

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_ 1

**Dr. David G. Kaiser, M.D., P.A.**  
**PATIENT INFORMATION**

PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
First Middle Initial Last

PATIENT SEX: \_\_\_\_\_ Male \_\_\_\_\_ Female PATIENT SSN \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY/STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE # ( ) \_\_\_\_\_

ALTERNATE PHONE # WHERE WE MAY REACH YOU ( ) \_\_\_\_\_

RESPONSIBLE PARTY NAME \_\_\_\_\_ REL TO PT \_\_\_\_\_

PHONE # ( ) \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY/STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE # ( ) \_\_\_\_\_

PRIMARY INS. \_\_\_\_\_ INSURED NAME \_\_\_\_\_

PHONE # \_\_\_\_\_ REL TO PT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_ GROUP/PLAN \_\_\_\_\_

EMPLOYER NAME, ADDRESS, PHONE # \_\_\_\_\_

SECONDARY INS. \_\_\_\_\_ INSURED NAME \_\_\_\_\_

PHONE # \_\_\_\_\_

**A COPY OF YOUR DRIVERS LICENSE and INSURANCE CARD IS NEEDED  
PAYMENT OF SERVICES IS HANDLED PRIOR TO YOUR SESSION**

**All reasonable requests for confidential handling of your health information by alternative means will be granted:**

- ❖ May we leave a message on your home answering machine? Y\_\_ N\_\_
- ❖ Do you have an alternate phone number we may use? Y\_\_ N\_\_ Phone # \_\_\_\_\_
- ❖ Emergency Contact Name \_\_\_\_\_ relationship \_\_\_\_\_  
& Phone Number \_\_\_\_\_
- ❖ May we share information regarding appointments or billing inquiries only with your spouse or an immediate family member? Y\_\_ N\_\_ Names: \_\_\_\_\_
  
- ❖ **If the patient is a Minor, are biological parents: married \_\_\_\_\_ never married \_\_\_\_\_ divorced \_\_\_\_\_. Minor Child Treatment Information may be shared with Non-Custodial Parent (if not specified otherwise in the court order) Y\_\_ N\_\_**  
**Non-Custodial Parent Name: \_\_\_\_\_**

Please complete the following section *only* if you want communications regarding your health care information or billing sent to an **alternate address** other than your residence.

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_ 2

**Dr. David G. Kaiser, M.D., P.A.**  
**Effective 7/16/08**

We are committed to providing our patients with the best possible care and we are pleased to discuss our professional services with you at any time. Your clear understanding of our Office Procedures and Financial Policies is very important. All patients must complete our "Patient Information Form" before seeing the Professional

**Payment of services is handled prior to your session.** Your insurance company mandates you must pay your co-payment at the time of service. If you cannot pay, you may be asked to reschedule.

We accept cash, checks, Visa, MasterCard, Discover, American Express, and Debit. If a check is returned for insufficient funds, we will not accept another check from the patient. Payment will have to be cash, credit or debit. There is a \$25 returned check fee. We do not accept temporary or post-dated checks if you are a new patient.

We charge for missed/cancelled appointment, unless cancelled at least 24 hours in advance. Our policy is to charge \$50.00 for missed/canceled appointments. Please do not rely on appointment reminder calls, as this is a courtesy. Having 3 or more no shows or cancellation of appointments can result in termination of treatment. Please help us serve you better by keeping scheduled appointments. NOTE: You may be asked to reschedule if you are more than 15 minutes late for your appointment. If you feel you were charged in error, please discuss this matter with our office manger.

We charge a service fee for certain form and/or letters that must be completed for a patient. Full one-month prescriptions will not be released without payment. We also require Self-Addressed, Stamped Envelopes for mailing prescriptions.

If you choose this office will provide you with a completed receipt showing charges, payments, which you may file with your insurance company.

Childcare is not provided for children. Please do not leave children unattended in the reception area.

**All Medicaid patients must present the current, monthly Medicaid Letter (not an Insurance card) at every visit as mandated by Medicaid or the visit will be rescheduled without exception.**

In the event of a Divorce, we must have a copy of the Divorce Decree signed by a judge. The decree must state which parent has Managing Conservatory privileges for the minor child.

**REGARDING INSURANCE ASSIGNMENT**

We will only file claims with insurance companies we are contracted with. In order to achieve this, we must have all current insurance information on file.

