Lakefront Wellness Center, S.C.
161 W. Wisconsin Ave. Ste 2B
Pewaukee, WI. 53072
Ph: 262.695.8857   Fax: 262.695.8879
www.lakefrontwellness.com

Patient Questionnaire - Adult

Date:__________________

Form 41fadult1 –updated 1/14 BJ

Welcome, we're glad you're here! Please take time to answer the following questions.
Confidential Record: Note that your information will not be released except when we are authorized to do so.

Name:________________________________ Age:________ Date of Birth:________

Home Ph:______________________________ Sex:________ Height:________

Work Ph:______________________________ Race:________ Weight:________

Address:____

City:________________________________ State: WI Zip:________

Email: ________________________________

How long at this address?__________________ With whom do you live?________________

Emergency Contact: ________________________ Phone________________________

Relationship Status

☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Remarried
☐ Widowed ☐ Significant relationship Number of marriages__________

Client statement of problem, needs, recovery goals:

____
____
____
____

When did this problem start?____________________________________
How is this problem impairing you? ________________________________
What makes this problem better?__________________________________
How will you know when your problem is solved?__________________________
____
What are your strengths for managing this problem?
____
Available supports: ____

Social History

Your birthplace (city):______________________ Has your family moved often?____________
Where were you raised?______________________
Are you adopted? ☐YES ☐NO

FAMILY MEMBERS

	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Your) **Mother**			

Describe your relationship: ____

____

____

	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Your) **Father**			

Describe your relationship: ____

____

____

□ N/A	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Your) **Stepmother**			

Describe your relationship: ____

____

____

□ N/A	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Your) **Stepfather**			

Describe your relationship: ____

____

____

	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Your) **Brothers and Sisters**			

Describe your relationship(s):

____

____

____

____

____

	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Your) **Spouse**			

Describe your relationship: ____

____

____

Length of relationship: ____

	FIRST NAME	OCCUPATION	MENTAL HEALTH
(Your) **Previous Spouse**			

Describe your relationship: ____

____

____

Length of relationship: ______________________Date of divorce or death: ______________________

	FIRST NAME/AGE	OCCUPATION	MENTAL HEALTH
(Your) **Child**			

Describe your relationship: ____

____

____

____

	FIRST NAME/AGE	OCCUPATION	MENTAL HEALTH
(Your) **Child**			

Describe your relationship: ____

____

____

	FIRST NAME/AGE	OCCUPATION	MENTAL HEALTH
(Your) **Child**			

Describe your relationship: ____

____

____

Clinician’s Notes:

____

____

____

____

____

____

____

Education

Last grade of completion:________________ Are you attending school now? ☐ Yes ☐No

Grade Level	What were your Grades? Academic Problems?	Did you make friends Easily? Bullied/teased?	Extra-curricular's?	Major disruptions? (e.g., move, divorce, Abuse, trauma?)
Grade school				
Middle school				
High School				
College				

Employment

Occupation:____

How long have you been at your present job?______________

Do you have any current employment concerns?____

Financial concerns?____

Military History

Are you ever in the military? ☐ Yes ☐ No If yes, did you have combat experience? ☐ Yes ☐ No

Legal

Have you ever been arrested? ☐ Yes ☐ No If yes, what charges?________________________________

Do you have any current legal concerns?____

Religion/ Faith

Do you profess a faith? ☐ Yes ☐ No

If yes, what activities do you participate in?____

Is this an import aspect of your life? ☐ Yes ☐ No Where do you attend activities?________________________

Is it too personal or sensitive for you to be asked about faith beliefs? ☐ Yes ☐ No

If yes, skip the following set of questions.

Has your belief system been affected by any major events in your life?________________________________

SUBSTANCE ABUSE SCREEN SELF-REPORT

Have you used or are you currently using: Please check if current:

Substance	Frequency / Amount	Current
Alcohol	Frequency / Amount:______	☐
Marijuana	Frequency / Amount:______	☐
Cocaine	Frequency / Amount:______	☐
Nicotine	Frequency / Amount:______	☐
Sleeping Pills	Frequency / Amount:______	☐
Caffeine	Frequency / Amount:______	☐
Chewing tobacco	Frequency / Amount:______	☐
Tranquilizers	Frequency / Amount:______	☐
Diet Pills	Frequency / Amount:______	☐

Please identify any other drugs you have used or are currently using:

______Frequency / Amount:______ ☐

______Frequency / Amount:______ ☐

______Frequency / Amount:______ ☐

Please check if yes:

Other people say you have a problem with drugs and/or alcohol? ☐

Has your use of drugs and/or alcohol interfered with your school or social functioning? ☐

