VOGELFANGER AND STRUBLE CLINIC
NEW PATIENT INFORMATION
(Please print.)

Patient name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone #: _____ Sex: ◯ **Male** ◯ **Female** Marital status: **S M W D Sep**

Date of birth: _____ Age: _____ Social Security #: _____

Patient's employer/school: _____ Work/school phone #: _____

Name of guardian (if applicable): _____

ALLERGIES: _____

Insured's name: _____ Insured's Social Security #: _____

Insured's address: _____ Insured's date of birth: _____

Insured's employer: _____ Insured's phone #: _____

Insured's employer's address _____ Insured's occupation: _____

Patient's relationship to insured party: **Self** **Spouse** **Child** **Other:** _____

Emergency contact person's name: _____ Phone #: _____

Here due to related injury or illness?: ◯ **Yes** ◯ **No** Date of accident or occurrence: _____

Primary insurance co.: _____	**Secondary insurance co.:** _____
Name of insured: _____	Name of insured: _____
Mailing address: _____	Mailing address: _____
_____	_____
Insurance co. phone #: _____	Insurance co. phone #: _____
Insured's ID #: _____	Insured's ID #: _____
Policy group #: _____	Policy group #: _____
Primary pharmacy name and #: _____	**Secondary** pharmacy name and #: _____
_____	_____

CONSENT TO TREATMENT

I do hereby seek and consent to assessment, examination, AND treatment by Vogelfanger and Struble Clinic and/or any of its associates. I understand that developing a treatment plan and regularly reviewing my progress toward meeting my treatment goals is in my best interest. I agree to participate actively in this process.

ASSIGNMENT OF BENEFITS

I authorize payment directly to Vogelfanger and Struble Clinic PLLC of any benefits payable under my insurance policy for the indicated services.

Patient/guardian signature: _____ Date: _____

VOGELFANGER AND STRUBLE CLINIC
Patient Rights and Responsibilities Statement

Patient Rights	Patient Responsibilities
• Patients have the right to be treated with dignity and respect. • Patients have the right to fair treatment regardless of race, religion, gender, sexual orientation, ethnicity, age, disability, or source of payment. • Patients have the right to have their treatment and other patient information kept private. Only when required by law will information and records be released without patient permission. • Patients have the right to access care in a timely fashion. Patients have the right to know about treatment options. This is regardless of cost or coverage by patient's benefit plan. • Patients have the right to participate in developing a plan of care. • Patients have the right to get information in a language the patient can understand. • Patients have a right to receive a clear explanation of their progress, condition, and treatment options. • Patients have the right to get information about their insurance plan, practitioners available, services available, and the insurance company's role in the treatment process. • Patients have the right to information about clinical guidelines used in providing and managing patient care. • Patients have the right to ask the provider about provider's work history and training. • Patients have the right to give input on the patient rights and responsibilities policy. • Patients have the right to know about advocacy, community, and prevention services. • Patients have the right to freely file a complaint or appeal to their insurance company and to learn how to do so. • Patient have the right to know their rights and responsibilities in the treatment process. • Patients have the right to receive services that will not jeopardize employment. • Patients have the right to identify certain preferences in selecting a provider.	• Patients have the responsibility to treat those giving them care with dignity and respect. • Patients have the responsibility to give the providers the information they need. This is so providers can deliver the best possible care. • Patients have the responsibility to ask questions about their care. This is to help them understand their care. • Patients have the responsibility to follow the treatment plan. The plan of care is to be developed and agreed upon by the patient and provider. • Patients have the responsibility to follow the agreed upon therapy and medication plan. • Patients have the responsibility to tell their provider and primary care physician about medication changes, including medication given to them by others. • Patients have the responsibility to keep their appointments. Patients should call their provider as soon as they know they need to cancel appointments. • Patients have the responsibility to let their provider know when the treatment plan is not working for them. • Patients have the responsibility to let their provider know about problems paying fees. • Patients have the responsibility to report abuse and fraud. • Patients have the responsibility to openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, that I understand this information, and that I have received a copy if requested.

Patient/guardian signature: _____ **Date:** _____

VOGELFANGER AND STRUBLE CLINIC
Intake Information

NOTICE OF PRIVACY PRACTICES

◯ I have received a copy of this office's notice of privacy practices.

HELPFUL RESOURCES

◯ I have received a list of helpful resources.

MENTAL HEALTH ADVANCED DIRECTIVE

◯ I currently have a mental health directive.

If you check here, please provide us with a copy.

◯ I do not have a mental health advanced directive.

If you check here, you may request and develop one at any time.

Signature of Patient/Guardian _____ Date _____

Signature of Staff _____ Date _____

VOGELFANGER AND STRUBLE CLINIC

AUTHORIZATION TO DISCLOSE INFORMATION TO PRIMARY CARE PHYSICIAN

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _____, hereby authorize **VOGELFANGER and STRUBLE CLINIC, PLLC**

(Please check one.)

◯ To release any applicable information to my Primary Care Physician

◯ To release medication information only to my Primary Care Physician

◯ Not to release any information to my Primary Care Physician

Primary Care Physician: _____

Address: _____

Phone Number: _____

◯ I do not have a Primary Care Physician (PCP)

_____ _____

Patient/Guardian Signature **Date**

_____

Please print name of patient.

