441 Watertower Circle, Suite 200
Colchester, VT 05446
Phone: (802) 404-1492 Fax: (802) 404-1490

INTAKE FORM

The treatment and counseling work we do is unique to you, just as it is to each one of our patients. Before we get started we need to collect some general information from you.

GENERAL INFORMATION

First Name | Last Name | Gender

Date of Birth (MM/DD/YYYY) | Social Security Number

Address

City | State | Zip Code

Main Phone | Other Phone

Email

EMERGENCY CONTACT

First Name | Last Name

Phone | Relationship

Do you authorize this person to discuss care or treatment with the office in the case of an emergency?

☐ **YES** ☐ **NO**

INSURANCE INFORMATION

PRIMARY INSURANCE | **Policy Holder**

Policy Holder D.O.B. (MM/DD/YYYY) | Relationship

Policy Holder Address

City | State | Zip Code

Policy Number | **Group Number**

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

SECONDARY INSURANCE **Policy Holder**

Policy Holder D.O.B. (mm/dd/yyyy) Relationship

Policy Holder Address

City State Zip Code

Policy Number **Group Number**

PARENT/GUARDIAN INFORMATION (If applicable)

First Name Last Name

Phone Relationship

First Name Last Name

Phone Relationship

MENTAL HEALTH HISTORY/STATUS

What problems are you seeking help for?

CURRENT MENTAL HEALTH TREATMENT

Are you currently receiving mental health services? ☐**YES** ☐**NO**

If yes, where are you receiving services? _____

If changing services, why are you making this change? _____

_____

Is someone (other than a parent for a child/adolescent) helping you complete these forms? ☐**YES** ☐**NO**

If yes, what is their name and role? _____

PAST MENTAL HEALTH TREATMENT

Have you ever been hospitalized for psychiatric reasons? ☐**YES** ☐**NO**

If yes, when and where? _____

Have you ever had outpatient treatment by a psychiatrist or psychiatric provider (e.g. NP or PA)? ☐**YES** ☐**NO**

If yes, when and by whom? _____

Have you ever received counseling or psychotherapy in the past? ☐**YES** ☐**NO**

If yes, when and by whom? _____

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

DIRECTIONS: Please place a check mark in the box that describes your experience with any of the medications listed below.

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
ANTIDEPRESSANTS							
Amitriptyline	Elavil	☐	☐	☐	☐	☐	
Bupropion	Wellbutrin, Wellbutrin SR, Wellbutrin XL	☐	☐	☐	☐	☐	
Citalopram	Celexa	☐	☐	☐	☐	☐	
Clomipramine	Anafranil	☐	☐	☐	☐	☐	
Desipramine	Norpramin	☐	☐	☐	☐	☐	
Desvenlafaxine	Pristiq	☐	☐	☐	☐	☐	
Doxepin	Sinequan, Silenor	☐	☐	☐	☐	☐	
Duloxetine	Cymbalta	☐	☐	☐	☐	☐	
Escitalopram	Lexapro	☐	☐	☐	☐	☐	
Fluoxetine	Prozac, Sarafem	☐	☐	☐	☐	☐	
Fluvoxamine	Luvox, Luvox CR	☐	☐	☐	☐	☐	
Imipramine	Tofranil	☐	☐	☐	☐	☐	
Isocarboxazid	Marplan	☐	☐	☐	☐	☐	
Levomilnacipran	Fetzima	☐	☐	☐	☐	☐	
Milnacipran	Savella	☐	☐	☐	☐	☐	
Mirtazapine	Remeron, Remeron SolTab	☐	☐	☐	☐	☐	
Nefazodone	Serzone	☐	☐	☐	☐	☐	
Nortriptyline	Pamelor	☐	☐	☐	☐	☐	
Paroxetine	Paxil, Paxil CR	☐	☐	☐	☐	☐	
Phenelzine	Nardil	☐	☐	☐	☐	☐	
Selegiline Transdermal	Emsam	☐	☐	☐	☐	☐	
Sertraline	Zoloft	☐	☐	☐	☐	☐	
Tranylcypromine	Parnate	☐	☐	☐	☐	☐	
Trazodone	Desyrel, Oleptro	☐	☐	☐	☐	☐	
Venlafaxine	Effexor, Effexor XR	☐	☐	☐	☐	☐	
Vilazodone	Viibryd	☐	☐	☐	☐	☐	
Vortioxetine	Trintellix, Brintellix	☐	☐	☐	☐	☐	
ANTIPSYCHOTICS "major tranquilizers"							
Aripiprazole	Abilify	☐	☐	☐	☐	☐	
Asenapine	Saphris	☐	☐	☐	☐	☐	
Brexpiprazole	Rexulti	☐	☐	☐	☐	☐	
Cariprazine	Vraylar	☐	☐	☐	☐	☐	
Chlorpromazine	Thorazine	☐	☐	☐	☐	☐	
Clozapine	Clozaril, FazaClo, Versacloz	☐	☐	☐	☐	☐	
Fluphenazine	Prolixin, Prolixin Decanoate	☐	☐	☐	☐	☐	
Haloperidol	Haldol, Haldol Decanoate	☐	☐	☐	☐	☐	
Iloperidone	Fanapt	☐	☐	☐	☐	☐	

