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 PhD LLC
One Huntington Rd #205
Athens, Georgia 30606

INFORMATION, AUTHORIZATION, & CONSENT TO TELEMENTAL HEALTH

"TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. . . . " (Excerpt from Georgia Code 135-11-.01)

The Different Forms of Technology-Assisted Media Explained

Video Conferencing (VC)

Video Conferencing is a preferred option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. I use a secure site named Doxy.me. This VC platform is encrypted to the federal standard (HIPAA compatible) and thus assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, I will give you detailed directions regarding how to log-in securely.

Landline Telephones and Cell phones:

Landline and cell telephones are not completely secure and confidential. It is possible that someone could overhear your conversation or see your telephone bill. Individuals who have access to your cell phone may be able to see who you have talked to, who initiated that call, how long the call was, and where each party was located. However, most people have and utilize a cell phone. I may also use a cell phone to contact you. I do not keep your phone number in my phone.

Text Messaging and Email:

Many people prefer to use these methods to communicate because they are convenient for conveying information. However, they are not private and risk compromising confidentiality. I recommend that you refrain from communicating therapeutic content or clinical information via these means to prevent compromising your confidentiality. They may be used for appointment scheduling.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

I do not use social media to provide TeleMental Health services . It is my policy not to accept "friend" or "connection" requests from any current or former patients on my personal social networking sites because it may compromise your confidentiality and blur the boundaries of our relationship.

Confidentiality & TeleMental Health

Just like in-person visits, the Confidentiality and Privacy of Information concerning you and your TeleMental Health visits is of primary importance. It is your responsibility to ensure that you are using secure technology and are at a secure location for the interaction. All of your interactions with me are considered privileged and confidential. Information regarding your evaluation and treatment here can be released only with your explicit authorization. The only exception is in situations where information is shared regarding potential child or elder abuse, in which cases I am legally obligated to file a report with DFCS. If you do wish to authorize release of information regarding your care here, you can complete the Authorization for Release of Information form found on the Patient Forms page of my website: https://appliedpsychhealth.com.

Communication with the Office

Judy is at the front desk from 12 pm till 5 pm Monday – Thursday. If you are not able to reach us you can leave a voicemail and we will return your call within 24 hours. After hours, on weekends, and during Holiday breaks all phone calls coming to the office number go into voicemail that I monitor. Unless there is a critical need, I may not respond to voicemails, texts, or emails until the next work day.

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- 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 911.
- Go to the emergency room of your choice. In Athens this is either St. Mary's Hospital, 1230 Baxter St. or Piedmont Athens Regional Hospital, 1199 Prince Avenue in Athens.

Emergency Procedures Specific to TeleMental Health Services

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and TeleMental Health services are not appropriate.
- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP here Name: _____Phone: _____

- You agree to inform me of your location at the beginning of every TeleMental Health session.

In Case of Technology Failure

In the event that the TeleMental Health session is interrupted due to technological problems, efforts will be made to restart the connection. The secondary option would be to use telephone.

Structure and Cost ofSessions

The structure and cost of TeleMental Health sessions are the same as face-to-face sessions described in my general "Information, Authorization, and Consent to Treatment" form. I may require a credit card ahead of time for TeleMental Health therapy for ease of billing. Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, most insurance companies currently cover TeleMental Health services at the same rate as in person services.

Cancellation Policy

In the event that you are unable to keep either a TeleMental Health appointment, we ask that you notify us at least 24 hours in advance. If such advance notice is not received, you may be subject to a $50.00 late cancellation fee. Please note that insurance companies do not reimburse for missed sessions.

Consent to TeleMental Health Services

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing me to utilize the TeleMental Health methods discussed.