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

http://www.med.navy.mil/sites/NMCP2/PatientServices/SleepClinicLab/Documents/Beck_Depression_Inventory.pdf

VOGELFANGER AND STRUBLE CLINIC PATIENT INTAKE QUESTIONAIRE

Patient Name:	DOB:	Age:

1. What is the chief complaint? Why is patient here?_____

2. History of psychiatric treatment. Please list previous psychiatric history, outpatient and inpatient. Include dates and whether treatment was helpful.

3. List all current and previous psychiatric medicines and tell if they were helpful.

4. Medical history. Issues with pain. Allergies. All current medications for medical problems.

5. Family and patient history of psychiatric issues or alcohol/drug abuse.

VOGELFANGER AND STRUBLE CLINIC PATIENT INTAKE QUESTIONAIRE

6. Was patient's birth planned? ☐Yes ☐No Were there any complications with pregnancy or labor? ☐Yes ☐No Identify:_____
   At what age did patient walk and talk? _____

7. If any identify: physical abuse_____, emotional abuse _____Sexual abuse_____, trauma_____, recent deaths or losses_____ _____, DCS involvement with family_____, disability_____.

8. Employer: _____
   Work problems: _____

9. School Name:_____ Current grade or highest grade completed:_____
   Problems at school:_____

10. Who lives in patient's home? _____
    Problems at home: _____

11. Hobbies or community/leisure activities: _____
    Problems in the community: _____

12. Religious and cultural affiliations: _____

13. Legal issues: _____

14. Financial issues: _____

Does patient have problems making or keeping friends?	Yes No
Any problems with memory?	Yes No
Nervous or upset often?	Yes No
Sleep problems?	Yes No
Depressed or "blue" for days in a row?	Yes No
Suicidal thoughts or plans considered as a solution for problems?	Yes No
Smoke or use tobacco? Frequency and rate:	Yes No
Issues regarding sexuality, sexual behavior, pregnancy, menstrual cycle?	Yes No

VOGELFANGER AND STRUBLE CLINIC

Initial Treatment Plan

(to be completed and signed at first appointment)

Patient Name:	DOB:	Age:

1. Problems identified by the patient and provider will be addressed at first appointment and following appointments. The goal is 80% reduction in symptoms. Duration of treatment to be determined by progress.	Problems identified with symptoms:
2. Frequency of appointments:	Every __ week; every ___ months
3. Modalities	◯ Assessment for medication needs and medication management ◯ Individual and/or family therapy to focus on managing symptoms
4. Referrals	◯ Appointment for psychiatric assessment ◯ Appointment for individual/family therapy ◯ Recommendation for more intense level of care
5. Informed consent to be obtained for every classification of medications prescribed.	◯ Informed consent signed by provider and patient/guardian.
6. Treatment plan to be updated every six months.	Treatment plan update to be signed by provider and patient/guardian.
7. Working diagnosis	

I am voluntarily seeking services at Vogelfanger & Struble Clinic. After consultation with my provider(s) I reasonably understand the nature of my current problem(s), condition(s), or diagnosis(es). The treatment(s) specified in this plan have been explained to me in a clear manner and I understand them. I have been given the opportunity to ask questions. I have reviewed and participated in the development of this initial treatment plan. I agree that my provider(s) and I will implement these treatments to help solve the problems we have identified. I agree to complete treatment assignments as part of my responsibility for my own treatment. My provider(s) and I have discussed the reasonable outcome, as well as potential risks, limitations and complications of these treatments. Alternative forms of treatment for my problem(s) have also been discussed. I was offered the opportunity to ask any questions regarding the proposed treatment plan. I understand that in the event of a mental health emergency during regular office hours (Monday-Friday 9 am-5 pm) I can call **(901) 767-1136** to determine the appropriate response to the emergency. Should I require emergency mental health services before or after regular office hours, on week-ends, or holidays I understand that I can call **(901) 767-1136** or **911**, or go to the nearest emergency room where determination of needed services can be assessed.

_____ Signature of Client/Guardian Date	_____ Signature of Provider Date
_____ Signature of Provider Date	_____ Signature of Provider Date

VOGELFANGER AND STRUBLE CLINIC

TENNderCare EPSDT INFORMATION, ASSESSMENT, AND REFERRAL SCREENING

(Required for ALL TennCare Patients under 21 Years of Age)

Tennessee Medicaid insurance coverage provides for the periodic diagnosis and treatment of dental, vision, and hearing problems for covered children and young adults under the age of 21 years

Date of most recent **DENTAL** examination: _____	Referral provided for Doral Dental: 1-888-233-5935 ◯ Yes ◯ No
Date of most recent **VISION** examination: _____	Referral provided for VISION SERVICES:* ◯ Yes ◯ No
Date of most recent **HEARING** examination: _____	Referral provided for HEARING SERVICES:* ◯ Yes ◯ No

*for referrals for VISION and HEARING services: call tor TennCare Health Plan Customer Service Center.

- United Health Care West TN: 1-800-690-1606
- BlueCAre West TN: 1-800-999-1658
- Amerigroup: 1-800-438-8789

Patient name: _____

Signature of patient if 18 years old or older/guardian if under 18 years old:

_____ Date: _____

Copy given to patient/guardian? ◯ Yes ◯ No

Staff signature: _____ Date: _____