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Insurance/Background Information Form

Please fill out this form prior to your initial appointment with me, and bring it with you to your first appointment. Although lengthy, this information is quite important for me to have in order to assess your situation both thoroughly and efficiently, and will serve as a starting point for more formal assessment. *Please fill in all the information requested, to the best of your ability.* Also please make sure to review and sign the Permissions on page two.

Identification Information (please print the information on this page):

Name: _____

Home Address: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____

Place Of Your Employment (Or Of Spouse If You Are Not Employed): _____

Date Of Birth: _____ Age: _____

Your Social Security Number: _____

Your Medical Insurance Company Name And Plan: _____

Your Insurance ID Number: _____

Your Insurance Group Number: _____

The Name of the Employer Through Which This Insurance Is Obtained: _____

Who is the primary insured on this policy (you? a spouse? a parent?):

Myself ___ Someone else (name? relation?) _____

If someone else will be responsible for the bill for services (e.g. a parent), who

is this? Name: _____

Address: _____

Phone: _____

Emergency Contact Person (Name, Phone Number, and Relationship): _____

Who referred you to Dr. Berlin? _____

Permissions:

My signature below indicates agreement with the following:

1) I will make sure I fully understand and am in agreement with any recommended treatment I decide to undertake.

2) I have read and accept the policies described in the attached "Patient Information" brochure.

3) I give permission for Dr. Berlin to communicate with the following health care providers about my ongoing treatment (please fill in the names of any providers that you would like me to coordinate with, including your primary care physician, psychotherapist if seeing, any specialists, or anyone else you'd like me to interact with about your care):

4) I give permission for clinical information about me to be released to my managed care insurance company when necessary to obtain permission to receive further treatment (applies only if you have managed care insurance).

5) I authorize insurance payment to provider by those insurers whom provider is required to bill directly.

6) I understand and agree to the following regarding fees:

I understand that there is a full charge to me, not covered by insurance, for sessions which are missed or canceled with less than 48 hours notice.

I also understand that there is a fee, not covered by insurance, for phoned or mailed prescriptions done at my request between office visits for routine reorders of medication, or for replacement of lost prescriptions. (There is no charge, of course, for prescriptions written during office visits, or for phoned prescriptions in clinically changing situations.)

I understand that all fees due from me are to be paid within 30 days of being billed, and I agree to pay all such fees within 30 days. Balances not paid within 30 days will have a monthly late fee added, unless alternative arrangements have been made due to personal financial issues.

7) [Required Notification] Do you have a "Mental Health Advanced Directive?" (This is a document specifying your wishes regarding certain psychiatric interventions if you become unable to make reasoned decisions for yourself.) If not, and you wish to have such a document, note that Pennsylvania has specific legal guidelines for this. Consult your attorney for further advice. No ____ Yes ____

[Please let Dr. Berlin know if you would have any problem with any of the above.]

Signature: _____ Date: _____

Reason For Seeking Treatment:

What are the problems or reasons for which you are now seeking help? Please note the type of problem, how long this has been going for, specific symptoms (for example of depression or anxiety), and how this is interfering with your life (use other side if more space is needed for this or any other question):

Stressors

Are there any serious stresses currently occurring in your life, or which have occurred in the past year or two? If so, please list and describe:

Past Treatment:

List all prior outpatient mental health evaluations and treatment you have had over the years. Please include the names of previous psychiatrists and therapists, when seen, and how beneficial this was. (Continue on other side if needed.)

List all prior psychiatric hospitalizations (name, when there, duration of hospitalization, reason for admission, and result of treatment there).

Please list all previous psychiatric medications you have ever taken, their names (if you can recall) when you took these, the length of time you took them, and result of each medication:

Depression:

If depression is a significant part of your current problem:

What are the symptoms of depression you are currently experiencing, and how severe are they??

Has depression been a problem for many years? If so, what has been the pattern of it?

Energy level changes?

Any current suicidal feelings, or feelings you might be better off dead?

If yes, how strong are these feelings?

Do you feel you might possibly act on these feelings?

Have you been thinking of ways by which you might suicide? If so, what ways?

Have you ever in the past intentionally harmed yourself or come close to it?
(describe)

Anxiety

Have you had significant problems in the past with anxiety or panic attacks?

Have you had any of these symptoms in the past 3 months?

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Throat tightness | <input type="checkbox"/> Trembling | <input type="checkbox"/> Numbness or Tingling |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Constant tenseness or fear |
| <input type="checkbox"/> Continuous worry | <input type="checkbox"/> Panic attacks | |
| <input type="checkbox"/> Fear of crowded places, malls, driving, bridges, tunnels, flying | | |
| <input type="checkbox"/> Excessive fear of losing control, having a heart attack, cancer,
brain tumor, AIDS, going crazy, dying, etc. | | |
| <input type="checkbox"/> Any other fears which cause panic and lead to avoidance | | |

Anger:

If anger is a significant part of the current problem:

Are you having trouble controlling your anger?

