Date:_____

FRAUKE C. SCHAEFER, MD, INC.

1709 Legion Rd., Suite 226, Chapel Hill, NC 27517 919-929-7640 Fax: 919-929-7648

Patient(s)/Client(s)Name_____
Address_____
City_____State_____Zip_____
Home Phone _____ May I leave a message? Yes No
Cell Number _____ May I leave a message? Yes No
Work Number _____ May I leave a message? Yes No
E-mail _____ May I leave a message? Yes No
Age _____Date of Birth ____/____/_____ Gender: Male ☐ Female ☐

If Adult:
Name of Employer_____Occupation_____
Spouse/Partner's Name_____
Children's Names and Ages_____

If Student/Senior: Parent/Guardian's/POA's Name_____
Relationship to _____ Best phone # to be reached at _____
School /College currently attending _____Grade/Year_____

In case of emergency notify:
Name_____ Relationship_____
Address_____ City_____ State _____ Zip_____
Work Phone_____ Home Phone_____ Cell Phone_____

Guarantor Information (If other than self):
Name_____ Relationship _____
Address_____ City_____ State _____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____

Insurance Company:_____ID#_____Group#_____
Policyholder_____ Employer _____
Claims Address_____City _____ State _____Zip _____
Copay, if known_____

Primary Care Physician: _____
Address _____ City/State/Zip _____
Phone _____ Fax _____

Pharmacy (Name/City/Street)_____Tel_____

Referral Source: How did you find out about us?
Friend ☐ Insurance Co. ☐ Health Care Professional ☐ Pastor ☐ Employer ☐ Internet ☐

Religion_____

Church Affiliation (if any)_____

Adult Intake Questionnaire

Please complete this form to help your clinician as he/she talks with you regarding your problems.
What is the primary reason you are seeking help at this time? _____
_____
_____Please check all that apply below:

[ ] Panicky feelings [ ] Fears [ ] Avoidance [ ] Procrastination [ ] Shyness [ ] Driven to perform certain behaviors
[ ] Difficulties making decisions [ ] Flashbacks [ ] Nightmares [ ] Feeling unreal [ ] Sensitivity to noise and lights
[ ] Temper outbursts [ ] Anger problems [ ] Bingeing [ ] Purging [ ] Disorganization [ ] No sense of purpose
[ ] Spiritual/ religious concerns [ ] Guilt [ ] Mood swings [ ] Seasonal variations of mood [ ] Mania
[ ] Suspicious of others [ ] Hearing unidentified sounds or voices [ ] Drug/alcohol abuse [ ] Sexual problems

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all **0**	Several days **1**	More than half the days **2**	Nearly every day **3**
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
i. Thoughts that you would be better off dead or of hurting yourself in some way				
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all	Some-what	Very difficult	Extremely difficult
In the past TWO years, have you felt depressed or sad most days, even if you felt okay sometimes?	Yes			Score:

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total Score:				

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:		
1. Have had nightmares about it or thought about it when you did not want to?	Yes	No
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
3. Were constantly on guard, watchful, or easily startled?	Yes	No
4. Felt numb or detached from others, activities, or your surroundings?	Yes	No

Mental Health History

Is there a family history of (check all that apply):

☐ Depression ☐ Anxiety ☐ Suicide ☐ Bipolar Disorder ☐ Psychosis ☐ Alcoholism ☐ Substance Abuse

If yes, please describe the relationship to you and the problem:

Concern_____ Which relatives_____

Concern_____ Which relatives_____

Concern_____ Which relatives_____

Have you attempted suicide? ☐ No ☐ Yes

Do you currently have suicidal thoughts? ☐ No ☐ Yes

Do you ever feel angry enough at home, work, or school to do something you might regret?

☐ No ☐ Yes

Childhood History

As a child did you have any problems with:			**Age**
☐ Learning disabilities	☐ No	☐ Yes	_____
☐ Hyperactivity	☐ No	☐ Yes	_____
☐ School fears	☐ No	☐ Yes	_____
☐ Depression	☐ No	☐ Yes	_____
☐ Sexual or physical abuse	☐ No	☐ Yes	_____

Did you have any other major childhood (0-17 years) school, learning, or emotional problems?

☐ No ☐ Yes If so, please describe: _____

_____

Personal History

Which of the following best describes the family in which you grew up?

Warm and Accepting			Average			Distant, Hostile and Fighting		
1	2	3	4	5	6	7	8	9

Was the family/home/or adult life disrupted by serious illness/accident/death/divorce?

☐ No ☐ Yes If yes, please describe _____

_____

Previous Counseling or Chemical Dependency Services:

Have you ever seen anyone or are you currently seeing anyone for:

Individual Therapy ☐ No ☐ Yes Marital/Couples Therapy ☐ No ☐ Yes

Group Psychotherapy ☐ No ☐ Yes Sex Therapy ☐ No ☐ Yes.

