



Dear New Patient,

We are so glad you have chosen Nicole Stahl, M.D. to provide a very important part of your health care. Our staff is committed to providing you with the most caring, professional and confidential services possible. We want you to feel comfortable and at ease in our office. This letter will provide details on what to expect at your first visit.

Your first appointment is a complete Psychiatric Evaluation. When you arrive, our patient service specialist will have you complete some initial paperwork. This will take approximately 15-20 minutes. After this is complete, Dr. Stahl will call your name and invite you into her office where you will spend up to an hour and a half in an interview type setting. Dr. Stahl will discuss with you the current problems that prompted you to seek treatment. She will also review your complete medical history, psychiatric history, social history and family history. At the end of the interview, she will discuss diagnostic impressions and treatment recommendations.

Important Issues:

1) INITIAL PAPERWORK

The Adult Intake Questionnaire is so important and required to be completed **prior** to your appointment along with a 2 day food log (attached). The estimated time to complete the initial paperwork is 60 minutes. *Please do not wait until the day before the appointment to complete this.* The doctor needs **ALL** the requested information in order to make an accurate differential diagnosis. Please submit **all requested symptom history** paperwork at least 1-2 business days prior to your appointment. We will have some additional office policy paperwork for you to complete when you arrive for your appointment. Please plan on arriving 15-20 minutes prior to your scheduled initial appointment time to take care of paperwork. If you arrive at your appointment time, the time for the evaluation may have to be abbreviated in order to stay on schedule and not delay the next patient's appointment. If we do not have enough time to complete the evaluation, you may have to schedule an additional appointment at an additional cost to complete the initial evaluation. We try our best to stay on schedule for our patients so you are not waiting to see the doctor!

2) FINANCIAL POLICY

Payment information is taken when you make your initial appointment. For the first appointment, a credit card must be left on file to be charged 2 business days prior to your initial appointment. If this card declines, you will be taken off the schedule if we are unable to reach you to obtain an alternative payment method. For all follow up appointments, we accept CASH, CHECKS, and all major CREDIT CARDS.

The following is a brief list of services: Initial Evaluation \$450.00
Follow Up Visits up to 30 minutes \$175.00
Follow up Visits up to 1 hour \$350

Regarding Insurance

We will provide you with all the documentation necessary to file an insurance claim on your own. Your insurance plan will reimburse you directly. Please contact your insurance company to find out what your benefit amount is. Dr. Stahl does not accept assignment of benefits and does not participate in any network. She will be considered an out of network provider by your insurance plan.

Missed Appointments

Unless canceled at least 2 full business days (48 hours prior not counting weekends) in advance, our policy is to charge the credit card left on file for missed appointments at the full fee. Dr. Stahl does not double book appointments. Your appointment time is reserved for you. Please help us to serve you better by keeping scheduled appointments.

3) OFFICE LOCATION Please do not rely on your GPS.

FROM I-10:

Travel west on I-10. Take Grand Parkway South Exit 743B and merge onto TX-99 S. Take exit for Cinco Ranch Blvd. Turn Right onto Cinco Ranch Blvd. In 5.4 miles, turn left on FM 1463. In approximately 0.8 miles (immediately after you pass Fry Rd), take a right into the driveway of Well Pet Center. Continue straight over the speed bumps until you come to the third building on your right after passing by the Well Pet Center. Turn right to get to our office parking lot and we are the fourth office on your right, Suite 304. The address is: *5757 Flewellen Oaks Lane, Suite 304, Fulshear TX 77441.*

FROM WESTPARK TOLLWAY:

Travel west on Westpark Tollway/FM1093 until you reach FM 1463. Take a right onto FM 1463. Immediately before you reach Fry Rd, take a left into the driveway of the Well Pet Center Veterinary Hospital. Continue straight over the speed bumps until you come to the third building on your right after passing by the Well Pet Center. Turn right to get to our office parking lot and we are the fourth office on your right, Suite 304. The address is: *5757 Flewellen Oaks Lane, Suite 304, Fulshear TX 77441.*

Please call our office at (713) 332-4388 if you get lost or have any additional questions.

I have read and acknowledge the above financial policies regarding service fees and missed appointments.

_____ Name

_____ Signature

_____ Date

Adult Intake Questionnaire

Please complete this form and submit it prior to your initial appointment

Thank you for taking the time to answer the following questions. Please fill out this form to the best of your knowledge. If some questions are not applicable to you write, N/A. If you need additional space, please feel free to write on the back of the sheet. This information is very helpful in making an accurate diagnosis.

Date _____

Referred by _____

A. General Information

Legal Name:		Address:	
Preferred Name:		City:	
DOB:		State:	
Current Age:		Sex: M F	Zip Code:

Primary Phone:		Drivers License:	
Secondary Phone:		Marital:	Single Married Divorced Widowed
Email:		Student Status:	None Part Time Full Time
Employer:			

Emergency Contact:		Primary Phone:	
Relationship to patient:		Secondary Phone:	

B. Current Presenting Symptoms

What is the reason that you have sought an appointment at this time? Please describe current symptoms.

Did something precipitate these symptoms? Does anything worsen them?

When did these symptoms first begin? Have there been symptoms free periods?

C. Current Symptom Checklist (Please check all symptoms that you are currently experiencing or have recently experienced)

- Sad mood
- Irritable mood
- Sleep difficulties (falling or staying asleep?) Please specify which one _____
- Problems with appetite (eating too much or too little) Please specify _____
- Low energy "feeling tired"
- Frequently thinking about suicide frequently thinking about self-harm
- Previous suicide attempts (please state when & how _____)
- Previous self-harming (please state when & how _____)
- Decline in work performance
- Not as engaged with friends and more avoidant of social opportunities
- Not taking care of personal hygiene
- Discrete periods of time where you do not seem like your usual self and...
 - more self-confidant extremely edgy and irritable very hyper feeling too good
 - getting involved in more risky behaviors (drugs, sexual interests, excessive spending)
 - racing thoughts more outgoing and talkative sleeping less without seeming tired
- Issues with law enforcement
- Excessive fear of something in particular (please note specifically) _____
- Excessive fear of social situations (talking in front of people, worries about people judging you)
- Excessive general worries about things working out for you or your future
- Recurring shortness of breath Recurring headaches Recurring stomachaches
- Recurrent and persistent thoughts (ex: concern about germs, getting ill, fear of something bad happening, intrusive thoughts about religion, health, superstitions, forbidden or perverse thoughts)
- Please specify type of intrusive thoughts _____
- Repetitive behaviors (ex: hand washing, checking behaviors, counting, redoing things repeatedly, hoarding, rituals, hair pulling, blinking) Please specify _____
- make careless mistakes
- have difficulty staying focused on what needs to be done
- difficulty focusing on what people are saying
- not following through on tasks or failing to finish projects
- difficulty organizing tasks
- avoiding/dislike tasks that require ongoing mental effort

- losing things necessary for tasks
 - easily distracted
 - forgetful in daily activities
 - fidgety
 - difficulty remaining seated
 - being "on the go"
 - talking too much
 - difficulty waiting turn
 - interrupting or intruding on others
 - Hearing voices
 - Delusional thoughts Please specify _____
 - Tics or other abnormal movements Please specify _____
 - Food cravings (such as dairy or carbohydrates) Please specify _____
 - Sensitivities to sounds, textures, or smells Please specify _____
 - Excessive time on electronics Please specify amount of time per day _____
- How many hours do you sleep each night? _____ Any naps? Y N
- Do you have a bowel movement at least once a day? Y N Any diarrhea? Y N

D. Previous Mental Health History

Have you been treated in the past for the symptoms you are seeking treatment for? Y or N

Have you been diagnosed with any mental health disorders in the past? If yes, please list previous diagnoses below.

Please list any professionals you have previously received care from for your current symptoms or other emotional/ behavioral problems such as ADHD, depression, anxiety, bipolar disorder, substance abuse, etc.

Please fill out all that apply.

Healthcare Profession list profession: physician, psychiatrist, Psychologist, Licensed professional counselor, or other)	Professional's Name	Duration of treatment (can approximate if don't know exact dates)	For Treatment of What symptoms or disorder	Results (positive/negative)
		From: To:		

Hearing difficulties? Y N

Please list any other medical illnesses you have (such as asthma, anemia, etc.)

Have you ever been medically hospitalized or had surgery? ___ No ___ Yes, list below

How many times have you been on antibiotics in your life? _____

Any Recent Lab work Y N Please specify _____

Allergies/Sensitivities (drugs, foods, etc.)

Current non-psychiatric medications (please include current dose and reason for medication)

Current supplements and/or Vitamins (please list DOSAGE and TYPE). For example, don't put just magnesium, but put specific type of magnesium such as magnesium oxide 200 mg twice a day or instead of Vitamin D, put Vitamin D3 2000 IU in the morning. Attach a list if list extensive.

