Cinco Ranch
PSYCHIATRY
NICOLE STAHL, MD

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 Intake Questionnaire is required to be completed **prior** to your appointment. The estimated time to complete the initial paperwork is 30 to 60 minutes. The doctor needs ALL the requested information in order to make an accurate differential diagnosis. Please bring the **completed** paperwork with you to your first appointment. We will have some additional paperwork for you to complete when you arrive for your appointment. Please plan on arriving at least 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 within the allotted time, you may have to schedule an additional appointment to complete the evaluation at an additional cost. We try our best to stay on schedule for our patients so you are not waiting to see the doctor!

2) OFFICE LOCATION- **Please do not rely on your GPS as our location is new!!**

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.

3) 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, we will call the number you have left on file. If we are unable to reach you to obtain an alternative payment method, you will be taken off the schedule. For all follow up appointments, we accept CASH (in **exact change** as we do not keep cash on hand), CHECKS, and all major CREDIT CARDS.

The following is a brief list of services:

Initial Evaluation $350.00
Medication Therapy $160.00
Telepsychiatry Appointments $200 (for established patients only)

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 if they cover out of network providers. 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. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We have no agreements to offer discounts for specific plans.

Missed Appointments
Unless canceled, at least 2 full business days in advance (48 hours prior notice not counting weekends), 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.

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

_____ _____ _____

Name Signature Date

Adult Intake Questionnaire

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 _____

Person completing this form _____

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. 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) _____

C. Current Presenting Symptoms

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

_____

_____

_____

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

_____

_____

_____

Did something precipitate these symptoms? Does anything worsen them?

_____

_____

_____

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 sought 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, social worker, 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:		
		From: To:		
		From: To:		
		From: To:		
		From: To:		
		From: To:		

Have you ever been admitted to an inpatient psychiatric hospital, a residential treatment program, or a rehabilitation facility? __ No __ Yes, please list below.

Name of hospital/ Facility	Date of admission	Duration of stay	Reason for admission

Have you ever attempted suicide? Y or N , Please explain method(s) and date of attempt(s).

Have you ever engaged in self harm behaviors such as cutting before? Y or N Please explain method(s) and date of last self harm behavior(s).

Have you ever been placed on medication for treatment of emotional/ behavioral problems? Y or N

Name of Psychiatric Medication	Dose	Length of Trial	Effects (improvement)			Side Effects (Please specify)
			None	Slight	Much	
Past		From: To:				
		From: To:				
		From: To:				
		From: To:				
		From: To:				
		From: To:				
Current		From: To:				
		From: To:				
		From: To:				
		From: To:				
		From: To:				

E. 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.

__ No __ Yes, please explain _____

_____

F. Medical Information and History

Primary Care Physician

Name _____ Phone # _____ Address _____

Date of last physical exam _____

Is your primary care physician aware of this appointment? Y N

Preferred Pharmacy

Name _____ Phone # _____ Nearest Intersection _____

Specialist

Have you ever seen a specialist such as a neurologist or cardiologist? __ No __ Yes, please list below

Name	Date	Reason for Consultation

Have you ever had a seizure? Y N

Have you ever had a head injury? Y N

Have you ever lost consciousness? Y N

Have you ever had any heart problems? Y N
(Including murmur, arrhythmias, high blood pressure, prolonged QT syndrome, high cholesterol/ triglycerides, other heart problems) Please specify _____

_____

Do you have any thyroid abnormalities? Y N

Do you have any genetic syndromes? Y N

Have you ever had diabetes? Y N

Have you ever had any vision difficulties? Y N

Have you ever had any hearing difficulties? Y N

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

_____

Have you ever been medically hospitalized or had surgery? __ No __Yes, list below

_____

_____

_____

Immunizations up to date Y N

Allergies _____

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

_____

_____

Current supplements and/or vitamins

_____

G. 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 ___ Alcohol ___ Drugs				
ADHD				
Suicide or suicide attempt				
Schizophrenia				
Sleep Disorder				
Other (specify type)				

H. Family Medical History

	Relationship to patient
Cardiac disease (including arrhythmias, sudden death, QT prolongation, hypertension)	
Diabetes (specify Type 1 or 2)	
Thyroid disease	
Seizures	
High Cholesterol/ Triglycerides	
Other:	

I. Current Symptom Checklist (Please put a check mark by all symptoms that you are currently experiencing)

__sad mood

__irritable mood

__abnormally elevated mood (feeling "on top of the world")

__sleep difficulties (falling or staying asleep) Please specify_____

__snoring

__feeling tired upon awakening

__problems with appetite (eating too much or too little) Please specify_____

__low energy

__excessive fear of something in particular. Please note specifically_____

__excessive fear of social situations

__excessive worries

__recurrent and persistent thoughts. Please specify_____

__repetitive behaviors Please specify_____

__failure to develop appropriate peer relationships/difficulty relating to other

__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

__Tics or other abnormal movements Please specify_____

__problems with bowel movements such as diarrhea or constipation (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 of sleep do you get each night?_____ Any naps? Y or N How long?_____

Please describe a typical diet for you.

Breakfast_____

Lunch_____

Dinner_____

Do you do any exercise? Y or N What type?_____How often and for how long?_____

Please complete this form and bring it with you to your initial appointment.

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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 full business days notice (48 hours 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 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 $350 for an initial appointment, $160 for a clinic follow up appointment, or $200 for a telepsychiatry 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