A Word of Welcome:

As the Medical Director for Bell Psychiatric, I wanted to thank you for scheduling an appointment with us. To expedite your care, **please complete and bring the following forms to your first appointment**.

- Bring completed **Personal Health Questionnaire** (form included in this packet)
- Bring a list of ALL of your medications including all vitamins, and supplements that you take daily
- Bring any relevant discharge paperwork (from previous clinics, hospitals, or treatment programs, if applicable)
- And finally, bring any other relevant documents: Testing, Laboratory reports, Genesight/Genomind Testing, Neuropsychological Testing, Individual Education Plans (IEPs), etc.

All patients under 18 years of age, need to have a parent or guardian present at the appointment as we will include them in the process.

If at all possible, please arrive 15 minutes early so that we can make sure all the necessary forms have been completed. You will likely be in our office for two hours during the initial evaluation process.

We look forward to serving your psychiatric needs.

Kindest Regards,

William Bryan Bell, MD

Authorization for Release of Information

Date: _____

Patient Name: _____ DOB: ____/____/____ SSN: _____-____-_____

I hereby authorize the release of my protected health information

From/To: William Bryan Bell, M.D.
2001 Mallory Lane, Suite 303
Franklin, TN 37067
Phone: (615) 567-7881
FAX: (615) 567-3381

From/To : _____
_____
_____
Phone: _____
FAX: _____

I hereby authorize the release of the following information: (check all that apply)

☐ Yes ☐ No HIV status and or related information including AIDS _____ initial
☐ Yes ☐ No Substance Abuse/Dual Diagnosis (including alcohol/drug abuse) _____ initial
☐ Yes ☐ No Medical History (Laboratory results, medications, treatment reports).
☐ Yes ☐ No Psychological test/psychiatric evaluation/neurological workup.
☐ Yes ☐ No Social history, including family, education, employment, arrest, and drug use information.
☐ Yes ☐ No Summary of previous mental health treatment.
☐ Yes ☐ No Periodic reports of treatment progress including attendance, participation and urine surveillance results.
☐ Yes ☐ No Other (specify)

I understand that this information will be used for other following specific purposes: (Check Yes or No)

☐ Yes ☐ NO To develop a diagnosis, treatment and rehabilitation plan.
☐ Yes ☐ NO To coordinate medical, psychological and social rehabilitative process.
☐ Yes ☐ NO To determine present and future eligibility for probation, parole, bail bond, pre-trial release or other diversion process within the criminal justice system.
☐ Yes ☐ NO To process insurance claims for services provided (diagnosis, number of visits, modalities, and expected length of treatment.)
☐ Yes ☐ NO Other (specify)

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that my protected health information, which is disclosed with this release, may be subject to re-disclosure by the recipient and no longer protected by law. Dr. Bell is not responsible for any alterations made on its medical record copies, which have been released to any party. I understand that any release which has been made prior to my revocation and which was made on the basis of this authorization shall not constitute a breach of my Right of Confidentiality. I understand my records are protected under the federal regulation 42, CFR Part 2, HIPPA and TCA 33 and cannot be disclosed without my written consent unless otherwise provided for in these regulations.

- I understand that I have a right to a copy of this authorization after I sign it.
- I understand that Dr. Bell will not condition any provision of treatment on my signing this authorization.
- **This authorization automatically expires in one year and may be revoked at any time with my written statement.**

_____ _____
Signature of Client Date Signature of Parent / Guardian Date

_____
Signature of Witness Date

Please include a photo ID when requesting an electronic release of records

PERSONAL HISTORY QUESTIONNAIRE

Adult Version

DATE: _____

By completing this questionnaire as fully and accurately as possible, you will be helping us to provide you the most timely and appropriate treatment. If you do not want to answer a question, write, "Do not care to answer" in the space provided. Thank you!

Client's Name: _____ Date of birth: _____

By whom were you referred to our clinic?

_____

Name of Referral Person Profession

_____

Referral Address City State Zip

Please describe the primary problem/concern for which you have come to our clinic:

_____

_____

When did your problem(s) begin (give approximate dates)? _____

_____

_____

What triggers or stressful life events play a role in the level of distress you have been experiencing? _____

_____

_____

Any other treatment (therapy, hospitalization, IOP, PHP, new medication, medication dosage changes, changes in therapy) to address your problem? _____

_____

_____

What led to your decision to seek psychiatric help, now?

