Ronald M. Kirsner, M.D., P.A.
9822 Tapestry Park Circle - Unit 206
Jacksonville, FL 32246
904/564-2232 fax:904/207-7897 www.ronkirsnermd.com

ron@ronkirsnermd.com ***patient name_____***

PLEASE PRINT THIS FORM SINGLE-SIDED

New Patient ☐ Returning Patient ☐

Today's Date: _____/_____/_____

Patient's Full Name: :_____
First Middle Last Title (Jr., Sr., etc)

Patient's Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Non-binary

Street Address: _____

Street Address line 2: _____

City: _____ State: ____ Zip: _____

Cell Phone: ( )_____ May we contact you/leave messages at this number? _____
Home Phone: ( )_____ May we contact you/leave messages at this number? _____
Work Phone: ( )_____ May we contact you/leave messages at this number? _____
Email Address: _____ May we contact you at your email address? _____

EMERGENCY CONTACT INFORMATION

(To be completed for all patients)

Emergency Contact Name:_____
First Middle Last

Relationship to Patient: _____

Cell Phone: ( )_____ Work Phone: ( )_____

Home Phone: ( )_____

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Patient Name _____

-PLEASE FILL OUT THIS PAGE ONLY IF THE PATIENT IS ***UNDER 18 YEARS OF AGE***, OTHERWISE SKIP TO THE NEXT PAGE-

Mother/ Legal Guardian Name:_____
First *M.I* *Last*

Street Address: _____

Street Address line 2: _____

City: _____ State: ____ Zip: _____

Cell Phone: ( )_____ Work Phone: ( )_____

Home Phone: ( )_____ Email:_____

How would you prefer that we contact you about the Patient's care? (Please indicate Y or N)

___ Cell ___Work ___ Home ___ Email

Permission to leave a voicemail/message? (Please indicate Y or N)

___ Cell ___Work ___ Home ___ Email

Father/ Legal Guardian Name:_____
First *MI* *Last*

Full Address: ____ Same as above (check if true)

Street Address: _____

Street Address line 2: _____

City: _____ State: ____ Zip: _____

Cell Phone: ( )_____ Work Phone: ( )_____

Home Phone: ( )_____ Email:_____

How would you prefer that we contact you about the Patient's care? (Please indicate Y or N)

___ Cell ___Work ___ Home ___ Email

Permission to leave a voicemail/message? (Please indicate Y for N)

___ Cell ___Work ___ Home ___ Email

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Patient Name _____

CONSENT FOR PSYCHIATRIC TREATMENT

Today's Date: ____/____/____

1. Consent to Evaluate/Treat: I voluntarily consent to participate in a mental health (or psychiatric) evaluation and/or treatment. I acknowledge that following the evaluation and/or treatment, information will be provided to concerning each of the following areas:

    a. The benefits of the proposed treatment;

    b. Alternative treatment modes and services;

    c. The manner in which treatment will be administered;

    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable); and

    e. Probable consequences of not receiving treatment.

    I understand that the evaluation or treatment will be conducted by a psychiatrist. Treatment will be conducted within the boundaries of Florida law.

2. Risks, Benefits, and Alternatives to Evaluation/Treatment: I understand that Dr. Kirsner may evaluate and treat me through a variety of methods, such as psychological/psychiatric interviews, psychological/psychiatric assessments or testing, psychotherapy, medication management, and that these methods may vary in length and frequency. I also understand that it will be beneficial to Dr. Kirsner, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning so that he can offer appropriate recommendations and treatments. Uses of Dr. Kirsner's evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning.

    I understand that possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations. Possible risks include bad interactions with prescribed medications, which could cause discomfort, injury or death. Alternatives to psychiatric treatment include mental health counseling, treatment by a general medical doctor, and self-help, such as through education or lifestyle changes.

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Patient Name _____

3. Confidentiality, Harm, and Inquiry: Information from Dr. Kirsner's evaluation and/or treatment is contained in a confidential medical record. I hereby consent to disclosure for use by Ronald M. Kirsner, M.D., P.A.'s staff for the purpose of continuity of my care. I acknowledge that pursuant to Florida mental health law, information provided will be kept confidential with the following exceptions:

    a. If I am deemed to present a danger to myself or others;

    b. If concerns about possible abuse or neglect arise; or

    c. If a court order is issued to obtain records.

4. Right to Withdraw Consent: I understand that I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to Dr. Kirsner.

CONSENT FOR PSYCHIATRIC TREATMENT

I have read and understand the above informed consent, have had an opportunity to ask questions about this information. I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment and I have not been deemed incapable of giving such consent by any court. I understand that I have the right to ask questions of Dr. Kirsner about the above information at any time. I acknowledge I received the patient's bill of rights.

Patient or Parent/Legal Guardian

Name:_____

Signature_____ Date ____/____/____

Witness_____ Date ____/____/____

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Patient Name _____

PATIENT FINANCIAL POLICY

PAYMENT METHODS. I understand that Dr. Kirsner does not accept insurance, Medicare, or Medicaid and that I am fully responsible for all financial obligations related to my evaluation and treatment with Dr. Kirsner. I understand that Dr. Kirsner accepts the following forms of payment: Visa, MasterCard, Discover, American Express, check or cash. I also understand that I am required to keep a credit card on file with Dr. Kirsner, and authorize Dr. Kirsner to **automatically bill my credit card** if I do not make payment at the time the service is provided, or if I otherwise incur any charges in accordance with this Patient Financial Policy.

INSURANCE CLAIMS. I understand that Dr. Kirsner's staff may, in its sole discretion, assist me in submitting a claim for insurance reimbursement. I authorize Dr. Kirsner and his staff to release any information necessary for such claims processing. I understand that there is no guarantee of payment by any insurance company or third party payer and I am ultimately responsible for payment in full at the time of service.

INITIAL VISIT FEE. I understand that Dr. Kirsner charges $390.00 for an initial visit.

FOLLOW-UP VISITS AND PHONE CALL FEES. I understand that Dr. Kirsner charges for follow-up visits and phone calls (including calls returned by Dr. Kirsner) based upon the length of the visit/call and the complexity of the matter involved. I understand that there is no financial charge for phone calls to Dr. Kirsner's staff regarding appointment scheduling, medication refill requests, billing, and other routine administrative matters.

NO SHOW/LATE CANCELLATION FEE. *You will be responsible for paying a no show fee for up to the full amount of the missed appointment for missed appointments or appointments not cancelled by 4:00 p.m. the previous business day.*

RETURNED CHECK FEE. You will be subject to an additional fee for returned checks, which will be determined by the depository bank.

DELINQUENT ACCOUNTS. Should your account be placed with a collection agency due to delinquent status, the administrative cost of such action, along with any attorneys' fees and court costs, will be added to the balance of the account at the time of placement with the collection agency.

BILLING. I understand that *Dr. Kirsner does not accept insurance,* Medicare or Medicaid, and that I am fully responsible for all financial obligations incurred. I understand that payment is due in full at the time of service.

Patient or Parent/Legal Guardian Name:_____

Signature_____ Date _____/_____/_____

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Patient Name _____

TREATMENT PROGRESS CONTACT INFORMATION

I authorize Dr. Kirsner to speak with the following individuals regarding the progress of my treatment, or to discuss billing, change the scheduling of appointments, get credit card information, etc. I understand that Dr. Kirsner may contact these individuals to ask questions about how I am doing in order to optimize my treatment.

I UNDERSTAND THAT I DO NOT NEED TO SIGN THIS FORM TO RECEIVE TREATMENT.

Name:_____ Phone _____ Relationship _____

Name:_____ Phone _____ Relationship _____

Name:_____ Phone _____ Relationship _____

EXPIRATION DATE: This authorization will expire **on completion of my treatment** unless a different expiration date or expiration event is written here: _____.

REVOCATION: I understand that I have the right to revoke this authorization in writing any time, however I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the Practice shall not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare when the law provides my insurer with the right to contest a claim under my policy. Written notice should be directed to Pat Kirsner, Ron Kirsner M.D., P.A.'s Privacy Officer.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I understand that treatment will not be denied if I decide to not sign this form.