Do you have feelings of wanting to physically hurt someone else?

In the past have you had trouble controlling your anger, resulting in destruction of property or injury to someone?

Sleep

Describe your current sleep patterns:

Do you snore heavily?

Do you have a lot of nightmares, or awaken in a panic?

Does your bed partner notice that in your sleep you seem to have trouble breathing, kick your legs a lot, or strongly thrash about?

Do you sleepwalk or bed wet?

Mania:

Have you ever had a period lasting at least several weeks during which you had boundless energy, little need for sleep, undertook many activities, talked a lot, became more social, made many phone calls, spent a lot, or did other uncharacteristic impulsive things?

OCD

Do you have to do certain things repetitively, such as check things or wash your hands?

Do you have thoughts that you can't get rid of that may not make a lot of sense, that trouble you, or make you anxious?

Eating Concerns:

Have you had any recent major changes in appetite or weight? (describe)

Do you worry a great deal about your weight?

Do you attempt to control your weight by very strict diets, fasting, intense exercise, vomiting after eating, or taking laxatives or diuretics for weight control?

Alcohol and Drug Use:

Alcohol: What is your current pattern of use of alcohol? (What kind of alcohol do you generally drink, in what quantity, how often?)

Do you sometimes end up drinking more than you planned to?

Have you ever felt you should cut down on your drinking?

Have you tried to reduce or stop drinking but failed?

Have friends or relatives worried or complained about your drinking?

Have you continued to drink even though you knew it caused problems?

How many drinks (or glasses of wine, or beers) does it take before you first begin to feel the effects of the alcohol?

Tobacco: Do you currently use tobacco (cigarettes/cigars/pipe/chewing tobacco)?
If so, what form, and how much do you use each day?

Drugs: Have you ever used illegal drugs?
If so, which drugs, how much, at what point in your life?

Alcohol or Drug Treatment: Have you ever had any treatment, or been part of a 12-step program, for a drug or alcohol problem? If so, give details:

Gambling

Do you gamble in any form? If so, what?
Have you had difficulty controlling your gambling?
Do you try to hide the extent of your gambling from family and others?
Has your gambling caused financial problems?

Family Information:

For each family member please give age (or when deceased) and some information about this individual's personality, and your relationship with each other:

Father:

Mother:

Brothers and Sisters: (continue on other side if needed)

Spouse or current significant other:

Children:

Background Information:

Where did you grow up? (cities lived in, ages when moved)

What was it like in your family's household when you were growing up?

Describe what you were like as a child:

What was grade school like for you?

What were your relationships with peers like as a child?

Were you or anyone else in your family subjected to abuse (emotional, verbal, physical, or sexual) when you were a child?

What were your teen years like?

What did you do after high school?

How far did you go in school? (If college, where attended and degrees earned)

What jobs have you had over the years? What is your current job?

Have you ever served in the military? If so, when, what branch, where served, discharge status:

What is your religion (if any)? How serious a part of your life is this?

Have you ever been arrested? If so, for what, and what was outcome?

How would you describe your present personality (including strengths and weaknesses)?

What are your current major sources of pleasure?

Have you had any close personal losses?

Have you had any serious traumas (not noted elsewhere on this form)?

Relationship History:

Please briefly describe the significant romantic relationships you've had over the years (continue on other side if necessary):

Medical History:

Please list any significant physical problems you have been treated for over the years:

List any hospitalizations you have ever had for physical problems (when, where, for what):

Who is your current family physician, as well as any specialists you see?

What is your height? _____ Current weight? ____

When was your last thorough physical exam?

When was the last time you had any blood tests done?

When was the last time you had an EKG (electrocardiogram) done?

Please list the names of any medications you are allergic to:

Please list *all* medications you are currently taking, including psychiatric medications, medication for physical problems, and any over the counter medications. Give name, dose, and how often taken. Also please list any vitamins, herbal preparations, 'nutritional supplements,' etc. that you take:

Sexual Functioning

Are you satisfied with your sexual functioning?

Are you concerned about having a level of sexual interest which is too low or too high?

Men: Any difficulty with achieving or maintaining erections, or with ejaculation?

Women: Any difficulty with arousal or achieving orgasm, or pain with sex?

Any concerns about sexual feelings which seem abnormal to you?

What form of birth control do you use (if applicable)?

Family Psychiatric/Medical History:

Please list any family member, close or distant, who is a *blood relative*, who has received any psychiatric treatment in the past. What sort of psychiatric problem did they have, if you know?

Has any blood relative ever had a problem with alcohol or drug abuse? If so, who, and what specific sort of problem?

Does any blood relative have any possibly hereditary medical illness of which you are aware?

Other Important Information?

What other information which has not been asked about above would it be helpful and important for me to know about you?