Mosaic Psychiatric Care
Bringing Together the Pieces of You

460 Hillside Ave, Suite C
Needham, MA 02494
781-531-8188
409-213-3005
contact@mosaicpsychiatriccare.com

PATIENT REGISTRATION & MEDICAL HISTORY

Note: If you have been a patient here before, please fill in only the information that has changed.

1. Today's Date:

Legal Name: | Date of Birth:

Preferred Name: | Legal sex (required for legal & insurance reasons): | Preferred Pronouns:

2. Street Address: | Apt./Unit #: | City: | State: | Zip Code:

Social Security #: | Cell Phone:

May I Leave a Message? ○ Yes ○ No

May I Text Reminders? ○ Yes ○ No

E-mail:

May I E-Mail Reminders? ○ Yes ○ No

Please indicate any restrictions re: calls, texts or emails:

3. Gender Identity: | Other:

Sexual orientation: | Other:

INSURANCE INFORMATION

If we do not accept your specific insurance plan for services you may still be able to receive reimbursement for your care by submitting your own claims to your insurance company on your own. We may attempt to assist in the process, but we are unable to submit claims for out of network plans.

4. Party Responsible for Payment: | Relationship: | Phone:

Street Address: | Apt./Unit #: | City: | State: | Zip Code:

5. Primary Insurance Company: | Effective date:

Member ID #: | Copay: $ | Insurance Subscriber Name & DOB (if different from Patient):

Relationship to Patient (Partner, Parent, etc:) | Group/Plan #: | Claims Address: | Apt./Unit #:

City: | State: | Zip Code:

6. Secondary Insurance Company: | Effective date:

Name of Insured: | Policy/Member #: | Copay: $

Subscriber Name/ID #: | Relationship: | Group/Plan #:

Claims Address: | Apt./Unit #: | City: | State: | Zip Code:

7. **Please upload clear image(s) of the front and back of your insurance card(s), (if you have an insurance plan the provider is in-network with).**

EMERGENCY CONTACT

8. **If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?**

Emergency Contact: | Relationship:

Home Phone: | Cell Phone: | Work Phone:

9. **In a few words, why are you requesting an appointment with a psychiatric nurse practitioner at this time?**

_____

_____

_____

_____

MEDICAL & REFERRAL INFORMATION

10. Name of Physician/Primary Care Provider: Phone:

_____ _____

Name of Therapist/Counselor: Phone:

_____ _____

By Whom Were You Referred? Relationship:

_____ _____

May I have your permission to thank this person for the referral?

○ Yes ○ No

YOUR MEDICAL HISTORY

11. **Please check all that apply:**

- ☐ Anemia
- ☐ Arthritis/Joint Pain
- ☐ Asthma
- ☐ Abnormal blood clotting
- ☐ COPD
- ☐ Cancer
- ☐ Chemotherapy History
- ☐ Cataracts
- ☐ Diabetes
- ☐ Elevated Cholesterol
- ☐ Fainting or blackout spells
- ☐ Frequent bladder infections
- ☐ Glaucoma
- ☐ Head injury/trauma
- ☐ Heart disease
- ☐ Heart attack
- ☐ Heart valve problems
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome/Colitis
- ☐ Cirrhosis
- ☐ Hepatitis (A, B, C)
- ☐ Loss of Consciousness
- ☐ Migraines/other headaches
- ☐ Obesity
- ☐ Periods of lost memory
- ☐ Prostate problem
- ☐ PMS
- ☐ Seizures
- ☐ Sexually transmitted infection
- ☐ Stroke
- ☐ Thyroid problem
- ☐ Tuberculosis
- ☐ Ulcers (stomach/intestine)

12. **Any ongoing health problems not listed above?**

○ Yes ○ No

If yes, please explain:

_____

13. Do you experience chronic pain?

○ Yes ○ No

If YES, how managed (PT, Rx, pain management clinic, yoga, acupuncture etc)?

_____

14. Operations and/or Hospitalizations for MEDICAL REASONS: (Please list surgeries and/or hospitalization reasons and dates)

	Surgery/Hospitalization	Reason	Dates
1			
2			
3			

15. When was your last complete physical exam including basic blood/lab work?

_____

CURRENT MEDICATIONS

16. Please list ALL your current medications, vitamins, & herbal supplements (or supply printed list).

	Medication Name	Dosage	Time of the Day Taken	Reason for Taking	Prescriber Name
1					
2					
3					

17. Current Medications (Printed List):

18. MEDICATION ALLERGIES/REACTIONS: Do you have allergies to any medications?

○ Yes ○ No

If yes, please list:

_____

19. OTHER ALLERGIES (Food/Environment):

○ Yes ○ No

If yes, please list:

_____

PAST PSYCHIATRIC MEDICATION

20. Please list all the past psychiatric medications you have tried. Include all medications for anxiety, depression, sleep, chronic pain management, and seizure disorder meds as many of these medications can have multiple uses. Please also include the last dosages you were prescribed, and side effects you experienced, and the length of time you took the medication.