Signature: _____ □ Patient □ Personal Representative

Date:_____

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Jacksonville, FL 32246

Patient Name _____

CREDIT CARD AUTHORIZATION

Patient Name:_____ Today's Date: ____/____/____

In accordance with the Patient Financial Policy, I understand that all payments are due at the time of service. Any charges not paid in full at the time of service, as well as any other fees charged in accordance with the Patient Financial Policy, will be automatically charged to my credit card.

Name on Credit Card: _____

Billing Address

Street Address: _____

Street Address line 2: _____

City: _____ State: ____ Zip: _____

Card Number: _____

Expiration Date: _____

3-Digit CVS Code (on back of card): _____ 4-Digit CVS Code for Amex (on front) _____

Type of Card (please circle one): Visa MasterCard Discovery American Express

I hereby authorize Ronald M. Kirsner, M.D., P.A. to maintain my credit card information on file and to charge my credit card for any services rendered if payment is not otherwise made at the time of my appointment or IF other payment arrangements are not approved by Dr. Kirsner. I also authorize Ronald M. Kirsner, M.D., P.A. to charge my credit card for any fees incurred in accordance with the Patient Financial Policy, including, but not limited to, late cancellation fees and returned check fees. I understand that any charges to my credit card will appear on my credit card statement as being billed by "Ron Kirsner, M.D."

Patient or Parent/Legal Guardian Name:_____

Signature_____ Date ____/____/____

Ronald M. Kirsner, M.D., P.A.
9822 Tapestry Park Circle - Unit 206
Jacksonville, FL 32246

RONALD M. KIRSNER, M.D. P.A.
9822 Tapestry Park Circle Unit 206 Jacksonville, Florida 32246
Phone #: (904) 564-2232, Fax #: (904) 207-7897

NOTICE OF PRIVACY PRACTICES

Effective Date: January 10, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

2. Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

3. Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization

- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

4. Our Responsibilities

- Maintain the privacy and security of your protected health information

1. Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this by contacting our Privacy Officer.

- We will provide a copy or a summary of your health information, usually within 30 days of your written request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us in writing to correct health information about you that you think is incorrect or incomplete. Ask us how to do this by contacting our Privacy Officer.

- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us in writing to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Ask us how to do this by contacting our Privacy Officer.

- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us in writing not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. Ask us how to do this by contacting our Privacy Officer.

- **If you pay for a service or health care item out-of-pocket in full**, you can ask us in writing **not to share** that information for the purpose of payment or our operations with your **health insurer**. We will say "yes" unless a law requires us to share that information. Ask us how to do this by contacting our Privacy Officer.

Get a list of those with whom we've shared information

- You can ask us in writing for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, whom we shared it with, and why. Ask us how to do this by contacting our Privacy Officer.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Ask us how to do this by contacting our Privacy Officer.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the Privacy Officer listed below.

- You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- We will not retaliate against you for filing a complaint.

2. Your Choices

For certain health information, you can tell us your choices about what we share.

- If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

- Share information in a disaster relief situation

- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us **written permission**:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you have the right to opt out, and we will honor your request if you tell us that you would not like to receive these communications.

3. Our Uses and Disclosures

How do we typically use or share your health information?

- We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
- *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- *Example: We give information about you to your health insurance plan so it will pay for your services*.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- *Example: We use health information about you to manage your treatment and services.*

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
- We can use or share your information for health research, so long as we obtain documentation that an alteration to or waiver of the individual authorization has been approved by either an Institutional Review Board (IRB) or privacy board.