**If there are any changes in your insurance coverage, you must notify our Business Office 5 days prior to your next appointment or the visit will be self-pay or rescheduled.**

The patient must stay current with the payment of their deductibles and co-payments. All information this office gives in reference to your insurance coverage is based on information obtained from your insurance company, is only descriptive of your benefits, and is not a guarantee of payment by your insurance company. An insurance company may quote benefits and give authorization, but clearly state in their disclaimer this is not a guarantee of payment. Therefore, any amount we collect at the time of service or quote as your responsibility is any estimate only. You are ultimately responsible for any and all balances on your account.

**Should you have any problems regarding your account or about the filing of claims, fees, or billing records, please do not hesitate to ask our Business Office Staff.**

**I HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES OF FAMILY PSYCHIATRY OF THE WOODLANDS.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Dr. David G. Kaiser, M.D., P.A.**

PLEASE REVIEW AND INITIAL THE FOLLOWING POLICIES FOR TREATMENT:

\_\_\_ **ITEM 1 – FEMALE PATIENTS**

Initial If taking medication I agree to notify *Dr. David G. Kaiser, M.D., P.A.* in the event that I am planning to become pregnant, or I become pregnant so that I may discuss the risks/benefits of medication.

\_\_\_ **ITEM 2 – ALCOHOL/DRUGS/HERBAL SUPPLEMENTS**

Initial It is recommended not to use alcohol/drugs or herbal supplements in combination with prescription psychiatric medication and I agree to notify *Dr. David G. Kaiser, M.D., P.A.* if this is a concern.

\_\_\_ **ITEM 3 – MEDICATION REFILLS**

Initial Medication is prescribed to last until your next appointment. You will need to make an appointment and be seen when medication refills are required.

\_\_\_ **ITEM 4 – LETTERS AND/OR FORMS**

Initial There will be a charge for any forms and/or letters that must be completed in this office by any practitioner or office staff.

\_\_\_ **ITEM 5 – THERAPY SESSIONS**

Initial Therapy sessions are scheduled for 30 or 45 minutes. In order that you receive your entire session, please be prompt for you appointment.

\_\_\_ **ITEM 6 – CONFIDENTIALITY**

Initial All information is guarded by strict confidentiality. We require your written consent in order to release / obtain information.

\_\_\_ **ITEM 7 – CONSENT FOR TREATMENT – CONSENT MUST BE SIGNED PRIOR TO THE START OF YOUR APPOINTMENT**

Initial I hereby give consent for myself or the above named patient to be treated/tested by *Dr. David G. Kaiser, M.D., P.A.* If the above named patient is a minor who is/has been involved in any court proceedings, I have provided proof by the attached court documents, that I have the legal right to request treatment for the above named minor. If you are **15-17 years of age**, you must co-sign. If you are **18 years of age**, you must sign yourself and are allowed the right to choose whether you wish anyone/parents to be present during your evaluation and treatment. Both parties must sign consent for treatment if seen for marital or co-joint therapy. A parent/guardian may not come in for an appointment without the patient. **The patient must be present at every visit.** **Patients under 18 years of age will only be seen with a parent or guardian present.**

\_\_\_ **ITEM 8 – TERMINATION OF TREATMENT**

Initial Assault or verbally threatening behavior towards staff, other patients, or physical property of *Dr. David G. Kaiser, M.D., P.A.* will be cause to terminate treatment and be held responsible for damages. Firearms and other weapons are prohibited, with exception for an officer of the law.

\_\_\_ **ITEM 9 – CANCELLATIONS**

Initial **Cancellations must be made 24 HOURS before your session.** Your session time is reserved for you and you will be charged a **\$50.00 no-show fee** for late cancellations or missed appointments. **Our office policy allows three no-show fees before terminating services.**

**\_\_\_ ITEM 10 – OUTSIDE LAB OR OTHER DIAGNOSTIC TESTS**

Initial We do not get authorization from your insurance for any ordered tests that are performed outside our office. We suggest you contact your insurance carrier to insure that you will be reimbursed for the charges and are aware of your benefit coverage.

**\_\_\_ ITEM 11 – MANAGED CARE PLANS**

Initial This practice has contracted with several managed care plans and will be handled according to our agreement with them. All co-payments must be paid at time of service. It is your responsibility to be aware of coverage variables, such as preventive health care, deductibles, etc., and to pay for services not covered by your insurance company. Following notification for the insurance company, any denied amounts would be due immediately, upon being notified by our office.