_____
Patient (Please Print)

_____ Date: _____
Patient Signature

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

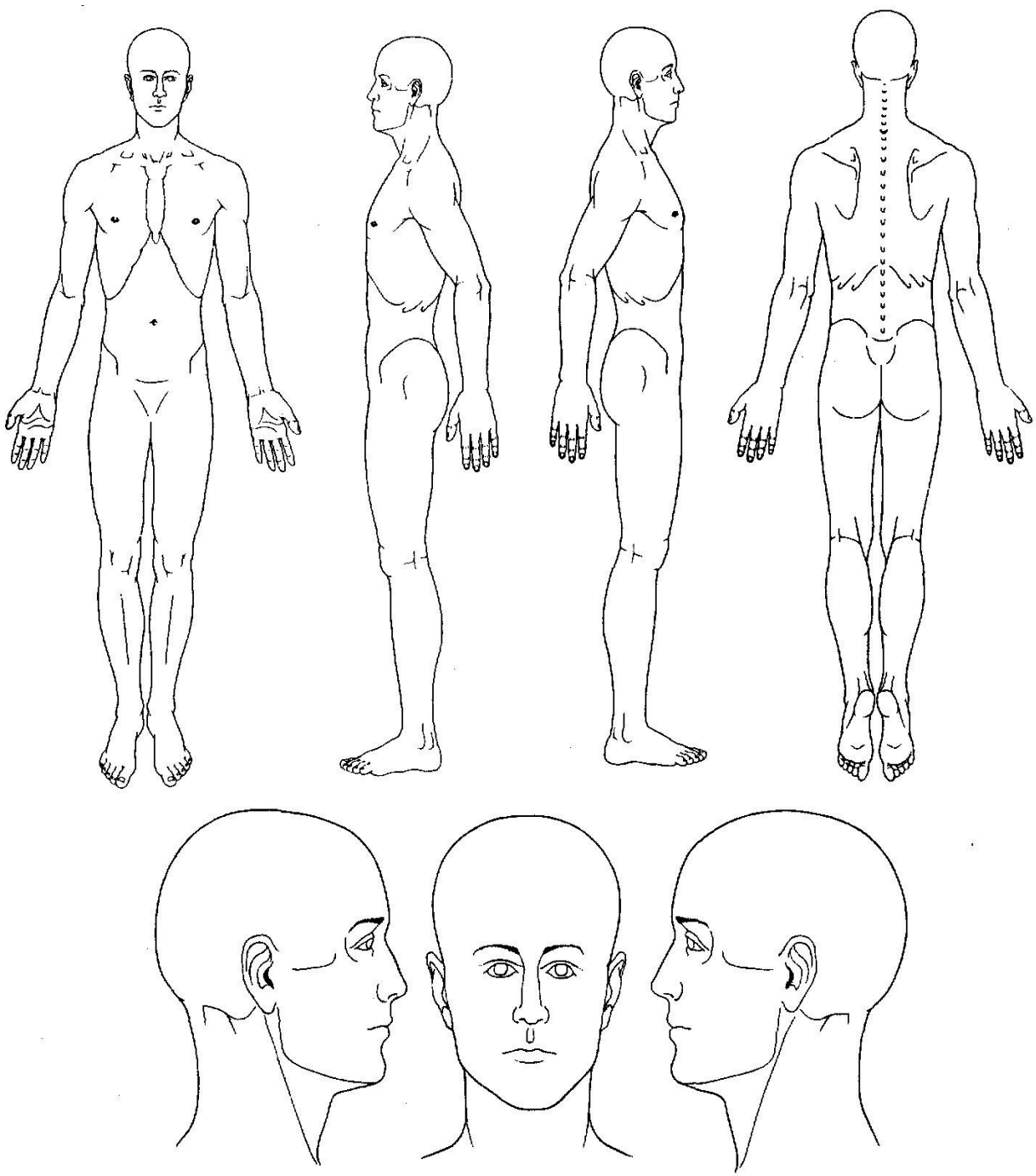
If there are other problems you are experiencing that aren't listed, please give a brief description below:

_____

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