	Medication Name	Last Dosage	Side Effects	Length of Use
1				
2				
3				

YOUR MENTAL HEALTH HISTORY

Below is a listing of common mental health symptoms. Please check all that apply to you currently or in your past.

21. DEPRESSION: In the past 2 weeks, have you been bothered by: **If feeling unsafe, please pause this survey and call 911

Frequency	None of the days	Several days	More than half the days	Nearly every day
Depressed mood				
Loss of interest				
Change in energy level				
Change in appetite				
Change in sleep				
Difficulty concentrating				
Feeling restless or sluggish				
Feeling bad about myself				
Thoughts of harming self, or not wanting to live				

When did depression begin? What makes it worse? What helps you cope with depression?

_____

22. ANXIETY: In the past 2 weeks, have you been bothered by:

	None of the days	Several days	More than half the days	Nearly every day
Feeling anxious				
Difficulty controlling worry				
Difficulty relaxing				
Worrying too much about different things				
Restlessness				
Irritability				
Feeling afraid as though something awful might happen				

When did anxiety begin? What makes it worse? What helps you cope with anxiety?

_____

23. Physical symptoms of anxiety:

- ☐ Fatigue
- ☐ Muscle tension or muscle aches
- ☐ Trembling, feeling twitchy
- ☐ Being easily startled

24. PTSD: Have you ever experienced any of the following, typically after witnessing or experiencing trauma? (Please keep in mind, there are different types of trauma, including subtle, sudden, ongoing, etc.)

- ☐ Hypervigilance: feeling "on edge" constantly for no known reason, having a heightened or exaggerated startle response.
- ☐ Avoidance: intentionally avoiding people or activities to limit triggering events
- ☐ Flashbacks/Nightmares of past painful experiences or reoccurring dreams with themes of being attacked, chased, falling, etc
- ☐ I believe I may have PTSD

25. BIPOLAR/MOOD DYSREGULATION: Have you ever experienced a distinct period (lasting most of the day, for at least 3-4 consecutive days) characterized by unusually elevated, expansive or irritable mood, increased energy, and:

- ☐ Inflated self-esteem or grandiosity
- ☐ Decreased need for sleep (e.g., feels rested after 3 hours of sleep.)
- ☐ More talkative than usual or pressure to keep talking.
- ☐ Flights of ideas or subjective experience that thoughts are racing.
- ☐ Increase in goal directed activity, or psychomotor agitation.
- ☐ Distractibility (too easily drawn to unimportant or irrelevant external stimuli).
- ☐ Excessive involvement in activities that have a high likelihood of negative consequences. (e.g., extravagant shopping, sexual adventures or improbable commercial schemes)
- ☐ There was a change in how I usually function
- ☐ I have been diagnosed with bipolar disorder in the past

26. ENERGY: My energy level is currently:

○ low ○ increased ○ normal

27. APPETITE: My appetite is currently:

○ low ○ increased ○ normal

28. SLEEP: I typically:

- ☐ Am able to fall & stay asleep most evenings without difficulty
- ☐ Require more than 8 hours to feel ok
- ☐ Experience difficulty Falling Asleep
- ☐ Experience difficulty staying asleep
- ☐ Experience early AM awakening
- ☐ Have frequent nightmares or night terrors

29. INATTENTION: The following symptoms have had negative consequences since a young age, and continue to affect my functioning:

- ☐ Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities
- ☐ Often have trouble holding attention on tasks or play activities.
- ☐ Often does not seem to listen when spoken to directly.
- ☐ Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked)
- ☐ Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked)
- ☐ Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
- ☐ Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones)
- ☐ Is often easily distracted
- ☐ Is often forgetful in daily activities.
- ☐ I believe I may have ADD/ ADHD
- ☐ I have been diagnosed with ADD/ ADHD in the past

30. HYPERACTIVITY/IMPULSIVITY: The following symptoms have had negative consequences since a young age, and continue to negatively affect my functioning:

- ☐ Often fidgets with or taps hands or feet, or squirms in seat
- ☐ Often leaves seat in situations when remaining seated is expected
- ☐ Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless)
- ☐ Often unable to play or take part in leisure activities quietly
- ☐ Is often “on the go” acting as if “driven by a motor”
- ☐ Often talks excessively
- ☐ Often blurts out an answer before a question has been completed
- ☐ Often has trouble waiting his/her turn
- ☐ Often interrupts or intrudes on others (e.g., butts into conversations or games)

31. COPING SKILLS: How would you rate your ability to cope with daily life stressors?

- ○ Good – I do not get easily distressed by minor life stresses
- ○ Fair – I have some ability to cope with stress most of the time, but occasionally I feel I react more negatively than someone else would in my situation. During these times I may try to cope by using negative or destructive means such as self-medicating (food, alcohol, drugs or self-harming behaviors).
- ○ Poor – I get overwhelmed easily and make poor choices when I am stressed such as using drugs or alcohol, spending money I do not have to feel good, promiscuous or dangerous sexual behaviors, or self-mutilation or harm.

32. PSYCHOSIS: Have you ever experienced any of the following?

- ☐ Hallucinations: hearing, seeing, or feeling (touch) things others said were not real
- ☐ Delusions: beliefs that others told you were “wrong” or “not true” even though it felt true to you. (ex. Believing that you could fly or that someone was out to hurt you or that you were being watched)
- ☐ Ideas of Reference: have you ever believed that seemingly normal or common occurrences had a special secret meaning meant only for you? (ex. Songs playing on the radio, commercials on TV, finding a particular object in a certain place)
- ☐ I believe I may have a thought disorder (schizophrenia, schizoaffective)
- ☐ I have been diagnosed with a thought disorder (schizophrenia, schizoaffective) in the past

33. SUICIDAL IDEATION: Do you have any history of self harm or suicide attempt?

○ Yes ○ No

34. HOMICIDAL IDEATION/VIOLENCE: Have you ever intentionally physically harmed another person or animal?

○ Yes ○ No

35. HOMICIDAL IDEATION/VIOLENCE: Have you ever been convicted of harming another person or animal (including but not limited to assault, battery, domestic violence, child or elder abuse/ neglect, animal abuse/ neglect, manslaughter, murder)?

○ Yes ○ No

PSYCHIATRIC HISTORY

36. CURRENT PROVIDERS: Are you currently under the care of a health care professional (therapist, psychiatrist or working with a primary care provider) regarding mental health needs?

○ Yes ○ No

37. If so please list their name, office location, and phone number in the space below.

	Name	Office Location	Phone Number
1			
2			
3			

38. PAST PROVIDERS: Have you previously been under the care of a health care professional for your mental health needs?

○ Yes ○ No

39. If so please list their name, office location, and phone number in the space below.

	Name	Office Location	Phone Number
1			
2			
3			

40. PSYCHIATRIC HOSPITALIZATION: Have you ever been treated in an inpatient psychiatric facility (voluntary or involuntary), residential treatment program for mental health or substance abuse issues, or participated in an intensive outpatient program or partial hospitalization program?

○ Yes ○ No

41. If so please list their facility name, office location, and phone number in the space below.

	Facility Name	Office Location	Phone Number
1			
2			
3			

DRUG AND ALCOHOL USE AND ABUSE HISTORY

42. Have you ever used any of the following? Check all that apply.

- ☐ Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
- ☐ Alcoholic beverages (beer, wine, spirits, etc.)
- ☐ Cannabis (marijuana, pot, grass, hash, etc.)
- ☐ Amphetamine type stimulants (Adderall, Ritalin, etc.)
- ☐ Cocaine (coke, crack, etc.)
- ☐ Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
- ☐ Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
- ☐ Inhalants (nitrous, glue, petrol, paint thinner, etc.)
- ☐ Opioids (heroin, morphine, methadone, codeine, etc.)
- ☐ Other

If other, specify:

_____

43. In the past three months, how often have you used the substances you mentioned?

	Daily	Weekly	Once a Month	Once or Twice in 3 Months	Never
Tobacco products (cigarettes, chewing tobacco, cigars, etc.)					
Alcoholic beverages (beer, wine, spirits, etc.)					
Cannabis (marijuana, pot, grass, hash, etc.)					
Amphetamine type stimulants (Adderall, Ritalin, etc.)					
Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)					
Cocaine (coke, crack, etc.)					
Inhalants (nitrous, glue, petrol, paint thinner, etc.)					
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)					
Opioids (heroin, morphine, methadone, codeine, etc.)					
Other					

If other, specify:

FAMILY MEDICAL HISTORY

(Parent, grandparent, sibling, children, aunt/uncle)

44.