**\_\_\_ ITEM 12 – ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION**

Initial I hereby authorize my insurance carrier to pay benefits directly to *Dr. David G. Kaiser, M.D., P.A.* for services provided to myself or my insured dependent, realizing I am responsible to pay for all services provided. I hereby authorize the release of pertinent information required by my insurance carrier to process insurance claims for payment to *Dr. David G. Kaiser, M.D., P.A.*

**\_\_\_ ITEM 13 – PAGING SYSTEM**

Initial There is a 24-hr paging system for emergency situations. There is a \$45.00 charge for non-emergent after hour calls.

**\_\_\_ ITEM 14 – EMERGENCY SERVICES**

Initial I agree to contact *Dr. David G. Kaiser, M.D., P.A.*s or 911 in the event that I feel suicidal or violent in order to follow steps to protect the safety of others and myself.

**\_\_\_ ITEM 15 – FINANCIAL POLICY**

Initial I acknowledge that I have read and understand the financial policies of this office.

**\_\_\_ ITEM 16 – NOTICE OF PRIVACY PRACTICES**

Initial I acknowledge that I have received a copy of the Notice of Privacy Practices of this office effective April 15<sup>th</sup>, 2003.

**\_\_\_ ITEM 17 – BILLING INQUIRY**

Initial If you have billing questions, we will be pleased to help you. Contact our billing office at 281-363-4693.

**Items 1 – 17, initialed by me, indicate my understanding of legal Terms and Conditions in connection with the treatment of patient.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Initials

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Initials

\_\_\_\_\_  
Date

**David G. Kaiser M.D., P.A.**  
**8701 New Trails Drive, Ste. 150**  
**The Woodlands, Texas 77381**

**Clients' Rights**

- 1. You have all the rights of any other resident of the State of Texas and the United States of America.**
2. You have the right to not be discriminated based on age, race, ethnicity, gender, sexual orientation, religion, national origin, physical or mental disability, or other attributes.
- 3. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.**
4. You have the right to be free from abuse, neglect, and exploitation.
- 5. You have the right to be treated with dignity and respect.**
6. You have the right to be told about the treatment you will be given, the risks, side effects, and benefits of all medications and treatment you will receive, the other treatments that are available, and what may happen if you refuse treatment.
- 7. You have the right to accept or refuse treatment after receiving this explanation.**
8. You have a right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
- 9. You have the right to know the qualifications of the staff responsible for your treatment.**
10. You have the right to refuse to take part in research without affecting your regular care.
- 11. You have the right not to be given medication you don't need, or too much medication.**
12. You have the right to have information about you kept private and to be told about the times when the information can be released without you permission.
- 13. Unless otherwise provided by law, you have the right to withdraw at any time you permission for something you agreed to earlier.**
14. You have the right to make a compliant and receive a fair response from this facility within a reasonable amount of time.
- 15. You have the right to contact and consult with counsel at your expense.**
16. You have the right to select practitioners of your choice at your expense.
- 17. You have the right to choose whether your parents may be present and participate in your treatment if you are at least 18 years of age.**

**I acknowledge having read and understood the above client rights.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_ 6

### **Initial Evaluation & Follow-up Medication Visits**

**Welcome to our practice. Please take a moment to read the following information regarding our office procedures.**

On your **First Visit:**

- A clinician will obtain a detailed medical and psychiatric history; taking up to 40 minutes.
- In a few cases, when the diagnosis is not clear from history, he may need additional testing before making treatment recommendations.
- The clinician then explains the diagnosis, treatment recommendations and answers any questions you may have.
- The clinician will also direct you to check out to schedule a follow-up appointment. It is wise to schedule that appointment while in the office, if at all possible.
- The **clinician** who took your history is your **primary contact person** in this office.

For follow-up **Medication Management Visits:**

- Patients routinely are scheduled with the clinician for follow-up medication management visits to assess your treatment response and monitor for side effects. The clinician will meet with you, obtain information regarding your response to the treatment plan.
- For your safety, medication changes are generally not made over the phone. However, if you feel you are having an adverse reaction, please call your primary contact person immediately.
- You will typically see the clinician for return visits. These visits are scheduled on the half hour through out the day. For sessions that extend past the 15 minutes, an additional charge will be applied.

