Kairos COUNSELING

**Clinician Approved**
**YES NO**

## Client Screening for Medication Management

Prospective Patient Name: _____ Gender: _____ SS# _____

Current Address: _____

DOB: _____ Referred By: _____

Caller (if different from patient) _____ Relationship: _____

Best Contact Number: _____ Alt: _____

Insurance Name: _____ ID #: _____

Mental Health Ph # (on back of card) _____

Secondary Insurance _____ ID #: _____

Policy Holder: _____ DOB: _____ SS# _____

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Previous Psychiatric Diagnosis/ Current Symptoms: _____

_____

_____

Have you previously or are you currently under the care of an MD/NP for mental health? If so, who and when? _____

If you have a provider, why are you changing providers? _____

_____

Have you ever been hospitalized for mental health reasons? Y _____ N _____

Is so WHEN: _____ WHERE: _____

Current medications: _____

_____

If on a benzodiazepine (Xanax, valium, Clonazepam, lorazepam, etc.) How much daily? _____

_____

Permission for me to check the PDMP? Y _____ N _____

On meds for pain? (Including implanted pumps): _____

Failed Past Medications (Past meds that didn't work or stopped working): _____

_____

_____

History of Chronic Illness: Y ____ N _____ If so what illness? _____

_____

History of Pain management (current/past): _____

Are you on disability? Y _____ N_____ If yes, why? _____

_____

**History of Addiction**

Do you currently use or have a history of use: _____

Methadone: Y____N_____If Y then when: _____

Suboxone: Y____N_____If Y then when: _____

Medical marijuana: Y____N_____

What is the use for? _____

How much is being used? (Daily/weekly amounts) _____

Marijuana for other purposes? Y____N_____

Alcohol? Y____N_____If Y then (amount/frequency): _____

Tobacco? Y____N_____If Y then (amount/frequency): _____

Vaping? Y____N_____If Y then what are you vaping: _____

**History of Eating Disorder**

What kind of ED? _____NEEDED: Ht_____ Weight_____

Are you currently working with a dietitian? _____

Working with a Therapist with ED experience? _____

If not, why not? _____

**Legal History**

Do you have any legal history? (DUI, incarcerations, etc.) *Non-disclosure could result in non-acceptance or dismissal from the practice.* Y_____ N _____

If yes, what legal history? _____

_____

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The completed form will be reviewed by Dr. Elizabeth Wheatley, Psychiatric Nurse Practitioner and you will receive a call back from our staff after she has reviewed the information. The initial interview, if agreed upon, will then allow you and Dr. Wheatley to decide if a professional relationship, with Kairos Counseling - Medication Management, is in your best interests. The initial visit is not a guarantee that medications will be provided.

**Please write question number if additional space is needed to provide more information **

Page for additional Information if needed: