellSpan Philhaven

Appointment Details

Appointment Date & Time:

Provider Name:

Welcome to WellSpan Philhaven Outpatient Services! Thank you for choosing us as your behavioral healthcare provider. We view our relationship with you as a partnership in your healthcare needs. We have prepared the following guidelines in an effort to ensure that we provide services to you in a highly efficient manner. Our physicians, therapists, and staff look forward to assisting you with your healthcare needs.

- Should an emergency occur when the office is closed, please contact Crisis Intervention at 1-800-673-2496.
- To avoid additional financial responsibility, please contact your insurance provider prior to your initial visit or if you change insurance companies during your treatment.
- For prescription refills please contact your pharmacy and allow 72 hours.
- Billing services are provided by WellSpan Physician Billing Services. If you have any questions regarding your bill, please call (717) 851-6816.
- Please bring in all insurance cards and photo identification at every visit.
- Employee Assistance Program (EAP) benefits may be available through your employer. The requested insurance information in this letter may not apply unless you continue beyond your EAP sessions.
- In the event of inclement weather, visit www.wellspan.org/weather to inquire if the office is delayed, closed or closing early. You may also contact the office prior to your appointment.
- WellSpan Philhaven is a fragrance-free facility; please do not wear any cologne or perfume to your appointments.

For Patients 18 years of age or older - Please review and complete the attached forms with the patient's information.

- ☐ Notice of Privacy Practices
- ☐ Consent for Treatment
- ☐ Medical Self-Report
- ☐ Personal History Form

For Patients 17 years of age and younger - Please review and complete the attached forms with the patient's information.

- ☐ Notice of Privacy Practices
- ☐ Consent for Treatment
- ☐ Medical Self-Report
- ☐ Personal History Form
- ☐ Developmental History
- ☐ Tips for Parents for a Successful Appointment
- ☐ Custody Acknowledgment From * bring current custody order/agreement
- ☐ Child/Adolescent Behavior Scale - To be completed by parent/guardian
- ☐ Vanderbilt ADHD Teacher Rating Scale - To be completed by teacher

Completion of these forms is necessary because of treatment needs, laws and governmental regulations.

Again, we look forward to assisting you with your healthcare needs. If you have any questions or concerns, please feel free to contact the office where your appointment is scheduled.

OFFICE	ADDRESS	PHONE #	FAX #
Meadowlands	3550 Concord Road, York, PA 17402	(717) 851-6340	(717) 851-3372
Edgar Square	1101 Edgar Street, Suite A, York, PA 17403	(717) 851-1500	(717) 851-1515
Gettysburg	40 V-Twin Drive Suite 202, Gettysburg, PA 17325	(717) 339-2710	(717) 339-2711
Stonebridge	781 Far Hills Drive Suite 600, New Freedom, PA 17349	(717) 812-2560	(717) 812-2569
South George Street	1600 South George Street, York, PA 17403	(717) 812-4200	(717) 845-4791

Notice of Privacy Practices

THIS NOTICE, IN COMPLIANCE WITH FEDERAL PRIVACY REGULATIONS, DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IN CASES WHERE STATE LAW IS MORE RESTRICTIVE THAN THE FEDERAL PRIVACY REGULATIONS, WELLSPAN HEALTH WILL COMPLY WITH STATE LAW. PLEASE REVIEW THIS NOTICE CAREFULLY.

WellSpan Health, through its affiliated entities and all of its employees, medical staff and other personnel, is committed to protecting medical information about you. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or hospital operation purposes described in this notice. To obtain a listing of all WellSpan Health entities and their locations, please log onto www.wellspan.org or contact the Public Relations and Marketing Department by phoning (717) 851-2424; or by emailing wsprcomm@wellspan.org

Understand Your Health or Medical Record Information

Each time you are treated at the hospital or by a physician or other healthcare provider, a record of your treatment is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care of treatment. This information is referred to as your health or medical record. Your health record is available to your treatment providers who use the WellSpan electronic health record. These health care providers may only access your health record as permitted by law.

Your Rights Regarding Your Health or Medical Record Information

Although your health record is the private property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, and health care operations, such as to a health care plan when you choose to pay out of pocket in full for health care services associated with a specific visit;
- Inspect and obtain a copy of the protected health information contained within your medical and billing records and in any medical practice record used to make decisions about your care and treatment. Associated fees may apply for processing the copies.
- Request an amendment to your health record if you believe there is an error or discrepancy within the documentation;
- Obtain an accounting of disclosures of your medical records made by WellSpan Health to other individuals or entities
- Request to receive confidential communications involving your protected health information by other reasonable means (such as secure email, faxing, or certified mail) or at alternative locations (other than home address).
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken;
- Obtain a copy of this notice of information practices upon request when receiving treatment.
- Request non-participation in a Health Information Exchange (HIE) (which is further explained below). If you do not want your protected health information to be accessible to authorized health care providers through the Health Information Exchange you may choose not to participate or “opt-out”. If you choose to opt-out and complete a Health Information Exchange Patient Opt-Out Form, health care providers will not be able to access your records through the HIE.

  If you previously submitted a Health Information Exchange Patient Opt-Out Form to opt-out of the HIE and would now like to begin participation again or “opt-in” to the HIE,you may complete a Cancellation of Health Information Exchange Patient Opt-Out Form. This includes any health information (such as test results) that was generated while you were opted-out. By submitting a Cancellation Form, your health information will be accessible to authorized health care providers through the HIE. Upon “opting-back-in”, your information may not be immediately available.

Please contact the WellSpan Privacy Officer at 1-800-320-6023 or email privacy@wellspan.org for additional information regarding any of your health information rights outlined above.

Our Responsibilities

WellSpan Health will:

- maintain the privacy of your protected health information as required by law;
- provide you with a copy of your protected health information when you request it in writing.
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- notify you if we are unable to agree to a requested restriction or requested amendment;
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations;
- notify you if a breach incident occurs during which your protected health information becomes unsecured;
- abide by the terms of this notice;
- reserve the right to change our practices and to make new provisions effective for all health information we maintain. Should our information practices change, notification will be provided on our website www.wellspan.org and at all WellSpan entity locations.

How We May Use and Disclose Medical Information About You

WellSpan Health can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each category we will explain we mean and give some examples. However, not every use or disclosure will be listed.

Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, clinical students, or other healthcare personnel who are involved in your care within WellSpan Health. For example, a doctor treating you for a broken leg may need to know if you have diabetes because it may slow the healing process. In addition, the doctor may need to tell a dietician if you have diabetes so that we can arrange for appropriate meals. Different departments or entities of WellSpan Health may also share medical information about you in order to coordinate the things you need, such as prescriptions, lab work, and x-rays. We also may disclose medical information about you to people outside WellSpan Health who may be involved in your medical care during and / or after your hospital stay, such as family members or others who provided or will provide services that are a part of your care.

Payment: We may use and disclose medical information about you so that the treatment and services you received at WellSpan Health may be billed, and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the hospital so you health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.

Health Care Operations: We may use and disclose medical information about you for WellSpan Health operational reasons. These uses and disclosures are necessary to run WellSpan Health and make sure that all of our patients receive quality care. For example, we may use and disclose medical information to review our treatment and services and to evaluate the performance of our staff in care for you, or to accrediting agencies that evaluate our performance. We may also combine medical information about many WellSpan Health patients to evaluate current services, decide what additional services WellSpan Health should offer, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, clinical students and other WellSpan Health personnel for review and learning purposes.

Business Associates: We may also disclose information to business associates who provide contracted services such as accounting, legal representation, claims processing, accreditation, and consulting. If such disclosures occur, we will do so subject to a contract that provides that the information will be kept confidential. We may also combine the medical information we have with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others can use it to study health care and health care delivery without learning who the specific patients are.

Health-Related Fundraising: Unless you choose otherwise, we may disclose information the departments/entities of WellSpan Health who raise money for WellSpan Health, its Foundations and charitable programs. We would only release contact information, such as your name, address, age, gender, insurance status, and dates you received treatment or services from WellSpan Health. If you do not wish to receive fund raising materials, you may submit your request in writing to Public Relations and Marketing Department at 50 North Duke St., York, PA 17401; by phoning (717) 851-2424; or by emailing wsprcomm@wellspan.org

Hospital Patient Information Services: We may include certain limited information about you in the patient information listing while you are a patient at a WellSpan Health hospital, unless you choose otherwise. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The information listed, except for your religious affiliation, may be released to people and the media who ask for you by name. This will allow your family, friends, and clergy to visit you in the hospital and generally know how you are doing. Your religious affiliation may be given to a member of the clergy even if they don't ask for you by names. You will have the option to not have your information listed. Information on patients who are admitted under behavioral health care is not released.

Individuals Involved in Your Care or Payment for Your Care: We may release information about you to family members, personal representatives, close personal friends, or any other person(s) you identify. This medical information will be relevant to that person's involvement in your care or payment related to your care.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process.

This process evaluates a proposed research project for its use of medical information, trying to balance the research needs with the patients' needs for privacy of their medical information. Before using or disclosing medical information for research, the project will have been approved through this research approval process. Medical information about you may be disclosed to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the WellSpan Health facility. We will generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the hospital.

Health Information Exchange: Generally, an HIE is an organization that regional health care providers participate in to exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that medical errors will occur.

The HIE allows patient health information to be shared among authorized health care providers (such as health systems, hospitals, physician offices and labs) and health information organizations for Treatment, Payment and Operations (TPO) purposes. The HIE is a secure electronic system designed according to nationally recognized standards, and in accordance with federal and state laws that protect the privacy and security of the information being exchanged. Patient health information shall be available to authorized health care providers through the HIE unless the patient declines to participate, or 'opts-out' by completing a Health Information Exchange Patient Opt-Out Form.

As Required by Law: We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone who is handling the situation.

Sale or Merger: If WellSpan Health at any time sells or merges any of its entities with another health system, the new owner may have access or acquire records associated with that entity.

Special Situations under which disclosures may be made without written authorization:

- **Organ and Tissue Donation** – information may be released to organ procurement organizations.
- **Military and Veterans** – information may be released to military command authorities.
- **Workers' Compensation** – information may be released on work-related injuries to employers and state agencies.
- **Public Health Risks** – information may be released to public agencies to prevent or control disease, report births and deaths, abuse or neglect and product problem/ recall issues.

- **Health Oversight Activities** – information may be released to agencies such as the Pennsylvania Department of Health, Joint Commission on Accreditation of Healthcare Organizations, the Pennsylvania Department of Welfare, Office of Attorney General, Office of the Inspector General, and peer review organizations designated by the Medicare program to review medical services provided to Medicare beneficiaries.
- **Lawsuits and Disputes** – information may be released in response to a court or administrative order, subpoena, discovery request or other lawful process.
- **Law Enforcement** – information may be released to law enforcement officials (1) in response to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness, or missing persons; (3) about the victim of a crime, under certain limited circumstances; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct at a WellSpan facility; and (6) in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors** – information may be released to identify a deceased person, determine cause of death, or for burial purposes.
- **National Security and Intelligence Activities** – information may be released to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others** – information may be released to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.
- **Inmates** – information may be released to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Uses and Disclosures for Which an Authorization is Required

Except for the general uses and disclosures and special situations described above, we will not use or disclose your protected health information for any other purposes unless you provide a written authorization. Under federal law the following uses and disclosures require a valid authorization:

- Psychotherapy Notes
  Exception: The provider who wrote the note may use it for treatment; for training programs involving students, trainees or providers and in defense of legal action or other proceeding brought by the individual against WellSpan Health.
- Marketing
  Exception: If the communication is in the form of a face-to-face communication between the individual and WellSpan Health; or a promotional gift of nominal value from WellSpan Health to the individual
- Sale of Protected Health Information (PHI). We will not sell your PHI without your written authorization.

For More Information or to Report a Problem or Concern

If you have questions and would like additional information, you may contact the WellSpan Privacy Officer at 1-800-320-6023 or privacy@wellspan.org

If you believe your privacy rights have been violated, you can file a complaint with the WellSpan Privacy Officer or with the U.S. Department of Health and Human Services, Office of Civil Rights. Contact information for the Office for Civil Rights can be obtained from the WellSpan Privacy Officer at 1-800-320-6023 or privacy@wellspan.org There will be no retaliation for filing a complaint.

Effective Date of Notice – April 14, 2003
Revised: 12/29/02, 12/23/02, 2/24/03, 3/20/03, 3/24/03, 9/23/13

WellSpan Philhaven

If label not available, please fill in below.

NAME: _____

DOB: _____

MRN: _____

CONSENT FOR OUTPATIENT TREATMENT

Name of Client: _____ DOB: _____

I consent to outpatient mental health and/or substance abuse evaluation and services to be provided by WellSpan Philhaven to the above-named client.