_____

_____

PERSONAL AND FAMILY MENTAL HEALTH HISTORY

Current Therapists/Counselor: _____

_____

Previous Psychiatrists: _____

_____

Previous Therapists/Counselors: _____

_____

If you have been in therapy before or received psychiatric assistance for your problems, what was the outcome of your treatment? _____
_____
_____

Have you ever been hospitalized for mental or emotional problems? YES NO If YES, when, where, and how may times?
_____
_____

Have you ever attempted suicide / homicide? YES NO If YES please describe: _____
_____

Do you have thoughts of suicide / homicide now? YES NO If YES please explain:_____
_____

Have you ever been arrested or had legal problems? YES NO If YES please explain :_____
_____

Does or has any member of your family ever suffered from an addiction, emotional / mental health problem or any problem that you would have considered a mental disorder? YES NO If YES please explain: _____
_____

Has any member of your family ever committed suicide or homicide? YES NO If YES please explain:_____
_____

MEDICAL HISTORY

Primary Care Physician, Pediatrician, Any other physician care:
(Please include name, address and phone numbers,) _____
_____
_____

Current/past medical illnesses (asthma, diabetes, thyroid, seizures, head injuries, heart disease, etc)
_____
_____
_____

Past Surgical History
_____
_____

Do you have any concerns about your physical health and/or chronic health problems? YES NO If YES please describe:
_____
_____

Have you lost or gained weight within the past few weeks without planning to do so? YES NO If YES describe: _____
_____

Current Height: _____ Current Weight: _____

CURRENT MEDICATIONS: Please list your CURRENT prescription and non-prescription medications; please include vitamins, home remedies, birth control pills, and herbal supplements. USE the back of this form if you need more room.

Please tell me what the medication is used to treat and current dose and when you take it. _____

_____

_____

_____

_____

_____

_____

_____

_____

Please list any known **MEDICATION ALLERGIES**: _____

SUBSTANCE USE HISTORY

Please include whether use is in the past and/or present. What is the frequency of use? When did you last use. Have you had any legal trouble because of use?

Alcohol: _____

Marijuana: _____

CBD Oil: _____

Cocaine/Methamphetamines: _____

Opiate/Narcotic pain medication: _____

Anxiety Medications (Benzodiazepines): _____

Stimulant medications: _____

Caffeine: _____

Tobacco (cigs, dip, vape): _____

Other: _____

_____

Please circle any medical condition which applies to **YOUR Family or BLOOD RELATIVES**:

Brain condition	Breathing problem	Diabetes	High blood pressure	Kidney problem
Bowel condition	Cancer / tumors	Heart condition	Hormonal problem	Thyroid problem

PERSONAL DEVELOPMENTAL AND SOCIAL HISTORY

Circle any of the follow as they apply to your childhood:

Happy childhood	Behavioral problems	Family problems	Physical abuse
Unhappy childhood	Legal problems	Medical problems	Emotional abuse
Emotional problems	School problems	Drug or alcohol problems	Sexual abuse

Where were you born? _____

Describe your childhood in a word or two: _____

Describe the family setting in which you were raised: _____
_____
_____

Current Marital / Relationship Status (How Long?) _____

Name of Spouse or significant other: _____

Who lives with you? _____

Any children? _____

Previous Marriages or Divorces? _____

What is your Occupation? _____

What is your Faith and would you consider your Faith important to your emotional health? _____
_____

Do you have any other information that you feel would be helpful for your doctor to know? YES NO If YES please describe:
_____
_____
_____

TREATMENT GOALS

Please identify **three** of the most important **goals** you have in coming to see us.
One: _____

Two: _____

Three: _____

Circle the Medications you have taken. **If No medications ever taken please circle NONE**