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Loxapine	Loxitane	☐	☐	☐	☐	☐	
Lurasidone	Latuda	☐	☐	☐	☐	☐	
Molindone	Moban	☐	☐	☐	☐	☐	
Olanzapine	Zyprexa, Zyprexa Zydis, Zyprexa Relprevv	☐	☐	☐	☐	☐	
Paliperidone	Invega, Invega Sustenna, Invega Trinza	☐	☐	☐	☐	☐	
Perphenazine	Trilafon	☐	☐	☐	☐	☐	
Pimavanserin	Nuplazid	☐	☐	☐	☐	☐	
Quetiapine	Seroquel, Seroquel XR	☐	☐	☐	☐	☐	
Risperidone	Risperdal, Risperdal Consta, Risperdal M-Tab	☐	☐	☐	☐	☐	
Thioridazine	Mellaril	☐	☐	☐	☐	☐	
Thiothixene	Navane	☐	☐	☐	☐	☐	
Trifluoperazine	Stelazine	☐	☐	☐	☐	☐	
Ziprasidone	Geodon	☐	☐	☐	☐	☐	
ANXIOLYTICS "anti-anxiety" "minor tranquilizers"							
Alprazolam	Xanax, Xanax XR	☐	☐	☐	☐	☐	
Buspirone	BuSpar	☐	☐	☐	☐	☐	
Chlordiazepoxide	Librium	☐	☐	☐	☐	☐	
Clonazepam	Klonopin, Klonopin Wafers	☐	☐	☐	☐	☐	
Clorazepate	Tranxene	☐	☐	☐	☐	☐	
Diazepam	Valium	☐	☐	☐	☐	☐	
Hydroxyzine	Vistaril, Atarax	☐	☐	☐	☐	☐	
Lorazepam	Ativan	☐	☐	☐	☐	☐	
Oxazepam	Serax	☐	☐	☐	☐	☐	
ANTICHOLINESTERASE/ALZHEIMER'S AGENTS							
Donepezil	Aricept	☐	☐	☐	☐	☐	
Galantamine	Razadyne	☐	☐	☐	☐	☐	
Memantine	Namenda, Namenda XR	☐	☐	☐	☐	☐	
Rivastigmine	Exelon	☐	☐	☐	☐	☐	
Selegiline	Eldepryl	☐	☐	☐	☐	☐	
Tacrine	Cognex	☐	☐	☐	☐	☐	
ALCOHOL/DRUG/SMOKING CESSATION AGENTS							
Acamprosate	Campral	☐	☐	☐	☐	☐	
Buprenorphine/ Naloxone	Suboxone, Bunavail, Zubsolv	☐	☐	☐	☐	☐	
Bupropion	Zyban	☐	☐	☐	☐	☐	
Disulfiram	Antabuse	☐	☐	☐	☐	☐	
Methadone	Dolophine	☐	☐	☐	☐	☐	
Naltrexone	ReVia, Vivitrol	☐	☐	☐	☐	☐	