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

4. Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Ronald M. Kirsner, M.D., P.A.
9822 Tapestry Park Circle - Unit 206
Jacksonville, FL 32246

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

- http://www.ronkirsnermd.com/

Ronald M. Kirsner, M.D., P.A.
9822 Tapestry Park Circle - Unit 206
Jacksonville, FL 32246

Privacy Officer

If you would like to contact us for information about this notice or to complain about our privacy practices, please contact:

- Pat Kirsner, Privacy Officer
- RONALD M. KIRSNER, M.D. P.A.
- 9822 Tapestry Park Circle, Unit 206
- Jacksonville, Florida 32246
- Phone #: (904) 564-2232, Fax #: (904) 207-7897

Other Instructions for Notice

Under Florida law, we will never share treatment records without your written permission for the following areas, unless an exception applies:

- Alcohol and substance abuse
- Genetic testing
- HIV/AIDS
- Mental Health

Acknowledgement

You will be asked to sign an acknowledgement of your receipt of this Notice of Privacy Practices. We are required by law to make a good faith effort to provide you with our Notice of Privacy Practices and obtain such acknowledgment from you. However, your receipt of care and treatment from Ronald M. Kirsner, M.D., P.A. is not conditioned upon your providing the written acknowledgement.

Ronald M. Kirsner, M.D., P.A.
9822 Tapestry Park Circle - Unit 206
Jacksonville, FL 32246

Patient Name _____

Acknowledgement of Receipt

I hereby acknowledge that I have received and reviewed a copy of Ronald M. Kirsner, M.D., P.A.'s Notice of Privacy Practices.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient/patient's representative Relationship to patient

Please send a copy of the front of your ***driver's license***. You may simply take a snapshot with your phone and email it along with this form or text it to 904 564-2232.

For Office Use Only

_____
Date Received

_____
Signature

Ronald M. Kirsner, M.D., P.A.
9822 Tapestry Park Circle - Unit 206
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Patient Name _____

HELP ME LEARN MORE ABOUT YOU:

How did you hear about Dr. Kirsner?

Have you ever been treated for or diagnosed with any psychiatric disorders? Y N

ABOUT YOUR FAMILY:

Please list the names and ages (or age at time of death if they have passed away) of: your parents, siblings, spouse or significant other, and your children.

Example: Betty – mother – 72 yo, Steven – brother – 42 yo

Please list any family history of mental health problems, including, but not limited to: depression, bipolar illness, alcoholism, drug addiction, anxiety, schizophrenia, and eating disorders, among others.

Name	Relationship to You	Mental Health Issue

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Patient Name _____

NEW PATIENT MEDICAL HISTORY

GENERAL MEDICAL HISTORY: *Place an **X** next to any illness or condition that you have had or have now.*

AIDS/HIV_____
Anemia_____
Arthritis_____
Asthma_____
Bloody or Tarry Stools _____
Bone Fracture _____
Cancer_____
Chronic Back Pain_____
Chronic Bronchitis_____
Chronic Constipation _____
Chronic Diarrhea_____
Congestive Heart Failure_____
Coronary Artery Disease_____
Crohn's Disease/Colitis_____
Diabetes_____
Diverticulitis_____
Dizzy Spells_____
Eczema_____
Emphysema_____
Fainting Spells_____
Fibromyalgia_____
Gallbladder Disease_____
Glaucoma_____
Gluten Intolerance _____
Gout_____
Headaches_____
Hearing Problems_____
Heartburn_____
Heart Attack_____
Hepatitis _____
Herpes_____
Hiatal Hernia_____
High/Low Blood Pressure_____
High Cholesterol _____
Incontinence_____
Irritable Bowel Syndrome_____
Jaundice_____
Kidney Disease_____
Kidney Stones_____
Lactose Intolerance _____
Lyme Disease_____
Mitral Valve Prolapse_____
Mononucleosis_____
Multiple Sclerosis_____
Narcolepsy_____
Neck Pain_____
Osteoporosis_____
Pancreatitis_____
Parkinson's Disease_____
Peptic Ulcer/Gastritis_____
Peripheral Neuropathy_____
Plastic Surgery_____

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Patient Name _____

Pneumonia_____
Prostate Problems_____
Psoriasis_____
Recurrent Nose Bleeds_____
Restless Leg Syndrome_____
Seasonal Allergies/Hay Fever _____
Seizures_____
Shingles_____
Sinus Problems_____
Sleep Apnea_____
Speech Problems_____
Stroke/TIA_____
Teeth Grinding/TMJ_____
Thyroid Disease_____
Tinnitus_____
Tremor _____
Ulcerative Colitis_____
Tuberculosis_____
Vision Problems_____

Current Height: _____ *Current Weight: _____*

Have you ever had or currently have any other significant illness or condition (circle one)?

