Richard Born, Ph.D. LLC
Applied Psychological Health

•PATIENT INFORMATION•

Patient Name: _____ Gender: ☐ M ☐ F Date of Birth: _____

Address: _____
Street City State Zip Code

Billing Address if different from above:

_____
Street City State Zip Code

Marital Status: ☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Telephone: Home: _____
Work: _____
Cell: _____
Email: _____

Is it OK to call and leave messages at these numbers? ☐ Yes ☐ No

Responsible party (if patient is a minor): _____

•PRIMARY INSURANCE INFORMATION•

Policy Holder Name: _____ Gender: ☐ M ☐ F Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Telephone: Home: _____ Work: _____ Cell: _____

INSURANCE COMPANY: _____

Phone No.: _____

Member ID#:_____Group #: _____

•SECONDARY INSURANCE INFORMATION•

Policy Holder Name: _____ Gender: ☐ M ☐ F Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Telephone: Home: _____ Work: _____ Cell: _____

INSURANCE COMPANY: _____

Phone No.: _____

Policy #:_____ Group #: _____

The office of Richard Born, Ph.D. LLC will bill your insurance carrier directly for all services. Your signature expresses your agreement that the dates of service, services rendered, and the diagnosis will be provided with the insurance claim as necessary to process the claim. The records that are associated with your care are private, but if you use your insurance these records may also be requested by and released to the insurance carrier. Your signature expresses your consent for releasing these records. Your signature also indicates that you understand and agree that you are liable for payment of any services not covered by your insurance company.

Signature: _____ Date: _____

Richard Born, Ph.D. LLC
One Huntington Road #205 Phone: (706) 543-7605
Athens, Georgia 30606 Fax: (706) 543-2397
Applied Psychological Health

New Patient Information Sheet – General

YOUR NAME: _____ **DATE:** _____

PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING YOURSELF:

Who referred you to our practice? _____
_____

Who is your primary physician? _____
Address: _____
Telephone: _____

What medications are you taking:

Name of Medication	Date Started	Dosage	Prescribed by

Please list any over-the-counter medications, herbs, or other supplements you take:

_____
_____

Do you have any allergies to medications? _____Yes _____No
Please list any allergies you have: _____

Have you ever been to a counselor, psychologist, or psychiatrist, or been admitted to a psychiatric hospital?

Yes _____ No _____ If "Yes", please list who you saw, when, and for what purpose.

_____

_____

What is your occupation? _____

If you are a student, where do you attend school? _____

What level of formal education have you reached? _____

Do you have children? _____Yes _____No. If "Yes", please list their names and ages:

_____

_____

Other people living in your home: _____

_____

Whom can we contact in case of emergency? _____

Relationship _____ Phone: _____

If we need to call you, can we leave a message? Yes _____ No _____

Do you smoke cigarettes? Yes _____ No _____ Use other tobacco products? Yes _____ No _____
Do you use alcohol? Yes _____ No _____ Use other psychoactive drugs? Yes _____ No _____
What do you estimate your average caffeine intake is? _____

Have you ever been in trouble with the law? _____Yes _____No
Are you presently involved in any litigation? _____Yes _____No

Please List any health problems you have: _____

_____

_____H

Have any of your family members experienced emotional problems? _____Yes _____No
If "Yes", who and what type of problem? _____
_____

_____

What is the reason for your current appointment here? _____

_____

What would you like to accomplish from your appointment or treatment here? _____

_____

Please list any specific questions you have for us:
_____

_____

Thank you for taking the time to complete this form. It helps us make the best use of our session time.

Richard Born, Ph.D. LLC
One Huntington Road, #205
Athens, Georgia 30606
Phone: 706.543.7605
FAX: 706.543.2397

NEW CLIENT INFORMATION AND RESPONSIBILITY INFORMATION
This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your practitioner or the office manager about these or any other matters. We are here to assist you.

FOR YOUR FIRST APPOINTMENT, PLEASE ARRIVE FIVE MINUTES EARLY SO THAT YOUR CHART CAN BE MADE AND WE CAN COLLECT ANY ADDITIONAL INFORMATION IF NEEDED. PLEASE HAVE THE ENCLOSED PAPERWORK COMPLETED WHEN YOU ARRIVE AND BRING YOUR INSURANCE CARD WITH YOU. THE CLINICIANS KEEP A TIGHT SCHEDULE AND WILL USUALLY START YOUR APPOINTMENT ON TIME.

OFFICE HOURS
Office hours may vary but are usually Monday - Thursday 10:00 - 6:00 and we are typically available during these times. If you need to contact us and no one is available to take your call, please leave a voice mail on the office phone and we will return your call as soon as possible. The first priority and our primary concern is your well-being.

EMERGENCY INFORMATION - If You Are in an Acute Crisis
- Call Behavioral Health Link/GCAL: 800-715-4225 or other 24 hour crisis hotline in your area
- Call the Advantage Behavioral Health Crisis Center direct line: **706.583.7307** located at 240 Mitchell Bridge Road in Athens. This is a Walk-in Center open 24/7 that provides Temporary Observation and Crisis Stabilization Services
- Call 911especially if medical emergency

APPOINTMENTS:
Appointments are most commonly scheduled via telephone or following a session. Initial interview, treatment, and biofeedback sessions typically run 50 - 60 minutes in length.

MISSED APPOINTMENTS:
Except in the case of an acute emergency, we require a 24-hour notice of any cancellation. Otherwise, your account will be subject to a fee. The current charge for a late canceled or missed session is $50.00. You are financially responsible for this charge since any insurance coverage will not apply. If our office is closed or we are not at the phone when you need to cancel an appointment, please leave a voice mail. Please let us know of a need to cancel or reschedule an appointment as soon as possible, since there are other patients who are on a 'call' list. _____ Initial

FEES:
Arrangements for payment of fees for professional services need to be made prior to or at the time of the first visit. We will file for payment through your insurance company whenever possible. When we file for insurance payment, it is still your responsibility to pay any deductible and co-payment amounts. It is important that you also understand that you are ultimately responsible for payment of the fees in the event that insurance doesn't pay.

_____ Initial

ASSESSMENT AND/OR TESTING:
Testing is billed on the basis of the type of test and the amount of time necessary to administer, score, analyze, interpret, and to report the results in written form. You will be provided with the type of test and the cost prior to testing. If during the evaluation process it is discovered that additional testing is required to make a final diagnosis, you will be informed before any additional procedures are initiated. In certain situations there may be additional fees for test scoring services and comprehensive report writing.

COMPLETION OF FORMS AND ADDITIONAL REPORTS:
Occasionally, situations may come up in which a patient requests that the psychologist complete additional forms, write letters, or develop additional reports, (ie. disability forms, reports to schools, employers, or insurance companies). The fees for completion of reports or development of reports or letters are billed on the basis of a pro-rated charge of $130.00 per hour, with a minimum charge of $25.00.

PLEASE READ THE FOLLOWING STATEMENT AND SIGN THE ACKNOWLEDGEMENT:

CONFIDENTIALITY and PRIVACY OF INFORMATION
The Confidentiality and Privacy of information regarding you and your treatment with my practice is very important. There are laws and legislation that govern this topic that we must abide by. Information regarding your assessment and treatment here is confidential and private and can only be shared with your explicit authorization.

I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

(1) When abuse or harmful neglect of children, the elderly, or disabled or incompetent individual is known or reasonably suspected

(2) When an immediate threat of physical violence against a readily identifiable victim is disclosed to the psychologist

(3) When the patient is perceived as being in danger of harming themselves by suicidal behavior

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:
I hereby voluntarily apply for and consent to psychological services. This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent. I understand that the potential benefits of undergoing psychological services may include obtaining a professional opinion, reduction of my psychological symptoms, and an increased understanding of myself. I understand that potential risks may include predictive validity of psychological assessment (when applicable), possible disagreement with the opinions offered to me, and possible emotional distress when addressing my situation. I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with the progress of my treatment.

By signing below, I acknowledge that I have read and accept the above information regarding professional services rendered.