F. Substance Abuse History

Chemical	Last Use	Amount	How Often Used	How Long Used
Alcohol				
Marijuana				
Cocaine/ Crack				
Inhalants				
LSD				
Prescribed Pills				
Heroin				
Other (specify)				

Have you experienced any of these due to alcohol and/or illegal substance use:

___ Blackouts ___ Withdrawal symptoms ___ Cravings ___ Overdoses

Have you ever experienced legal problems (including arrest) due to alcohol and/or illegal substances.
__Yes __No If yes, please elaborate _____

G. Developmental and Social History

Family Background and Childhood History

Where were you raised? _____

Were you adopted? Yes No List your brothers and sisters and their ages: _____

Father's Occupation _____ Mother's Occupation _____

Did your parents divorce? Yes No If so how old were you? _____

Did your father remarry? Yes No If so how old were you? _____

Did your mother remarry? Yes No If so how old were you? _____

Describe your relationship with your father _____

Describe your relationship with your mother _____

How old are your parents now? Father _____ Mother _____ How old were you when you left home? _____

Has anyone in your immediate family ever died? Yes No Who and when? _____

Were you ever physically and sexually abused? Yes No If so at what age(s) _____ By whom? _____

Educational History

Did you enjoy school? _____

What kind of grades did you make? _____

Describe your social life at school _____

What things got you in trouble in school? _____

Did you attend college? Yes No Where? _____ Major? _____

Highest educational level or degree attained? _____

Occupational History

Are you currently working? Yes No How long in current position? _____

What is your occupation? _____ Where do you work? _____

Where have you worked before and for how long? _____

Marital Status/ Current Family

Marital Status: Single Married Separated Widowed Divorced

How long in current status? _____ If married, what is your spouse's occupation? _____

Describe your relationship with your spouse or significant other: _____

Have you had any previous marriages? Yes No If so, how many? ____ For how long each? _____

Do you have children? Yes No Names and ages: _____

Religion

What is your religious affiliation? _____ Where do you attend services? _____

For how long? _____ Do you attend regularly? Yes No

Please rate the importance of your religion or spiritual beliefs in your life:

All Important Very Important Important Somewhat Important Not Important

Stressors

Have you experienced any of the following stressors (check all that apply)

- recent move
- change in schools
- job change
- financial problems
- personal/ family health problems
- marriage
- divorce
- death
- violence
- substance abuse
- Other (please explain) _____

H. Family Mental Health History (please notate whether on maternal or paternal side)

Please list any blood relatives that have been treated or hospitalized for any mental/ behavioral problems.

	Relationship to patient	Outpatient Treatment (specify)	Medications (specify)	Hospitalizations (specify number)
Depression				
Bipolar disorder				
Anxiety disorder				
Eating disorder				
Learning disorder				
Substance Abuse <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs				
ADHD				
Suicide or suicide attempt				
Schizophrenia				
Sleep Disorder				
Other (please specify)				

I. Family Medical History

	Relationship to patient
Cardiac disease (including arrhythmias, QT prolongation, hypertension)	
Diabetes (specify Type 1 or 2)	
Thyroid disease	
Seizures	
High Cholesterol/ Triglycerides	
Early cardiac death of family member (under the age of 40)	

J. Two Day Food Log (please list items eaten and approximate time of day)

	Day 1	Day 2
Breakfast		
Lunch		
Dinner		
Snacks		
Drinks		
Exercise		
Wake Time		
Bed Time		

Please remember to bring any of the following paperwork to your appointment if applicable: Previous Psychiatric/ Therapy Records. We will also need a copy of your drivers license and a copy of insurance card if applicable in case medication is prescribed and a prior authorization is requested by insurance company. We do not personally work with any insurance company.



Credit Card Authorization

I understand that payment is expected at the time of service by either cash, check, or credit card. I understand that the financial responsibility for services provided is mine, and that insurance is for my reimbursement if I choose to do so. I understand that I must file the insurance claim and that the physician will not file it for me.

I understand that the credit card listed below will be charged for missed appointments and cancellations with less than 2 business days notice (48 hours prior not counting weekends). I am aware that insurance will not cover charges for missed or cancelled appointments. With appropriate notice, appointment slots can almost always be used to serve another patient.

I understand that if this credit card declines for a charge, that I will be billed for the missed appointment. No further appointments may be scheduled until the outstanding balance is paid.

I agree to notify the receptionist when I become aware of any changes in my payment method, address, phone number, marital status or responsible party that has occurred since my last appointment.

I, _____, hereby authorize Nicole Stahl, M.D., P.A. to charge my credit card for services rendered and time allotted for treatment at a rate of \$450 for an initial appointment, \$175 for up to a 30 minute follow up appointment and \$350 for an hour follow up appointment. If I am leaving this credit card on file for someone other than myself, I understand that my credit card can be charged for the patient's **appointments, unpaid fees, missed appointments or cancellations with less than 2 business days notice.**

Credit card # _____ Security Code _____ Exp. date _____

Name as printed on card _____

Billing Address: _____ City: _____ State: _____

Zip _____ (Note: zip code must be for where the credit card statement is sent to.)

By signing below, I am authorizing Nicole Stahl M.D. P.A. or Cinco Ranch Psychiatry to charge my credit card for the professional services as described above. I certify that I am the owner of the credit card listed on this page and can thereby authorize this card to be charged:

Patient's Name

Date

Responsible Party's Name

Date

Responsible Party's Signature

Date