(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

Department of Psychiatry – Patient Demographic Information

Patient's Social Security #: _____ Patient's Date of Birth: _____

Patient's Full Legal Name: _____
first Middle Last Maiden

Permanent Address: _____
Street Apt #

_____
City State Zip Code Country

Home Phone: ( ) _____ Work Phone: ( ) _____ Message: ( ) _____

E-mail: _____ Cell Phone: ( ) _____ Other: ( ) _____

Please check the box next to acceptable methods of communication from this office:
☐ letter ☐ home phone ☐ work phone ☐ e-mail ☐ page ☐ cell phone ☐ other

Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-binary ☐ Other_____

Preferred Name: _____ Identified Pronouns: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership/Civil Union ☐ Involved with multiple partners
☐ Separated from spouse/partner ☐ Divorced/permanently separated from spouse/partner
☐ Widowed ☐ Other _____

Race/Ethnic Origin: _____ Religious Preference: _____

EMPLOYMENT INFORMATION: Occupation: _____

Patient's Employer: _____ Date of Hire: _____

Employer Address: _____
Street City State Zip

Employer Phone: _____ Employment Status: ☐ full-time ☐ part-time ☐ disabled ☐ student ☐ self-employed ☐ retired, date: _____ ☐ unemployed

INSURANCE POLICY HOLDER: (if patient is not insured, please list guarantor information)

Name of Policy Holder: _____ Relationship to Patient: _____

Phone: ( ) _____ Address: _____

Social Security #: _____ Date of Birth: _____ Occupation: _____

Employer: _____ Phone: ( ) _____

Insurance Name: _____ Member/Subscriber ID: _____ Group Number: _____

Address: _____
Street City State zip

IN CASE OF EMERGENCY, we should notify: _____

Relationship to Patient: _____

Mobile Phone: ( ) _____ Work Phone: ( ) _____

_____ _____ _____
Signature Date Time

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UAMS | Psychiatric Research Institute

Admission/Consent Agreement

Patient Status: ☐ Inpatient ☐ Outpatient

1. **Consent for Medical Treatment:** I now voluntarily consent to inpatient and/or outpatient care and treatment by physician and all other health care providers at UAMS Medical Center Psychiatric Research Institute (PRI). UAMS is a teaching facility where medical students, residents and others in a training program will be involved in my care and treatment under the supervision of a qualified professional. I also consent to routine hospital services, diagnostic procedures, medical treatment, and other services and care as deemed necessary by the health care providers treating me. Except in emergency situations, it is it is the provider's responsibility to adequately inform me or my representative concerning proposed treatment and to obtain my or my representative's consent. I understand that the price of medicine is not an exact science and there is no guarantee that any particular treatment will be successful. I understand that I have the right to consent or refuse to consent to any proposed treatment and to discuss it with my health care provider. I understand and give authorization for my physician to access information from an online pharmacy data base about medications that I may be taking for the purpose of continued treatment.
2. **Inpatient Nursing Care:** UAMS PRI provides general duty nursing care unless additional care is required in special care units.
3. **Personal Information:** I certify that the information I have provided is true and accurate to the best of my knowledge. I understand this information is subject to verification with credit agencies, federal and/or state agencies and others as required. I authorize my employer to release to UAMS proof of my income. I consent to provide my cell phone number to UAMS, their designated collection agency, or attorney for them to contact me directly, by an automated dialing system or through a prerecorded messaging system to discuss payment of any unpaid financial obligation I have at UAMS PRI.
4. **Valuables:** I understand that UAMS PRI is not responsible for any valuables that I keep in my possession while in the hospital. I understand that valuables should be sent home with family / friends and those that cannot be sent home may be stored in the hospital safe.
5. **Assignment of Benefits:** In consideration of services rendered, I hereby assign any benefits due under my insurance coverage, benefits or inpatient/outpatient services to UAMS Medical Center/PRI and/or to physician services for my treating physicians. I understand I am financially responsible for all charges not covered including deductibles, co-pays, and co-insurance. After reasonable notice, accounts not paid may be turned over to a collection agency and/or attorney. Attorney fees, the cost of collection and court costs will be the patient's responsibility.
6. **Financial Disclosure:** I understand that my doctor and others that care for me at UAMS may have financial relationships (make money) with other companies. I understand that UAMS may have financial relationships with other companies in the health and medical field. If I want more information about this, I can ask my health care provider or call the UAMS Conflict of Interest office at (501) 686-6447.
7. **Text Messages:** By providing UAMS with my cell phone number and the cell phone numbers of any family and friends, I agree that UAMS can send text messages that may contain my health information. Text messages may include, but are not limited to, reminders of upcoming appointments, prescription refill reminders, my status during a surgery or Emergency Department visit, such as a text message that informs my family, friends and/or others who I choose that I am out of surgery and in a recovery room, treatment plans, and text messages for other similar purposes. UAMS does not guarantee information sent via a text message to a cell phone is secure and encrypted. There are security risks associated with texting information in an unsecure and unencrypted manner, including, but not limited to, an unauthorized person or entity accessing or using the information. I acknowledge and agree I have been warned of and accept such risks.