Have you ever been arrested for behavior that occurred while under the influence of drugs and/or alcohol (e.g. disorderly conduct, traffic violations, other crimes)? ☐

Have you ever tried to cut back on your use of drugs and/or alcohol and been unsuccessful? ☐

Have you noticed that it takes more of your drug or alcohol to reach the same effect? ☐

When you stop taking your drug and/or alcohol, do you experience any side effects? ☐

Does your behavior seem to be geared toward obtaining drug and/or alcohol? ☐

Are you preoccupied with your next use or obtaining the drug? ☐

Have you stopped doing many activities because you are using drugs and/or alcohol? ☐

Previous Treatment (when, where, outcomes):

______

______

______

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Client's Bill of Rights and Grievance Process

Form 4d

The client has the right to:

- Receive treatment that is respectful, helpful, and free from sexual, physical, and emotional abuse. The treatment should be given in a safe environment and the client can end treatment without obligation or harassment.
- Report unethical and illegal behavior by a therapist.
- Ask questions about therapy services, including alternatives of treatment modalities and possible side effects of medications.
- Request that your therapist make fair and reasonable decisions about your treatment.
- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
- Written information about fees, methods of payment, insurance reimbursement, number of sessions, therapist substitutions (in cases of vacation), and cancellation policies before beginning therapy.
- Refuse to answer any questions you choose not to reveal.
- Refuse electronic recording.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, or others with whom your therapist will discuss your case.
- Request, and in most cases, receive a summary of your file; including the diagnosis, progress, and type of treatment.
- Request a transfer of a copy of your file for another therapist or agency.
- Receive a second opinion at any time about your therapy and therapist's methods.
- Not be given unnecessary or excessive medication.
- Not be restrained or placed in a locked room (seclusion) unless in an emergency when it is necessary to prevent physical harm to you or to others.

Records

- Client's treatment information must be kept private and client's records cannot be released without the client's consent unless the law specifically allows for it.
- Clients can ask to see their records. Clients must be shown any records about their physical health or medications. Clients may be limited to how much they may see of the rest of their record while receiving services. Clients must be informed of the reasons for any such limits. Clients can challenge those reasons in the grievance process. After discharge, clients can see their entire record if they ask to do so.
- If clients believe something in their records is wrong, they can challenge the accuracy. If staff will not change the challenged part of a record, clients can put their own version in the record.
- Clients may request their treatment record, in writing, be released to another licensed professional.
- Records shall be destroyed after 7 years.
- Records shall remain in the custody of the clinic if the client's provider leaves employment with the clinic.
- Certain health information is electronic and is transmitted electronically for insurance purposes.

Grievance Resolution Process:

- If you feel your rights have been violated, you may file a grievance. You cannot be threatened or penalized in any way for filing a grievance. The service provider or facility must inform you of your rights and how to use the grievance process. You may, at the end of the grievance process, or any time during it, choose to take the matter to court. The Client Right Specialists at Lakefront Wellness are Dr. Beth A. Johnson and Dr. Peder Piering.

Involuntary Discharge:

- A client may be asked to leave at the discretion of the director for: non-payment, inappropriate behavior, or due to the clinic not being able to sufficiently treat the client due to their unique mental health needs.

I have read and understand the above information about patient rights and grievances.

______________________________ __________________________
Patient Signature **Date**

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INFORMED CONSENT AGREEMENT

Form 4c

PURPOSE

The purpose of this agreement is to set forth the basic provisions concerning your treatment provider, admission, treatment, discharge, and follow-up.

UNDERSTANDING

1. Admission to outpatient treatment is voluntary and may be terminated by the patient at any time for any reason. Consent may be withdrawn in writing.
2. You have the right to have your treatment provider make fair and reasonable decisions about your care and participate in your treatment planning.
3. Treatment methods, benefits, and possible alternatives will be explained to you as well as the consequences of not receiving treatment. The risks and benefits will be explained to you. You have the right to decline these treatments.
4. Fees and billing procedures will be explained to you in advance.
5. You will not be recorded or videotaped without your written consent or knowledge.
6. Any testing, reports, consultation, and/or referral procedures will be explained to you.
    a) A copy of your rights as a patient, as approved for under Wisconsin Statute 51.61, has been given to you. These rights explain grievance procedures.
    b) You may ask to see or be seen by your therapist's supervisor.
    c) A copy of this signed form is available to you upon request.
7. Treatment information is considered confidential within certain state and federal limitations.
8. The limits (exceptions) to confidentiality of treatment information are:
    a) To prevent harm or injury to myself or someone else, including child and elder abuse; and
    b) By order of a judge.
9. Your treatment provider may terminate your admission during the course of treatment for the following reasons:
    a) Noncompliance with the course of treatment or violation of clinic rules;
    b) Repeated cancellations or missed appointments;
    c) Not contacting the clinic for 30 consecutive days;
    d) Aggressive or violent behavior toward the therapist or others in the clinic;
    e) If you need services beyond the specialty or knowledge of your treatment provider, in which case your provider will help with a referral;
    f) Refusal to pay or make arrangements for paying, in which case, you have the right to be referred to other services.
10. Lakefront Wellness Center may follow up after treatment with contact by phone, mail or email. _____.