Yes No *If yes, please explain:*

Have you ever been knocked out after being hit on the head? (Sports, motor vehicle accident, fight, etc.)

Yes No *If yes, please explain.*

*Are you **ALLERGIC** to any medicines or foods? Yes No (Circle one)*

If so, which ones? What allergic reaction do you have?

Medicine: *Allergic reaction:*

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Have you ever had any surgical procedures or been hospitalized for any other reason (except childbirth)?

Approximate Date *Reason*

*Please list all current **prescription** medications that you are taking.*

Medication Dose Schedule (for example:1 pill in the morning; 2 pills at night; as needed, etc.)

*Please list all **vitamins, herbals, supplements, nutraceuticals, powders, over-the-counter medications, etc.** that you are taking:*

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Patient Name _____

Psychotropic Medications Taken in the Past

If you can recall, have you ever taken any of the following medications? Please check all that apply.

Medication	**Ever taken?**		
Abilify - Aripiprazole	_____	*Xanax – Alprazolam*	_____
Adderall – Amphetamine	_____	*Zoloft – Sertraline*	_____
Ambien – Zolpidem	_____	*Zyprexa - Olanzapine*	_____
Ativan – Lorazepam	_____	*Other*	_____
Atenolol - Tenormin	_____	*Other*	_____
Buspar – Buspirone	_____		
Celexa – Citalopram	_____		
Concerta – Methylphenidate	_____		
Cymbalta – Duloxetine	_____		
Dexedrine -Dextroamphetamine	_____		
Effexor – Venlafaxine	_____		
Elavil- Amitriptyline	_____		
Geodon – Ziprasidone	_____		
Imipramine - Tofranil	_____		
Inderal- Propanolol	_____		
Klonopin – Clonazepam	_____		
Lamictal – Lamotrigine	_____		
Latuda – Lurasidone	_____		
Lexapro – Escitalopram	_____		
Librium - Chlordiazepoxide	_____		
Lithium - Lithium Carbonate	_____		
Lunesta – Eszoplicone	_____		
Paxil - Paroxetine	_____		
Pristiq – Dexvenlafaxine	_____		
Prozac- Fluoxetine	_____		
Remeron – Mirtazapine	_____		
Risperdal-Risperidone	_____		
Ritalin – Methylphenidate	_____		
Seroquel – Quetiapine	_____		
Serzone – Nefazodone	_____		
Sonata – Zaleplon	_____		
Tegretol - Carbamazepine	_____		
Trazodone - Desyrel	_____		
Trintellix – Vortioxetine	_____		
Valium - Diazepam	_____		
Viibryd – Vilazodone	_____		
Vyvanse – Lisdexamfetamine	_____		
Wellbutrin - Bupropion	_____		

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Patient Name _____

FOR WOMEN ONLY:

Age of First Menstrual Period _____

First Day of Last Menstrual Period _____

Are your periods regular? _____

How many times have you been pregnant? _____

How many children were born alive? _____

Do you think you may be pregnant now? _____

Have you ever undergone fertility treatments? Yes No

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Patient Name _____

SOCIAL HISTORY

Please answer the following questions so that I can get to know you better!

1. Where were you born?

2. Where did you grow up?

3. How would you describe your socioeconomic status while you were growing up (underprivileged, middle class (upper/lower), wealthy, etc.)?

4. What is the highest level of education you achieved? What schools have you attended? When did you graduate? What was your major course of study?

5. Are you employed outside of the home? If so, where? What is your job title?

6. What are some of the jobs you might have held in the past?

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Jacksonville, FL 32246

Patient Name _____

7. What is your religion, if any? Are you religious? Do you attend religious services?

8. With whom do you live? Where (single family home, apartment, condominium, etc.)?

9. What are your hobbies? What do you like to do for fun?

10. Whom do you turn to when you need emotional support?

11. What are some of your strengths, talents, and other positive attributes? (C'mon- write 'em down!)
(Please answer this before addressing question #15)

12. Have you ever had any legal problems, either criminal or civil? If yes, please explain.

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13. Have you ever been in the military? If so, when and what branch? What was the highest rank you achieved?