	Check if YES	If yes, who?
Anemia		
Arthritis/Joint Pain		
Abnormal blood clotting		
Cancer		
Chemotherapy history		
Cataracts		
Diabetes		
Elevated Cholesterol		
Fainting or blackout spells		
Frequent bladder infections		
Glaucoma		
Heart Disease		
Heart Attack		
Heart Valve problems		
High Blood Pressure		
HIV/AIDS		
Obesity		
Memory problem		
Prostate problem		
Seizures		
Stroke		
Thyroid problem		
Tuberculosis		
Ulcers (stomach/intestine)		

45. Any ongoing health problems not listed above?

○ Yes ○ No

If yes, please explain:

_____

46. If Yes, please indicate relation, condition, treatments, & medications.

	Condition	Treatments	Medications
Mother			
Father			
Sibling(s)			
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Unknown/Adopted			

FAMILY MENTAL HEALTH HISTORY

47. Has anyone in your family ever been diagnosed with a mental illness, had a psychiatric hospitalization or suicide attempt, or struggled with drugs or alcohol?

○ Yes ○ No

HISTORY OF ABUSE/TRAUMA

48. Have you witnessed or experienced emotional, physical, or sexual abuse as a child?

○ Yes ○ No

49. Have you witnessed or experienced emotional, physical, or sexual abuse as an adult?

○ Yes ○ No

50. If yes to either, do you still have contact with the abuser?

○ Yes ○ No

51. Have you been involved in a serious situation, accident, or natural/manmade disaster that has caused you significant distress?

○ Yes ○ No

52. Are you actively enlisted or formerly enlisted in the military, and have experienced combat?

○ Yes ○ No

53. Does your employment or career involve you being in situations where your life may be compromised or you have been exposed to traumatic events (including but not limited to police/fire/ems worker/emergency department/security personnel)

○ Yes ○ No

54. Legal: If not already stated above

Have you ever been arrested, charged with or convicted of a felony or misdemeanor?
○ Yes ○ No

Are you currently on probation or parole?
○ Yes ○ No

Are legally required to attend mental health treatment as a condition of an early release or controlled release program or in lieu of jail time?
○ Yes ○ No

PREVENTION & SAFETY

55. Do you wear your seatbelt?

○ Yes ○ No

56. Wear a biking helmet?

○ Yes ○ No

57. Are Firearms kept in your home?

○ Yes ○ No

58. Are other weapons kept in your home? [Including but not limited to hunting equipment, crossbows, knives (outside of kitchen cutlery), swords]

○ Yes ○ No

59. Vaccinations: Have you received all standard vaccinations for someone your age?

○ Yes ○ No

60. Sexual Partner(s) last 12 months:

☐ Men ☐ Women ☐ Transgender
☐ None/abstinent ☐ Prefer not to answer

Number of partners:

_____

61. ACTIVITY (check one):

- ○ Sedentary life with little exercise
- ○ Occasional vigorous activity with work or
- ○ Mild Exercise with job, house, or recreation (climb stairs, walk over 3 blocks, etc)
- ○ Regular vigorous exercise program or hard work

62. Do you have an advanced health directive, such as a "do not resuscitate" or Medical/financial Power of Attorney?

- ○ Yes
- ○ No

Location:

_____

I verify that the above information is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my provider of any changes in my medical status.

63. Please upload an image of a state issued photo ID.

64. Please upload clear image(s) of the front and back of a credit card belonging to the party responsible for payment, named above.

Patient/Guardian signature

_____ _____

Signature Date

THE REMAINDER OF THIS PAGE IS FOR INTERNAL USE ONLY

65. New Patient Paperwork Chain of Custody

Paperwork Received on: Reviewed by Intake on: Referred to Provider for acceptance on:

_____ _____ _____

Accepting Provider:

_____

Provider Signature

_____

Signature

66. Received back to Intake on: _____ Patient contacted regarding acceptance on: _____ ☐ Contact Made ☐ Voicemail Left

Initial Appointment Offered:
☐ Patient Declined ☐ Patient Accepted

Policies and Procedures Reviewed with Patient: _____

Initial Appointment Date Scheduled for: _____ All paperwork must be uploader to HER prior to patient's first appointment _____

Initial Appointment:
☐ Completed ☐ Rescheduled ☐ Patient No Showed

67. _____