I understand the nature and purpose of the services to be provided. I have had the opportunity to ask questions and any questions I may have had have been answered. I understand I can ask questions and receive further explanation at any time. I also understand that I may withdraw my consent at any time.

I understand that relevant diagnostic and treatment information, including but not limited to information regarding mental health care or treatment for drug and alcohol use may be shared for purposes of treatment, payment and/or operational purposes.

FOR ADULTS (<u>over 18</u>):

Client Printed Name: _____

Client Signature: _____ Date: _____ Time: _____

FOR MINORS (<u>at least age 14 but not yet 18 years of age</u>):

Client Printed Name: _____

Client Signature: _____ Date: _____ Time: _____

Parent Printed Name: _____

Parent Signature: _____ Date: _____ Time: _____

FOR MINORS (<u>UNDER 14</u>):

Parent or Legal Guardian Name (Please Print): _____

Relationship to minor: _____ Parent _____ Legal Guardian
_____ Parent with Joint Custody
_____ Other (describe): _____

Printed Name: _____

Signature: _____ Date: _____ Time: _____

WCNP0001

WellSpan® Philhaven

If label not available, please fill in below

NAME: _____

DOB: _____

MRN: _____

MEDICAL SELF REPORT

Date of Birth _____ Date Completing this Form _____

1. Whom shall we notify in case of emergency? _____
   a. What is this person's phone number? _____
   b. How is this person related to you? _____
2. Name of Family Physician: _____ Date of Last Exam _____ / _____ / _____
3. Do you have any medical concerns at the present time? ☐ No ☐ Yes
   If "yes," please describe: _____
   _____
   _____
4. Please list all medications that you are ***currently*** taking, including both physician-prescribed and over-the-counter medications (aspirin, laxatives, vitamins, herbal supplements, diet pills, etc.).
   Clinicians: add addendum if needed.

MEDICATION	DOSAGE & DIRECTIONS	TAKING AS PRESCRIBED?	HOW LONG HAVE YOU TAKEN?	WHO PRESCRIBES?	SIDE-EFFECTS?

5. Please list any prior medications that you have taken: _____
   _____
   _____
6. Are you exposed to any chemicals (acids, alkalis, detergents, toxic sprays, poisons, etc.) at work, home or with hobbies? ☐ No ☐ Yes: _____
7. Are you allergic to any medications or environmental substances (i.e. pollen, molds, etc.)?
   ☐ No ☐ Yes: _____
8. Are you up to date on your immunizations and TB tests? ☐ No ☐ Yes
9. Do you want a referral to a family doctor/primary care physician? ☐ No ☐ Yes
10. Have you had any unexpected weight gain or weight loss within the past 3 months? ☐ No ☐ Yes
    If "yes," please explain: _____
    _____

WPCF0001

WellSpan Philhaven

If label not available, please fill in below

NAME: _____

DOB: _____

MRN: _____

MEDICAL SELF REPORT

11. Do you experience physical pain that interferes with your daily activities? ☐ No ☐ Yes
    If "yes," please explain: _____
    _____

12. Information about recent falls, clumsiness, head injury:
    a. Have you fallen recently? ☐ No ☐ Yes
    b. If yes, are issues about falling being addressed by anyone? ☐ No ☐ PCP ☐ Psychiatrist ☐ Other
    c. If completing this form for a child/adolescent, has there been an increase in falling or clumsiness lately? ☐ No ☐ Yes
    d. If yes, has there been: ☐ a change in medication? ☐ Other explanation: _____
    _____
    Clinicians: If fall risk identified, implement departmental-specific fall precautions
    e. Have you ever had a head injury or lost consciousness? ☐ No ☐ Yes: Explain _____
    _____

13. Do you use caffeine (coffee, tea, cola, iced tea, chocolate) more than four (4) times a day? ☐ No ☐ Yes
14. Do you smoke cigarettes, pipes, cigars, vape or chew tobacco? ☐ No ☐ Yes
15. In the past year have you consumed five (5) or more alcoholic drinks (beer, wine, liquor) on any single occasion? ☐ No ☐ Yes
16. Have you ever used drugs other than those prescribed for you by a healthcare provider? ☐ No ☐ Yes
17. If you answered "yes" to question 13, 14, 15 and/or 16, please complete the following chart regarding your ***current*** and ***past use*** of substances. Include caffeine, tobacco, alcohol and street drugs, as well as any abuse of over-the-counter or prescribed medications:

NAME OF DRUG	FREQUENCY	QUANTITY	LAST USE	DURATION OF USE

18. Are you currently taking or have you taken any of the following in the ***past year***?

☐ pain medication
☐ steroids or cortisone
☐ weight loss pills
☐ heart pills
☐ blood pressure pills
☐ medications for TB
☐ blood thinning pills
☐ insulin
☐ anti-depressants
☐ herbal therapy
☐ vitamins
☐ tranquilizers
☐ antibiotics
☐ hormones
☐ thyroid pills
☐ HIV medication
☐ medication for Hepatitis (Interferon)

WPCF0001

WELLSPAN® Philhaven

If label not available, please fill in below

NAME: _____

DOB: _____

MRN: _____

MEDICAL SELF REPORT

19. **Family Medical History**
To the best of your knowledge, please put a ✓ if you have or anyone in your family has had the following:

	Self	Mother	Father	Brother	Sister	Children	Grand-parent	Other Family	Clinician Comments
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	
Eating Disorder	☐	☐	☐	☐	☐	☐	☐	☐	
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐	
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Problems	☐	☐	☐	☐	☐	☐	☐	☐	
Irritable Bowel	☐	☐	☐	☐	☐	☐	☐	☐	
HIV/AIDS	☐	☐	☐	☐	☐	☐	☐	☐	
Kidney Problems	☐	☐	☐	☐	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐	
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐	

20. In addition to what is listed above, please list any **serious health problems** and/or **hospitalizations** you have had in the past including dates and a brief description: If "yes," please explain: _____

_____

_____

_____

_____

_____ _____ _____

Patient Printed Name | Patient Signature | Date & Time of Signature

FOR OFFICE USE ONLY

_____ _____ _____

Intake Clinician Printed Name | Intake Clinician Signature & Credentials | Date & Time of Signature

WellSpan® Philhaven

If label not available, please fill in below

NAME: _____

DOB: _____

MRN: _____

PERSONAL HISTORY FORM

Why are you seeking treatment at this time? Today's Date_____

_____

_____

_____

Have you had any previous mental health or substance abuse treatment such as Inpatient Psychiatric Hospitalization, Detox, Residential Rehab, Partial Hospitalization, Intensive Outpatient, Outpatient? ☐ No ☐ Yes

If you checked "yes," please complete the following chart:

Where?	When?	For what problem?

Are you currently receiving mental health or substance abuse treatment elsewhere? ☐ No ☐ Yes

If you checked "yes," please list the type of services you receive and where you receive them:

_____

Are any of the following services or agencies currently involved in your life and/or providing you with services?

☐ Children and Youth ☐ Probation/Parole ☐ MHIDD (Mental Health Intellectual & Developmental Disabilities)

☐ York County Drug & Alcohol ☐ Domestic Relations ☐ Social Security

☐ Office of Vocational Rehabilitation ☐ Other agencies/services: _____

What is your current support system? ☐ Family ☐ Friends ☐ Support Group ☐ Religious organization

☐ No support system ☐ Other: _____

What is the attitude of your primary social support person(s) regarding your desire to participate in our services?

☐ Supportive ☐ Willing to be involved ☐ Non-supportive ☐ Opposed to my seeking help ☐ I have no support system

☐ Please describe:_____

What are your strengths (good qualities)? _____

_____

What are your challenges (weaknesses)? _____

_____

Military Status: _____ Branch: _____

Do you have any cultural or religious practices that may impact your treatment? ☐ No ☐ Yes

If "yes," briefly describe_____

Are there any firearms in the home? ☐ No ☐ Yes If "yes," briefly describe what type and how they are stored:

_____

WPCF0001

WELLSPAN® Philhaven

If label not available, please fill in below

NAME: _____

DOB: _____

MRN: _____

PERSONAL HISTORY FORM

HOMICIDE/VIOLENCE SCREEN

Have you had any homicidal or violent thoughts towards others? (within the last 30 Days) ☐ Yes ☐ No

Have you had any violent/assaultive behaviors towards others? (within the last 30 Days) ☐ Yes ☐ No

If yes to any of the above two questions, specify when and explain: _____

_____

_____

Have you ever had a PFA (Protection from Abuse) filed against you ☐ Yes ☐ No

SUICIDAL SCREEN

Have you ever experienced suicidal thoughts? (within the last 72 hours) ☐ Yes ☐ No