Generic Name of Medication	Common Brand Names	Dose	When taken and for how long? Note any side effects
Amphetamine	Evekeo		
Amfetamine + Dexamfetamine	Adderall, Adzenys, Dyanavel		
Dexamfetamine	Dexedrine, Dextrostat, Zenzedi		
Lisdexamfetamine	Vyvanse		
Methylphenidate	Ritalin, Concerta, Metadate, Daytrana Patch		
Dexmethylphenidate (XR)	Focalin, Focalin XR		
Atomoxetine	Strattera		
Clonidine	Kapvay		
Guanfacine	Intuniv, Tenex		
Alprazolam	Xanax		
Chlordiazepoxide	Librium		
Clonazepam	Klonopin		
Clorazepate	Tranxene		
Diazepam	Valium		
Lorazepam	Ativan,		
Oxazepam	Serax		
Buspirone	BuSpar,		
Hydroxyzine	Atarax, Vistaril		
Carbamazepine	Carbatrol, Equetro, Tegretol		
Gabapentin	Neurontin		
Lamotrigine	Lamictal		
Levetiracetam	Keppra		
Lithium salts	Eskalith, Lithobid, Sedalit		
Oxcarbazepine	Trileptal		
Topiramate	Topamax		
Sodium valproate	Depakene, Depakine Enteric		
Divalproex sodium	Depakote		
Amitriptyline	Elavil, Endep		
Amoxapine	Asendin		
Bupropion SR/XL	Wellbutrin, Wellbutrin SR, Wellbutrin XL		
Citalopram	Celexa		
Clomipramine	Anafranil		
Desipramine	Norpramin		
Desvenlafaxine	Pristiq		
Doxepin	Silenor, Sinequan		
Duloxetine	Cymbalta		
Escitalopram	Lexapro		
Fluoxetine	Prozac, Sarafem, Symbyax		
Fluvoxamine	Luvox		
Imipramine	Tofranil		
Levomilnacipran	Fetzima		
Mirtazapine	Remeron		
Nortriptyline	Aventyl, Pamelor		
Paroxetine	Paxil, Pexeva		
Phenelzine	Nardil		
Protriptyline	Vivactil		
Selegiline	Emsam		
Sertraline	Zoloft		
Tranylcypromine	Parnate		

Trazodone	Desyrel, Oleptro		
Venlafaxine	Effexor, Effexor XR		
Vilazodone	Viibryd		
Vortioxetine	Trintellix, Brintellix		
Eszopiclone	Lunesta		
Ramelteon	Rozerem		
Suvorexant	Belsomra		
Temazepam	Restoril		
Triazolam	Halcion		
Zaleplon	Sonata		
Zolpidem	Ambien CR, Intermezzo		
Aripiprazole	Abilify, Abilify Maintena		
Asenapine	Saphris		
Brexiprazole	Rexulti		
Cariprazine	Vraylar		
Chlorpromazine	Thorazine		
Clozapine	Clozaril		
Fluphenazine	Sinqualone		
Haloperidol	Haldol, Haldol Decanoate		
Iloperidone	Fanapt		
Lurasidone	Latuda		
Olanzapine	Zyprexa, Zyprexa Relprevv		
Olanzapine/Fluoxetine	Symbyax		
Paliperidone	Invega, Invega Sustenna		
Perphenazine	Trilafon		
Pimozide	Orap		
Promethazine	Neuraxph, Prothazin		
Quetiapine (ER)	Seroquel (XR)		
Risperidone	Risperdal, Risperdal Consta		
Thioridazine	Mellaril,		
Thiothixene	Navane		
Trifluoperazine	Stelazine		
Ziprasidone	Geodon		
Modafinil	Provigil		
Amodafinil	Nuvigil		
L-Methylfolate	Deplin		
Prazosin	Minipress		
Melatonin			
Cyproheptadine	Periactin,		
Diphenhydramine	Benadryl		
Hydroxyzine	Atarax, Vistaril		
Promethazine	Phenergan		
Propranolol	Inderal		
Varenicline	Chantix		
Acamprosate	Campral		
Buphrenorphine	Subutex		
Buphrenorphine / Naloxone	Suboxone		
Dislufiram	Antabuse		
Methadone	Dolophine		
Naltrexone	ReVia, Vivitrol		
			List any other psychiatric medications which you may have taken:

*(Thank you for taking the time to fill out this questionnaire. Please bring this form to the receptionist at your appointment.)