14. Do you currently (Circle, please):

Smoke Cigarettes? Yes No

If yes, how many packs per day? _____

If no, have you ever smoked, and quit in the past? _____

What is the longest period of time that you have ever been smoke-free? _____

Vape? Yes No

If yes, how frequently? _____

Use medical marijuana/THC/CBD? Yes No

Chew tobacco? Yes No

Drink coffee/tea/energy drinks? Yes No

If yes, about how many cups a day? _____

Exercise? Yes No

If yes, about how many times per week? _____

What type? (weight training, cardio, running, walking?)

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15. *Everyone has a characteristic set of strengths and virtues; that is, things they are "good" or "strong" on. They are the characteristics most essential to who we are.*

Place an "x" next to each of the following strengths and virtues that help define you:

_____ ***Creativity (originality, ingenuity):*** *Thinking of novel and productive ways to conceptualize and do things.*

_____ ***Curiosity (interest, novelty-seeking, openness to experience):*** *Taking an interest in an ongoing experience for its own sake; exploring and discovering.*

_____ ***Open-mindedness (judgment, critical thinking):*** *Thinking things through and examining them from all sides; weighing all evidence fairly.*

_____ ***Love of learning:*** *Mastering new skills, topics, and bodies of knowledge, whether on one's own or formally.*

_____ ***Perspective (wisdom):*** *Being able to provide wise counsel to others; having ways of looking at the world that make sense to oneself and to other people.*

_____ ***Bravery (valor):*** *Not shrinking from threat, challenge, difficulty, or pain; acting on convictions even if unpopular.*

_____ ***Persistence (perseverance, industriousness):*** *Finishing what one starts; persisting in a course of action in spite of obstacles.*

_____ ***Integrity (authenticity, honesty):*** *Presenting oneself in a genuine way; taking responsibility for one's feeling and actions.*

_____ ***Vitality (zest, enthusiasm, vigor, energy):*** *Approaching life with excitement and energy; feeling alive and activated.*

_____ ***Love:*** *Valuing close relations with others, in particular those in which sharing and caring are reciprocated.*

_____ ***Kindness (generosity, nurturance, care, compassion, altruistic love, "niceness"):*** *Doing favors and good deeds for others.*

_____ ***Social intelligence (emotional intelligence, personal intelligence):*** *Being aware of the motives and feelings of other people and oneself.*

_____ ***Citizenship (social responsibility, loyalty, teamwork):*** *Working well as a member of a group or team; being loyal to the group.*

_____ ***Fairness:*** *Treating all people the same according to notions of fairness and justice; not letting personal feelings bias decisions about others.*

_____ ***Leadership:*** *Encouraging a group of which one is a member to get things done and at the same time maintain good relations within the group.*

_____ ***Forgiveness and mercy:*** *Forgiving those who have done wrong; accepting the shortcomings of others; giving people a second chance; not being vengeful.*

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_____ ***Humility / Modesty:*** *Letting one's accomplishments speak for themselves; not regarding oneself as more special than one is.*

_____ ***Prudence:*** *Being careful about one's choices; not taking undue risks; not saying or doing things that might later be regretted.*

_____ ***Self-regulation (self-control):*** *Regulating what one feels and does; being disciplined; controlling one's appetites and emotions.*

_____ ***Appreciation of beauty and excellence (awe, wonder, elevation):*** *Appreciating beauty, excellence, and/or skilled performance in various domains of life.*

_____ ***Gratitude:*** *Being aware of and thankful of the good things that happen; taking time to express thanks.*

_____ ***Hope (optimism, future-mindedness, future orientation):*** *Expecting the best in the future and working to achieve it.*

_____ ***Humor (playfulness):*** *Liking to laugh and tease; bringing smiles to other people; seeing the light side.*

_____ ***Spirituality (religiousness, faith, purpose):*** *Having coherent beliefs about the higher purpose, the meaning of life, and the meaning of the universe.*

Anything else you might like to share?

Thank you for your patience!

-Dr. Kirsner