ACCEPTANCE

I, ___________________________________, have read/discussed these provisions with my therapist and I do accept the conditions governing my admission, treatment, discharge, and follow-up. This consent is effective from the date of signature for no more than 15 months, at which time it shall be renewed if I wish to continue treatment.

____ ______________________

Patient or Guardian Signature **Date**

____ ______________________

Witness/Therapist Date

Form Updated April 2003

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Medical Screening Form

Form 4g1

Client Name: ________________________________ DOB:____________

Current Medical Problem(s):

Current Medication(s): Prescribed by Dr. ___________________

Past Health Problems:

Past Medication(s): Prescribed by Dr. ___________________

Date of Last Physician Visit: ____

Name of Current Physician: ____

DO YOU HAVE:

____ Heart Disease
____ Diabetes
____ Cancer
____ Seizures
____ Stroke
____ Tuberculosis
____ Headaches
____ Chest Pains
____ Shortness of Breath
____ Stomach Problems
____ Dietary Restriction
____ Activity Restriction

____ Allergy ____

____ Disability ____

____ Other infectious disease ____________________________________

____ Other ____

How to Reach Your Therapist in Case of Emergency
Please Keep this Sheet

Form 8a1

Dear Client,

Your therapist desires to provide service in case of emergency. Examples of emergencies include, but are not limited to, serious changes in mental health, suicidal or homicidal thoughts, threats of abuse to self or others, and reckless behavior. To accommodate emergencies, we maintain accessibility by an urgent notification system in the regular voicemail system. It is activated when you press #71# ***after* you leave your voicemail message on your therapist's voicemail**. **Please remember to leave your name, number and the nature of the emergency. Your therapist may not have your number if you do not leave it.**

Please do not use the urgent notification system for non-urgent situations. During normal office hours (9am -5pm) it is best to also speak directly to the office manager to increase our responsiveness to you. Please note that we cannot guarantee emergency coverage but we will do our best to help you!

Some therapists use texting. Texting or emailing is not the correct way to notify your therapist of your emergency need. Please avoid texting your therapist unless your therapist has texted you to clarify an appointment.

If you or the office manager is unable to reach your therapist in cases of emergency and you need immediate service, we recommend that you call your nearest hospital that provides psychiatric services or present yourself there. We do not anticipate that this would happen but we must be cautious and direct you what to do in advance. We ask that you notify us as soon as possible if you are hospitalized without our assistance. The simplest method of obtaining emergency services is to call **911** but we have prepared a list of local psychiatric hospitals and a few crisis lines.

General Help	
HELPLINE	*414.773.0211*
Domestic Violence	
Advocates "Friends for Victims of Abuse"	*414.375.4034*
Domestic Violence Unit	*414.278.4792*
Compassionate Friends-Waukesha City Chapter	*262.462.3903*
Children and Teens	
Teen Hotline or Dial Harmony (for parents and teens)	*262.547.3388*
Nationwide Girls and Boystown Hotline	*800.448.3000*
Cope Teen Line	*262.377.7786*
Child Adolescent Treatment Center	*414.257.7611*
Child Protective Services	*414.289.6444*
Rogers Memorial Hospital (West Allis)	*414.327.3000*
Rogers Memorial Hospital (Oconomowoc)	*800.767.4411*
Emergency Psychiatric	
Milwaukee City Psychiatric Crisis Service	*414.257.7620*
Columbia St. Mary's Hospital	*800.457.6004 or 414.291.1620*
Community Memorial Hospital	*262.251.1005*
Aurora Psych	*414.454.6600*
Rogers Memorial Hospital (West Allis)	*414.327.3000*
Rogers Memorial Hospital (Oconomowoc)	*800.767.4411*
St. Michael's Hospital	*414.527.8131*
St. Mary's Ozaukee	*262.243.7388*
Waukesha Memorial Hospital	*262.928.4036*