If you need **Psychotherapy:**

- Nurse Practitioners do not see patients for psychotherapy.
- The clinician will refer you to a therapist in our office, if possible, on your insurance plan.

\_\_\_\_\_ I have read the above policy and understand it.

Initials

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_ 7

**Dr. David G. Kaiser, M.D., P.A.**  
**8701 New Trails Drive, Ste. 150**  
**The Woodlands, Texas 77381**  
**Phone: 281-367-1015 Fax: 281-367-1966**

**Effective Date: April 14, 2003**

If you have any questions about this notice, please contact HIPAA grievance officer 281-367-1015. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

**WHO WILL FOLLOW THIS NOTICE**

Any physician or health care professional authorized to enter information into your chart. All departments of the practice. All employees, staff and other office personnel. All these individuals. In addition we may share with each other and third party specialists for treatment, payment, and purposes described in this notice.

**WE ARE REQUIRED BY LAW TO:**

Make sure that medical information that identifies you is kept private. Give you notice of our legal duties. Follow the terms of the notice that is currently in effect.

**HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

Treatment- We may use medical information about you to provide you with medical treatment services. We may disclose medical information about you to people outside the office who may be involved in your care. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.

Payment- We may use and disclose medical information about you so that treatment and services you receive at our office may be billed to and payment collected from you, and insurance company or a third party.

Appointment Reminders- We may use and disclose medical information to contact you as a reminder that you have an appointment for medical services at the office. We do notify our patients by telephone.

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

**SPECIAL SITUATIONS**

Health Oversight Activities- We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes- If you are involved in a lawsuit or a dispute we may disclose medical information about you in response to a court order. We may also disclose information about you in response to a subpoena.

Coroners, Medical Examiners, and Funeral Directors- We may release medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

Right to Inspect and Copy- If you request a copy of the information we may deny your request due to mental health liabilities.

Right to Amend- If you feel that medical information we have about you is incorrect or incomplete you may ask us to amend the information. In addition you must provide a reason that supports your request. We may deny your request for an amendment but your request will be put into your permanent file as you requested it be changed.

Right to Request Restrictions- You have the right to request a restriction or limitation on the medical information we disclose about you for treatment, payment, or health care operations.

Right to paper copy of this notice- You have the right to a paper copy of this notice. To obtain a paper copy of this notice please contact us at David G. Kaiser, M.D., P.A. HIPAA Privacy Officer @ 8701 New Trails Drive, Ste 150 The Woodlands, Texas 77381

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice.

**COMPLIANTS**

If you believe your privacy rights have been violated. You can file a complaint with our Grievance Officer at 281-367-1015.

**OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice will only be made with your written permission. You may revoke that permission in writing at any time; if you do we will no longer use or disclose medical information. Understand that we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

**Patient & Family History – New Patients**

**Presenting Problem:**

Please state the reason and/or symptoms that brought you here today: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are there any significant events associated with the above reason? Yes \_\_\_ No \_\_\_

If yes, please provide more information: \_\_\_\_\_

\_\_\_\_\_

**Check all symptoms you have been experiencing:**

- ( ) recent weight gain                      How much? \_\_\_\_\_
- ( ) recent weight loss                      How much? \_\_\_\_\_
- ( ) difficulty falling asleep (insomnia) ( ) Excessive sleeping      ( ) Fatigue
- ( ) Middle of the night awakening      ( ) Decreased energy      ( ) Lack of motivation
- ( ) Restlessness or agitation              ( ) Decreased appetite      ( ) Increased appetite
- ( ) Frequent mood swings                  ( ) Frequent anger              ( ) Irritability
- ( ) Complaints of despair, hopelessness, worthlessness      ( ) Inattention
- ( ) Inability to experience pleasure      ( ) Inability to express feelings
- ( ) Withdrawal from others                  ( ) Difficulty concentrating
- ( ) Loss of Libido                              ( ) Loss of thought process
- ( ) Difficult focusing resulting in unfinished task

Are you presently having **thoughts of suicide**? Yes \_\_\_ No \_\_\_

If yes, please provide more information: \_\_\_\_\_

\_\_\_\_\_

Have you ever made a **suicide attempt**? Yes \_\_\_ No \_\_\_

If yes, Please provide more information. (When, how) \_\_\_\_\_

\_\_\_\_\_

**Patient Medical History:**

Have you ever had **psychiatric treatment**? Yes \_\_\_ No \_\_\_

If yes, please describe: Date: \_\_\_\_\_ Provider: \_\_\_\_\_

Reason: \_\_\_\_\_

\_\_\_\_\_

**History of Substance Use and/or Abuse:**

Have you ever used **drugs**? ( ) no ( ) yes

<u>Substance</u>	<u>Age began</u>	<u>Frequency/amount</u>	<u>Last time used</u>
1.			
2.			
3.			