If yes, please explain: _____

Have you engaged in any self-harmful acts? (within the last 72 hours) ☐ Yes ☐ No

If yes, please explain: _____

***Emergency services are available 24 hours a day, seven days a week. Individuals in a crisis can call our crisis information hotline toll free at 1-800-673-2496.**

HISTORY OF ABUSE

Are you now or have you ever been threatened or abused by anyone? ☐ No ☐ Yes If yes, please complete below:

	Physical	Sexual	Emotional	Verbal
Survivor of				
Perpetuator of				
Abused by				

Has abuse been reported? ☐ No ☐ Yes If yes: to Whom: _____ When: _____

Have you ever witnessed any of the type of abuse listed above? ☐ No ☐ Yes If yes, please describe: _____

_____

Do you consider your living environment a safe place? ☐ No ☐ Yes If no, please describe: _____

_____

If Patient is under 18 years old, please complete parental information

Parents' Names	Home Phone	Work Phone	May we call you at work?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

VOCATIONAL STATUS

I am presently:

☐ Employed Full-Time ☐ Employed Part-Time ☐ Assigned Temporary Work

☐ Unemployed ☐ Disabled/On Disability ☐ Retired

☐ Student ☐ On Leave-of-Absence ☐ Laid-Off

WPCF0001

WellSpan Philhaven

If label not available, please fill in below

NAME: _____

DOB: _____

MRN: _____

PERSONAL HISTORY FORM

FACTORS AFFECTING LEARNING

What is the highest grade you completed in school? _____

What language(s) do you speak? ☐ English ☐ Spanish ☐ Other: _____

What language(s) do you read? ☐ English ☐ Spanish ☐ Other: _____

Do you need an interpreter? ☐ No ☐ Yes _____

Do you have any physical disabilities? ☐ No ☐ Yes _____

Do you wear/need contacts or glasses? ☐ No ☐ Yes _____

Do you wear/need hearing aides? ☐ No ☐ Yes _____

Do strong feelings make it hard for you to learn? ☐ No ☐ Yes _____

_____

Do you have any learning disabilities? ☐ No ☐ Yes _____

Did you experience any developmental delays? ☐ No ☐ Yes If yes, please specify: _____

_____

OPTIONAL: In order for us to provide culturally-sensitive treatment, please indicate to which race/ethnic group(s) you belong:

☐ African-American/Black ☐ Alaskan Native ☐ American Indian ☐ Asian or Pacific Islander

☐ Caucasian/White ☐ Cuban ☐ Mexican ☐ Puerto Rican

☐ Other Hispanic/Latino ☐ Other: _____

What is the best way for you to learn new things?

☐ Verbal Instruction ☐ Audiovisual (hearing and seeing) ☐ Written Instruction ☐ All Types

PLEASE CHECK ANY OF THE FOLLOWING THAT ARE CURRENTLY PROBLEMS FOR YOU

☐ **Family Problems** (i.e. death of family member, health problems in family, arguments in family, abuse in family, divorce, separation, etc.)

☐ **Social/Friendship Problems** (i.e. death or loss of fiend, lack of social support, isolated from others, discrimination, don't get along well with others, etc.)

☐ **Job or School Problems** (i.e. unemployment, stressful schedule, poor work, school conditions, job satisfaction, don't get along with boss/teachers or co-workers/classmates, etc.)

☐ **Housing Problems** (i.e. homeless, poor housing conditions, unsafe neighborhood, problems with neighbors, problems with landlord, etc.)

☐ **Money Problems** (i.e. cannot pay bills, not enough money for basic necessities like food, shelter, clothing, excessive debt, bankruptcy, etc.)

☐ **Problems with Health Care** (i.e. do not have a doctor, do not have a way to get to appointments, do not have health insurance, cannot obtain needed medication, etc.)

☐ **Legal Problems** (i.e. involved in court, on probation or parole, victim of a crime, pending lawsuit, DUI, etc.)

☐ **Gambling Problems** (i.e. lack of control, being deceptive about the amount spent or frequency of gambling, etc.)

PLEASE CONTINUE ON WITH THE MEDICAL SELF-REPORT ➡

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Intake Clinician Printed Name	Intake Clinician Signature & Credentials	Date	Time

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