Facility/Counselor Name	Month/Year Seen	Reason Seen	Helpful?
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes

Have you experienced any unusually severe stresses during the past year? ☐ No ☐ Yes

If yes, please describe: _____

_____

_____

_____

Job Satisfaction*:* ☐ Very Satisfied ☐ Fairly Satisfied ☐ Not At All Satisfied

Have you ever taken work leave for mental health/chemical dependency problems?

☐ No ☐ Yes How Long? _____

What is your job/profession?_____

Medical/Lifestyle History

Current health ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Do you have any medical problems or diseases? _____

_____

Did you ever have a head injury? ☐ Yes ☐ No
Did you ever have seizures? ☐ Yes ☐ No

PLEASE NOTE ANY MEDICAL CONDITIONS (ONGOING PAST AND PRESENT)

1. General wellbeing (pain, insomnia, fever, weight, etc.) ☐
2. Eye conditions (vision, pain, discharge, etc.) ☐
3. Ears/Nose/Mouth/Throat concerns ☐
4. Cardiovascular (hypertension, irregular beat, pain, etc.) ☐
5. Respiratory (asthma, infection, COPD, apnea, etc.) ☐
6. Gastrointestinal (constipation, diarrhea, pain, etc.) ☐
7. Genitourinary (frequency, prostate issues, stones, etc.) ☐
8. Musculoskeletal (pain, weakness, arthritis, etc.) ☐
9. Skin conditions (rash, itching, lesions, hair loss etc.) ☐
10. Neurological (headache, tremor, seizures, MS, etc.) ☐
11. Endocrine (thyroid, diabetes, menstrual irreg., etc.) ☐
12. Hematological/Lymph (known disease, bleeding,..) ☐
13. Allergies/Immune (food, pollen; autoimmune, etc. ☐
14. Other:

Medications currently used:

Medication/Dose	When Prescribed	Why Prescribed	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take any herbal medications? ☐ No ☐ Yes, please name_____
Do you have medication allergies? ☐ No ☐ Yes, please name_____

Past Hospitalizations (Psychiatric/Chemical Dependency)

Date(s)	Reasons	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Alcohol use

How often do you use alcohol? ☐ None ☐ Monthly ☐ Weekly ☐ Daily

On the days that you drink, how many drinks do you usually have?
☐ Less than 2 ☐ 2-5 ☐ 5 or more

Do you consider it a problem? ☐ No ☐ Yes; Do others consider it a problem? ☐ No ☐ Yes
Do you have problems at work/school because of drinking or drug use? ☐ No ☐ Yes
Have you had problems with alcohol in the past? ☐ No ☐ Yes

Nicotine use

Do you smoke or use tobacco now? ☐ No ☐ Yes, how much/day? ____
Have you smoked or used tobacco in the past? ☐ No ☐ Yes

Caffeine

How many cups of caffeinated coffee/tea do you drink a day?_____
How many caffeinated soft drinks?_____

Drug use

Marijuana: ☐ None ☐ Occasionally ☐ Daily ☐ Weekly
Do you use other non-prescription substances? ☐ No ☐ Yes, what substance?_____

Legal History: ☐ None ☐ Litigation ☐ Arrest ☐ Victimization, specify _____
Are you presently involved in a court case? ☐ No ☐ Yes

PSYCHATRIST-PATIENT/CLIENT SERVICES AGREEMENT
FRAUKE C. SCHAEFER, MD, INC.

I. I have received a copy of the Frauke C. Schaefer, MD, Inc. PSYCHIATRIST-PATIENT/CLIENT SERVICES AGREEMENT and a copy of the Frauke C. Schaefer, MD, Inc. PRIVACY NOTICE.

_____
Initials/ Date

II. ***(This must be signed by your first session.)***

I have read, understand, and accept the following by initialing each item:

_____ that Frauke C. Schaefer, MD, Inc. may disclose Protected Health Information as necessary to my insurance company if I want my insurance to be filed. If this is not initialed, I understand that I must pay in full for services.

_____ that Frauke C. Schaefer, MD, Inc. may use Protected Health Information within the practice for the purpose of Treatment/Consultation

_____ that Frauke C. Schaefer, MD, Inc. may share Information as necessary with my primary care physician. If you do not wish information to be shared with your physician initial the "no" block below.

____ NO, do not share information with my physician

Please initial the following if Frauke C. Schaefer, MD, Inc. staff:

_____ may contact you or leave messages at your **home** telephone number

_____ may contact you or leave messages at your **work** telephone number

_____ may contact you or leave messages at your **cell phone** telephone number

_____ may contact you by **e-mail,** if desired specify address_____

I have read, understand, and accept all of the provisions of the Frauke C. Schaefer, MD, Inc. PSYCHIATRIST-PATIENT/CLIENT SERVICES AGREEMENT and the Frauke C. Schaefer, MD, Inc. PRIVACY NOTICE.

_____ _____
Name (Patient/Client or Representative) Date

_____
Relationship to Patient/Client