_____
PRINTED NAME OF PATIENT/person responsible for payment

_____
SIGNATURE OF PATIENT/person responsible for payment

_____
DATE

SYMPTOM CHECKLIST

Richard Born Ph.D. LLC
One Huntington Rd. #205
Athens, GA 30606 Applied

Phone: 706.543.7605
FAX: 706.543.2397

NAME: _____ AGE: _____ DATE: _____

The following questions are meant to help your therapist determine the types of difficulties you are experiencing. Please check the boxes to the right of each "problem" which you have experienced in the last month. If you have not experienced a problem listed, check the "None" box. Thanks!

F32.XX	**NONE**	**MINIMAL**	**MODERATE**	**SEVERE**
Depressed Mood	☐	☐	☐	☐
Loss of self-esteem	☐	☐	☐	☐
Loss of interest or pleasure	☐	☐	☐	☐
Decreased appetite	☐	☐	☐	☐
Feeling slowed down	☐	☐	☐	☐
Loss of energy	☐	☐	☐	☐
Feeling guilty or worthless	☐	☐	☐	☐
Difficulty concentrating	☐	☐	☐	☐
Recurrent thoughts of death or dying	☐	☐	☐	☐
Thoughts of harming oneself	☐	☐	☐	☐
Suicide plans	☐	☐	☐	☐

F31.XX	**None**	**Minimal**	**Moderate**	**Severe**
Feeling on top of the world with no reason	☐	☐	☐	☐
Decreased need for sleep	☐	☐	☐	☐
Being more talkative than usual	☐	☐	☐	☐
Having racing thoughts	☐	☐	☐	☐
Feeling speeded up	☐	☐	☐	☐
Overspending, being sexually overactive, driving too fast. etc.	☐	☐	☐	☐

Brief "attacks" in which any of the following occur (circle which do)– shortness of breath, choking feeling, dizziness, rapid heart beat, trembling, sweating, nausea, or abdominal distress, feelings of unreality, chest pains, overwhelming feelings of doom or imminent death, fear of going crazy or losing control	☐	☐	☐	☐

41.1				
Unrealistic or excessive anxiety and worry about things in your life	☐	☐	☐	☐
Tension, restlessness and fatigue	☐	☐	☐	☐
Feeling keyed up and on edge	☐	☐	☐	☐
Can't sleep	☐	☐	☐	☐
Mind going blank because of anxiety	☐	☐	☐	☐
Irritability	☐	☐	☐	☐

F42	**None**	**Minimal**	**Moderate**	**Severe**
Persistent thoughts that you can't get out of your mind.....	☐	☐	☐	☐
Having problems of hoarding, excessive fears of being exposed to germs, washing hands over and over	☐	☐	☐	☐
F10.XX				
Using a larger amount of a drug or alcohol than intended.....	☐	☐	☐	☐
Using drugs or alcohol despite arguments from spouse, family and/or friends to stop	☐	☐	☐	☐
F50.X				
Overeating, vomiting or abusing laxatives	☐	☐	☐	☐
Loss of more than 25 pounds in the past year	☐	☐	☐	☐
Using food to comfort oneself when sad, angry, anxious	☐	☐	☐	☐
F90.2				
Difficulty in sitting still, not fidgeting	☐	☐	☐	☐
Being easily distracted	☐	☐	☐	☐
Difficulty sustaining attention	☐	☐	☐	☐
Acting without thinking, being impulsive	☐	☐	☐	☐
Currently being physically abused	☐	☐	☐	☐
Having an outside force control my thoughts	☐	☐	☐	☐
Hearing a voice when no one is around	☐	☐	☐	☐
Knowing special secrets known by no one else	☐	☐	☐	☐
Having someone read my mind or tamper with my thoughts.	☐	☐	☐	☐
Being able to control the thoughts of others	☐	☐	☐	☐
Feeling detached from my mind or body	☐	☐	☐	☐
Feeling like in a trance or dream state	☐	☐	☐	☐
Memory lapses or altered states of consciousness unrelated to drug or alcohol use	☐	☐	☐	☐
Having trouble controlling anger	☐	☐	☐	☐
Having thoughts of harming other people or property	☐	☐	☐	☐
Difficulty relating to boy or girlfriend, spouse, or romantic Difficulty relating to friends	☐	☐	☐	☐
Difficulty relating to parents, siblings, family	☐	☐	☐	☐

Has there been some event that has happened in the past three months from which most of your problems result? ☐ Yes ☐ No

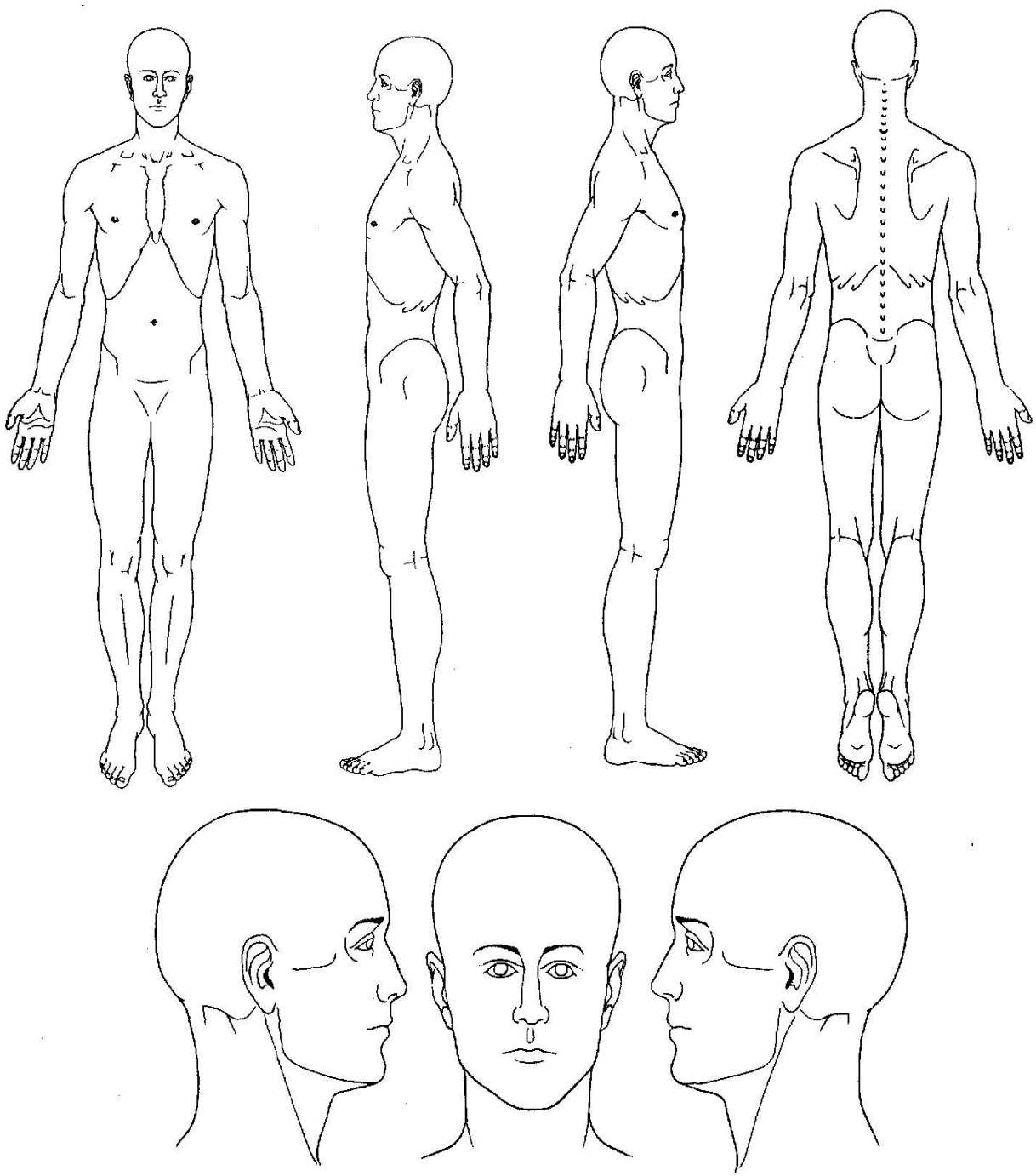
If there are other problems you are experiencing that aren't listed, please give a brief description below:

_____

Name: _____ Date: _____

Pain Diagram

At this time, where is your pain?
Please mark on the drawings the area where you feel pain:



PAIN INVENTORY

Applied Psychological Health
Richard Born, Ph.D. LLC
One Huntington Rd. #205
Athens, Georgia 30606
tel 706.543.7605 Fax 706.543.2397

Date: _____

Name: _____

Pain Location: _____

1.Please rate your pain by circling the one number that best describes your pain at its **worst** during the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain Ever/ Unbearable

2.Please rate your pain by circling the one number that best describes your pain at its **least** during the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain Ever/ Unbearable

3.Please rate your pain by circling the one number that best describes your pain **on average**.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain Ever/ Unbearable

4.Please rate your pain by circling the one number that best describes your pain **right now**.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain

Put a check beside things that make your pain feel better:

- O Prescription Medication
- O Non-prescription Medication
- O Rest/Lying Down
- O Massage
- O Use of Heat or Ice
- O Sleep
- O Other _____
- o Stretching
- o Exercise
- o Relaxation Exercise
- o Warm bath/shower
- o Pain Injections
- o Chiropractic Care
- o Getting Mind of of Pain
- o Work on Hobby
- o Watch TV/Listen to Music
- o Talking with Someone
- o Getting in a 'just right' position
- o Walk

Put a check beside things make your pain feel worse:

- O Sitting longer than 15 minutes
- O Sitting longer than 30 minutes
- O Standing longer than 15 minutes
- O Standing longer than 30 minutes
- O Lying down longer than 15 minutes
- O Lying down longer than 30 minutes
- O Other _____
- O Stress/Worry
- O Stretching Exercise
- O Driving
- O Walking
- O Bending over
- O Any physical exercise
- O Hot or Cold temperatures
- O Feeling tired/fatigued
- O Riding in Car
- O Weather change
- O Lifting
- O Time of day (specify _____)

On average for the past few days, how many hours per day (from 8 am - 8 pm) do you spend either laying down or sitting due to your pain? _____

Thank you for completing this form!

McGill Pain Questionnaire - Short Form Richard Born, Ph.D. LLC 1-2021

DIRECTIONS: Please read each word below, and decide whether it describes what your pain has felt like over the PAST 4 WEEKS. If a word *does not* describe your pain, circle NO (DOES NOT APPLY), and go on to the next item. If a word *does* describe your pain, then rate how strongly you have felt that sensation (1=Mild, 2=Moderate, 3=Severe). Remember, make these ratings as to how your pain has felt over the PAST 4 WEEKS.

My pain felt like it was . . .	*DOES NOT* APPLY	MILD	MODERATE	SEVERE
THROBBING ….....	NO	1	2	3
SHOOTING ….....	NO	1	2	3
STABBING ….....	NO	1	2	3
SHARP ….....	NO	1	2	3
CRAMPING ….....	NO	1	2	3
GNAWING ….....	NO	1	2	3
HOT - BURNING ….....	NO	1	2	3
ACHING ….....	NO	1	2	3
HEAVY ….....	NO	1	2	3
TENDER ….....	NO	1	2	3
SPLITTING ….....	NO	1	2	3
TIRING - EXHAUSTING ….....	NO	1	2	3
SICKENING ….....	NO	1	2	3
FEARFUL ….....	NO	1	2	3
PUNISHING - CRUEL ….....	NO	1	2	3

Please circle the number which describes your level of pain ***right now***:

0	1	2	3	4	5	6	7	8	9	10
NO PAIN				MODERATE PAIN					WORST POSSIBLE PAIN	

Please circle the number which describes your ***typical*** *level* of pain:

0	1	2	3	4	5	6	7	8	9	10
NO PAIN				MODERATE PAIN					WORST POSSIBLE PAIN	

Please check the word that best describes your pain right now:

_____ NO PAIN
_____ MILD
_____ DISCOMFORTING
_____ DISTRESSING
_____ HORRIBLE
_____ EXCRUCIATING