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8. **Release of Information:** I understand my information will be released in accordance with UAMS Notice of Privacy Practice.
9. **Discharge:** I agree to prompt discharge following my physician's order for discharge. If I leave against medical advice (AMA) or elope, I release the physician, or other health care providers, UAMS Medical Center/PRI and FGP, its employees, agents and assigns from any and all responsibility from any ill effects, sickness, disability, infirmity, damages, death and claims that may result.
10. **Tobacco Use:** UAMS is a TOBACCO FREE CAMPUS. I understand that I may no use any tobacco product on campus.
11. **Living Will:** In accordance with Arkansas Right of the Terminally Ill or Permanently Unconscious Act (Ark. Code Ann. Section 10-17-201 through 218, Supp. 1989). I acknowledge receipt of information regarding the living will and health care power of attorney.
12. **I understand that all patient rooms, hallways, and other areas of PRI are monitored by video recordings for security and safety reasons.**

I, or my legal representative, have read and agree to the above.

_____ _____ _____
Patient or Legal Representative Signature Date Time

_____ _____
Relationship of Legal Representative Person Providing Verbal Consent

_____ _____ _____
Witness Signature Date Time

Inpatients only:
Please initial: ____ I have received a copy of the UAM Admission Packet which includes a copy of the Advanced Directives and a copy of the Patient's Rights and Responsibilities.

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UAMS Medical Center

Department of Psychiatry and Behavioral Sciences
Patient Questionnaire

Please bring this completed questionnaire to your first appointment.

Preferred Name: _____ Date: _____

What problem(s) are you seeking help for? _____

_____

What are you expectations for your care in this clinic? _____

_____

PRESENT STATE OF HEALTH

If you have been experiencing any of the following symptoms, please check or circle and describe:

Physical Pain: ☐No Problems

☐ Yes, rate the level of pain on the following scale:

Low Moderate High

1 2 3 4 5 6 7 8 9 10

Eyes ☐ No Problems

☐ wear corrective lenses ☐ visual changes ☐ glaucoma ☐ other: _____

Ears, Nose, Mouth & Throat ☐ No Problems

☐ nose bleeds ☐ white patches in mouth ☐ hoarseness ☐ hearing difficulty ☐ sore throat

☐ other concerns: _____

Heart & Circulation (cardiovascular system): ☐ No Problems

☐ palpitations or fluttering sensation of heart ☐ chest pain ☐ tightness in chest with exertion

☐ other concerns: _____

Lungs & Breathing (respiratory system): ☐ No Problems

☐coughing up phlegm or excretions ☐ shortness of breath ☐ asthma ☐ emphysema

☐ other concerns: _____

Stomach & Intestines (gastrointestinal system): ☐ No Problems

☐ stomach pain ☐ changes in diameter of stools (bowel movement)

☐ feel full quickly after eating small amounts of food ☐ abdominal pain

☐ diarrhea ☐ constipation ☐ dark tarry appearing stools or blood in stools

☐ changes in weight or appetite Other concerns: _____

Female / Male Reproductive & Urinary Systems (genitourinary system): ☐ No Problems

☐ Last menstrual period: ☐ No menstrual periods (never had / hysterectomy / menopause)

☐ infections (yeast / chlamydia / syphilis / HIV / genital warts / gonorrhea / other: _____)

☐ sexual symptom(s) (premature ejaculation / poor erections / no orgasm / pain with intercourse)

☐ difficulty with fertility ☐ loss of pregnancy / infant ☐ bladder infections ☐ kidney stones

☐ currently attempting to conceive ☐ birth control practices (the pill / condoms / diaphragm / other)

☐ change in desire for sexual activity ☐ blood in urine ☐ burning or difficulty urinating

☐ testicular lump ☐ other concerns : _____

Muscles & Bones (musculoskeletal system): ☐ No Problems

☐ muscle weakness ☐ arthritis or joint pain ☐ other concerns: _____

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Department of Psychiatry and Behavioral Sciences
Patient Questionnaire

Skin (Integumentary): ☐ No Problems

☐ rash ☐ breast lumps / discharge ☐ skin changes / growths ☐ chew or pick fingernails
☐ pull our hair ☐ other concerns: _____

Nervous System (neurologic system): ☐ No Problems

☐ numbness /tingling ☐ seizures ☐ poor coordination ☐ weakness or decreased energy
☐ head injury history ☐ tremor or muscle twitches ☐ sleep problems
☐ learning, reading, memory problems ☐ other concerns: _____