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Varenicline	Chantix	☐	☐	☐	☐	☐	
MOOD STABILIZING AGENTS/AED's							
Carbamazepine	Tegretol, Tegretol XR	☐	☐	☐	☐	☐	
Fluoxetine/Olanzapine	Symbyax	☐	☐	☐	☐	☐	
Gabapentin	Neurontin	☐	☐	☐	☐	☐	
Lamotrigine	Lamictal, Lamictal XR, Lamictal ODT	☐	☐	☐	☐	☐	
Levetiracetam	Keppra, Keppra XR	☐	☐	☐	☐	☐	
Lithium	Eskalith, Eskalith CR, Lithobid	☐	☐	☐	☐	☐	
Oxcarbazepine	Trileptal	☐	☐	☐	☐	☐	
Tiagabine	Gabitril	☐	☐	☐	☐	☐	
Topiramate	Topamax	☐	☐	☐	☐	☐	
Valproate	Depakene, Depakote, Depakote ER, Valproic Acid	☐	☐	☐	☐	☐	
PSYCHOSTIMULANTS							
Amphetamine Salts	Adderall, Adderall XR	☐	☐	☐	☐	☐	
Armodafinil, Pemoline	Nuvigil, Cylert	☐	☐	☐	☐	☐	
Atomoxetine	Strattera	☐	☐	☐	☐	☐	
Dexmethylphenidate	Focalin, Focalin XR	☐	☐	☐	☐	☐	
Dextroamphetamine	Dexedrine, Dextrostat	☐	☐	☐	☐	☐	
Lisdexamfetamine	Vyvanse	☐	☐	☐	☐	☐	
Methylphenidate	Ritalin, Ritalin SR, Ritalin LA, Concerta, Metadate ER/CD, Methylin, QuilliChew ER, Quillivant XR	☐	☐	☐	☐	☐	
Methylphenidate Transdermal	Daytrana	☐	☐	☐	☐	☐	
Modafinil	Provigil	☐	☐	☐	☐	☐	
SEDATIVE/HYPNOTICS							
Chloral Hydrate	Noctec	☐	☐	☐	☐	☐	
Eszopiclone	Lunesta	☐	☐	☐	☐	☐	
Flurazepam	Dalmane	☐	☐	☐	☐	☐	
Ramelteon	Rozerem	☐	☐	☐	☐	☐	
Suvorexant	Belsomra	☐	☐	☐	☐	☐	
Temazepam	Restoril	☐	☐	☐	☐	☐	
Triazolam	Halcion	☐	☐	☐	☐	☐	
Zaleplon	Sonata	☐	☐	☐	☐	☐	
Zolpidem	Ambien, Ambien CR, Intermezzo, Edluar	☐	☐	☐	☐	☐	
OTHER							
Benztropine	Cogentin	☐	☐	☐	☐	☐	

NORTH COUNTRY BEHAVIORAL MEDICINE
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MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Clonidine	Catapres, Kapvay	☐	☐	☐	☐	☐	
Cyproheptadine	Periactin	☐	☐	☐	☐	☐	
Diphenhydramine	Benadryl	☐	☐	☐	☐	☐	
Guanfacine	Tenex, Intuniv	☐	☐	☐	☐	☐	
Prazosin	Minipress	☐	☐	☐	☐	☐	
Propranolol	Inderal	☐	☐	☐	☐	☐	
Trihexyphenidyl	Artane	☐	☐	☐	☐	☐	
HERBAL PREPARATIONS							

☐ I am unable or unwilling to complete this form. ☐ I have completed this form to the best of my ability.

Signature of Patient/Parent/Guardian: **Date:**

☐ Reviewed in person with the patient.

☐ Reviewed over the phone with the parent/guardian of the patient.

☐ Reviewed in person with the patient and / or parent/guardian of the patient.

Signature of Psychiatrist/NPP: **Date/Time:**

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

Alcohol, Drug, and Tobacco Use

Describe your use of alcohol:

Describe your use of recreational drugs:

Describe your use of tobacco:

Please list any additional notes that you think would be helpful for treatment below:

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

CLINIC POLICY AGREEMENT

First Name: Last Name:

ACKNOWLEDGEMENT OF CLINIC ATTENDANCE POLICY:

INITIAL ___ I understand that North Country Behavioral Medicine requires that all appointments be cancelled no later than ***24 business hours before the appointment is scheduled (Monday through Friday 8:00 am to 5:00 pm, excluding holidays).***

INITIAL ___ I understand that ***if I no-show or cancel an initial evaluation with our clinic with less than 24 business hours' notice, my file will be closed***.

INITIAL ___ I understand that I will be allowed 3 (three) late cancellations in a 12 month period. If this number is exceeded, ***I understand that my file will be closed***.

INITIAL ___ I understand that I will be allowed 2 (two) no-shows in a 12 month period. ***If this number is exceeded, I understand that my file will be closed***.

INITIAL ___ Notwithstanding the above, I understand that I will be allowed a **combined total** of 1 (one) no-shows and 2 (two) late cancellations in a 12 month period. ***If this number is exceeded, I understand that my file will be closed***.

INITIAL ___ I understand that ***if I have commercial insurance I will be charged $75 for any no-show appointment***.

INITIAL ___ I understand that it is ***my responsibility to call the office at (802) 404-1492, or via our appointment reminder system, to cancel any appointment***.

By signing below I acknowledge that I have read, understand and will abide by the above policies and that if I do not, my file with North Country Behavioral Medicine will be closed.

Printed Name _____

Signature _____ Date _____

Additionally, I understand that the office of North Country Behavioral Medicine PLLC will attempt to bill my insurance, however ***if my insurance does not pay, for whatever reason, I am responsible for any remaining balance*.** This may include deductibles, copays, or out of pocket expenses.

My signature acknowledges:

- In the case of a Psychiatric Emergency I will call 911 or go to the nearest hospital
- 72 business hours is required for any prescription renewals.
- I will adhere to the guidelines above to the best of my ability.

Patient Name (please print) _____

Patient/Guardian Signature _____ Date _____