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_ 9

Have you ever been in **treatment** (hospital or outpatient) **for drug** and or **alcohol abuse**? Yes \_\_\_\_\_  
No \_\_\_\_\_ If yes, please describe, providing date, provider and type of treatment:

\_\_\_\_\_

Do you use any **tobacco product**? Yes \_\_\_\_\_ No \_\_\_\_\_

Allergies to medications? \_\_\_\_\_

History of any of the following conditions? Yes \_\_\_\_\_ (Check below), None \_\_\_\_\_

- Meningitis
- Hepatitis
- Mononucleosis
- Renal KIDNEY problems
- Diabetes
- Heart Disease
- High Blood pressure
- Low Blood pressure
- Rheumatic fever
- Seizures (other than febrile)
- Serious head injury. With or without loss of consciousness? (circle)
- Other: \_\_\_\_\_

Surgery: Yes \_\_\_\_\_ (Check below), None \_\_\_\_\_

- Tonsillectomy
- Adenoidectomy
- Appendectomy
- Gallbladder removal (Cholecystectomy)
- Hysterectomy (partial or complete?)
- Other: (specify) \_\_\_\_\_

Current Medical Conditions (diabetes, seasonal allergies, high blood pressure, etc.):

\_\_\_\_\_

Females: Last menstrual period: \_\_\_\_\_

Are you currently pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

Breastfeeding? Yes \_\_\_\_\_ No \_\_\_\_\_

Developmental history (**Children and adolescents ONLY**):

- Was the pregnancy \_\_\_\_\_ planned or \_\_\_\_\_ unplanned?
- Was it full-term? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Normal pregnancy? Yes \_\_\_\_\_ No(explain) \_\_\_\_\_
- How did the mother feel about this pregnancy? \_\_\_\_\_
- How did the father feel? \_\_\_\_\_
- Were any alcohols, drugs, or medications used during pregnancy? \_\_\_\_\_ Yes \_\_\_\_\_ No
- If yes, please describe: \_\_\_\_\_
- Were there any problems with the pregnancy? \_\_\_\_\_
- Delivery: Normal vaginal \_\_\_\_\_ C-Section \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_ 10

- Was the baby \_\_\_\_\_ breast fed \_\_\_\_\_ bottle fed \_\_\_\_\_ both?
- Who was the primary caretaker for the child? \_\_\_\_\_
- Estimate when your child first:
 

Smiled _____	Sat up on own _____
Crawled _____	Stood _____
Walked _____	Ran _____
Said first word _____	Said phrases _____
Fed self _____	Dressed self _____
Toilet trained _____	

**Current Medications:** (Example: Prozac 20mg one a day. Include all meds, not just psychiatric ones. Also include any over-the-counter meds, vitamins, etc.)

Medication Name	Dose	How Often	Reason/Treatment of

**Family Medical History:** check & list – i.e. Mother (M), Father (F), Paternal Grandmother (PGM), etc.)

- Diabetes \_\_\_\_\_
- Thyroid disorder \_\_\_\_\_
- Heart attack or heart disease \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- Stroke \_\_\_\_\_
- Alzheimer’s Disease \_\_\_\_\_
- Parkinson’s Disease \_\_\_\_\_
- Migraine Headaches \_\_\_\_\_
- Other (list): \_\_\_\_\_

**Family Psychiatric History:** (check & list as above)

- Depression \_\_\_\_\_
- Bipolar Disorder (Manic Depression) \_\_\_\_\_
- Schizophrenia \_\_\_\_\_
- Alcoholism \_\_\_\_\_

**Family Psychiatric History Con’t:** (check & list as above)

- Drug abuse or dependency \_\_\_\_\_
- ADHD or ADD \_\_\_\_\_
- Obsessive Compulsive Disorder \_\_\_\_\_
- Anxiety or Panic symptoms \_\_\_\_\_
- Other (list) \_\_\_\_\_

**Religious preference:** \_\_\_\_\_

Are there any cultural issues or religious beliefs that might affect your treatment?

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No \_\_\_ Yes (explain) \_\_\_\_\_  
\_\_\_\_\_

**Current Marital Status:** Married\_\_\_\_, Divorced\_\_\_\_, Separated\_\_\_\_, Single\_\_\_\_, Widowed\_\_\_\_,  
Number of Marriages\_\_\_\_, **Non-applicable (child)**\_\_\_\_

Years in current marriage? \_\_\_\_\_

**Is spouse supportive?** Yes\_\_\_\_ No (explain)\_\_\_\_\_

**Children?** Yes\_\_\_\_ How many? \_\_\_\_\_

Child's Name	Age	Biological, step, adopted, foster
1.		
2.		
3.		

**Describe who lives in household:** (e.g. husband, wife, children, mother, father, siblings,  
pets,etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Education:** (Check all that apply.)

- Currently in \_\_\_\_\_ grade at \_\_\_\_\_ (name of school) in \_\_\_\_\_ (school district).
- Dropped out of school in the \_\_\_\_\_ grade.
- High School graduate Major/Skill learned? \_\_\_\_\_
- GED
- Some college Major/Skill learned? \_\_\_\_\_
- 2 year degree (college) Major/Skill learned? \_\_\_\_\_
- 4 year degree (college) Major/Skill learned? \_\_\_\_\_
- Graduate degree Major/Skill learned? \_\_\_\_\_
- Other \_\_\_\_\_

**Work History of Patient:** (Current job, how long at job, do you enjoy your work, work stressors?)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family of origin:** Grew up in intact family (i.e. Mother & father stayed married.)

- Parents divorced when patient \_\_\_\_\_ years old. Patient lived with: mother\_\_\_\_ father\_\_\_\_.
- History of physical abuse at hands of \_\_\_\_\_.
- History of sexual abuse at hands of \_\_\_\_\_.
- History of emotional abuse at hands of \_\_\_\_\_.
- Siblings: brothers\_\_\_\_ sisters\_\_\_\_ (how many?)
- Close family relationships.
- Not very close family relationships.

**Completed by:** \_\_\_\_\_ **(Patient or Parent/Guardian)**  
(Signature)

**Reviewed by:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_ 12

**Dr. David G. Kaiser, M.D., P.A.**  
8701 New Trails Drive, Ste. 150  
The Woodlands, TX 77381

**PRIMARY CARE PHYSICIAN CONTACT FORM**

I, (patient name) \_\_\_\_\_, SSN \_\_\_\_\_, DOB \_\_\_\_\_, authorize Dr. David G. Kaiser, M.D., P.A., for the purpose of case consultation/continuity of care, to release & receive information re: my evaluation & treatment to:

**Primary Care Physician:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone #** \_\_\_\_\_ **Fax #** \_\_\_\_\_

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This consent shall expire on: \_\_\_\_\_.

Patient Signature: \_\_\_\_\_ Witness Signature: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\***DO NOT WRITE BELOW THIS POINT**\*\*\*\*\*

**This patient is currently under my care for:** \_\_\_\_\_ Evaluation only  
\_\_\_\_\_ Medication management  
\_\_\_\_\_ Detoxification from \_\_\_\_\_  
\_\_\_\_\_ Other \_\_\_\_\_

**This patient has been placed on the following medication(s)/dosage(s):**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This office has ordered the following labs/tests (circled):**  
CBC                      Depakote level                      Lithium level                      Serum pregnancy  
Chem 20                      Desipramine level                      Tegretol level                      Urine pregnancy  
Liver function                      Doxepin level                      Urinalysis                      Urine drug screen  
Thyroid profile                      Imipramine level EKG                      Other \_\_\_\_\_

**I have requested that this patient consult you re:** \_\_\_\_\_  
\_\_\_\_\_

**I have also referred this patient to:** \_\_\_\_\_  
\_\_\_\_\_

If you have any questions or concerns regarding my treatment of this patient, please feel free to contact my office.

**Treating practitioner:** \_\_\_ **David G. Kaiser, M.D.**  
\_\_\_ **Aveleigh Cook, PMHNP**

Mailed to PCP by \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_ 13