Endocrine / metabolic: ☐ No Problems

☐ cold / heat intolerance ☐ vitamin deficiency (B12) ☐ parathyroid problem ☐ thyroid problem
☐ pancreatitis ☐ diabetes ☐ Addison's disease ☐ kidney disease ☐ liver disease
☐ other concerns: _____

Hematologic / Lymphatic (blood flow system): ☐ No Problems

☐ anemia ☐ enlarged lymph nodes ☐ fever ☐ other concerns: _____

Allergic / Immunologic: ☐ No Problems

☐ NO KNOWN DRUG ALLERGIES ☐ medication allergies : _____
☐ allergies to foods, insects, environmental: _____
☐ autoimmune diseases ☐ other concerns: _____

PAST MEDICAL HISTORY:

Date of last physical exam: _____ Physician's Name: _____

1. List all past hospitalizations, emergency room visits, outpatient surgeries (include reason and date):
   _____
   _____
   _____
2. List all current medical problems: _____
   _____
   _____
3. Family Medical History: List any mental and medical illnesses (i.e. history of bipolar/schizophrenia, substance abuse, suicide attempt or completion) among your biological relatives (parents, siblings, grandparents, aunts, uncles):
   _____
   _____
   _____
4. Abuse History: Have you ever been abused (emotional, physical, sexual), a victim of a crime or experienced trauma? ☐ no ☐ yes, _____
   Risk of Exploitation? ☐ no ☐ yes, _____
5. Do you have a Psychiatric Advanced Directive? ☐ no ☐ yes, _____

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Department of Psychiatry and Behavioral Sciences
Patient Questionnaire

MENTAL HEALTH HISTORY

List all previous mental health and substance abuse treatments (include reason and date):

Circle any types of medications that you have or are currently taking: ☐ never taken medication

Antidepressants: Prozac / Zoloft / Celexa / Paxil / Luvox / Elavil / Wellbutrin / Effexor / Serzone / Tofranil / Anaframil / Pamelor / Sinequan / Nardil / Remeron / Other: _____

Nerve pills: Xanax / Valium / Klonopin / Buspar / Ativan / Other: _____

Sleeping pills: Ambien / Restoril / Daimane / Other: _____

Mood stabilizers: Tegretol / Lithium / Lamictal / Depakote / Neurontin / Other: _____

Antipsychotics: Risperdal / Haldol / Proixin / Stelazine / Clozaril / Geodon / Seroquel / Zyprexa

Other: _____

Other: Vistaril / Benadryl / Cogentin / Artane / Ritalin / Adderall / other: _____

HABITS:

Do you currently smoke cigarettes? ☐ no ☐ yes, packs per day: _____ Years smoked: _____

Do you use other tobacco products? ☐ no ☐ yes

If you drink alcohol at least once a month, please estimate how much: _____

Have you ever used or currently use recreational drugs? ☐ no ☐ yes, please circle types:

Marijuana / Cocaine / Methamphetamine / Hallucinogenics / Other: _____

_____

Recreational / Social Activities (please list): _____

_____

Sexuality:

Do you have any sexual concerns you wish to discuss? ☐ no ☐ yes, _____

Spirituality:

Do you have any spiritual concerns you wish to discuss? ☐ no ☐ yes, _____

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Patient Questionnaire

Nutrition Screening

Please indicate all that apply – refer to dietitian or Primary Care Provider if YES to any of the following and patient is not being currently followed for the problem(s).

		Staff Use Only. **For "yes" answers, please check as appropriate.**			
	Please Circle	Addressed	Refer	Not Addressed	See intake
Have you had an unintentional weight loss of over 10lbs in the last month?	Yes / No				
Have you had an unintentional weight gain of over 10 lbs in the last 10 months?	Yes / No				
Do you have difficulty chewing / swallowing?	Yes / No				
Do you suffer from chronic nausea / vomiting / constipation / diarrhea?	Yes / No				
Are you pregnant or nursing?	Yes / No				
Do you have a history of an eating disorder?	Yes / No				
Are you currently being followed for any of the nutrition problems noted above?	Yes / No				
Do you have dental problems?	Yes / No				

Patient
Signature: _____ Date: _____ Time: _____

Staff Member
Signature: _____ Date: _____ Time: _____

Staff Member Printed Name: _____

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UAMS Medical Center

UAMS Department of Psychiatry Medication Tracking Sheet *

Print Name: _____

Please help us care for you better by listing ALL
prescription and over-the-counter medications you take.

Note any Medication Allergies: _____
_____

Prescriptions:			
Name of Medicine	**Dosage**	**How many times/day?**	**MD who prescribed?**

☐ check here if your medication list is continued on the back of this page

Please list over-the-counter medications, including herbal remedies and vitamins:			
Name of medicine		**How often do you take it?**	

_____ _____ _____
Signature Date Time

**You may be asked to complete this: upon program entry, upon transfer to another program and/or discharge.*