

**HANCOCK COUNSELING & PSYCHIATRIC SERVICES  
MEDICAL HISTORY FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female

Family Physician: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

*Check below any illnesses you have had:*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Neuritis            |
| <input type="checkbox"/> Aneurysm            | <input type="checkbox"/> Hemorrhoids            | <input type="checkbox"/> Pancreatitis        |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Polio               |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Hernia                 | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> HIV                    | <input type="checkbox"/> Skin Disorder: list |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Stomach Trouble     |
| <input type="checkbox"/> Cancer -- Tumors    | <input type="checkbox"/> Irregular Heart Rhythm | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Thyroid Illness     |
| <input type="checkbox"/> Diverticulosis      | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Lupus                  | <input type="checkbox"/> Ulcer leg           |
| <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Mononucleosis          | <input type="checkbox"/> Ulcer Duodenal or   |
| <input type="checkbox"/> Eye Disease         | <input type="checkbox"/> Multiple Sclerosis     | <input type="checkbox"/> Stomach             |
| <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Nervous Breakdown      | <input type="checkbox"/> Venereal Disease    |

List any other illnesses: \_\_\_\_\_  
\_\_\_\_\_

***Operations***

Type	Month/Year	Name of Hospital

***Hospitalizations***

Type	Month/Year	Name of Hospital

*Allergies*

\_\_\_\_\_ Aspirin  
 \_\_\_\_\_ Morphine

\_\_\_\_\_ Codeine  
 \_\_\_\_\_ Penicillin

\_\_\_\_\_ Demerol  
 \_\_\_\_\_ Sulfa

Please list any other allergies: \_\_\_\_\_

*Family History*

Please list any history of psychiatric symptoms, psychiatric illness or substance abuse in family members:

	AGE	HEALTH STATUS G=GOOD F=FAIR P=POOR	KNOWN ILLNESSES	AGE AT DEATH	CAUSE OF DEATH
<b>Father</b>					
<b>Mother</b>					
<b>Brothers</b>					
<b>Sisters</b>					
<b>Spouse</b>					
<b>Sons</b>					
<b>Daughters</b>					

Are you taking any medications now?      Yes                  No

Please List: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Hancock Counseling & Psychiatric Services  
Biopsychosocial

**PATIENT HISTORY FORM**

**Instructions To Patient/Family – Please complete this form. It will provide us with important information about you and your needs.**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Current Living Situation – Complete the following table regarding your immediate family:**

Family Member	Age	Relationship To Patient	Living With Patient?	Education Level	Occupation

**Family/Other Important Relationships – Please note marital status, past marriages, divorces, dating and relationships. Describe degree of support received from family, friends, school, support groups.**

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**Family Of Origin – Please describe your relationships with parents/caregivers and brothers/sisters. Note any family problems that were present, such as history of substance abuse or mental illness in family members.**

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**Education – Provide level of schooling completed.**

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**Financial** – Are there current financial problems?

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**Employment** – Provide work history, retirement, terminations, problems on the job, EAP involvement, relationships with co-workers and bosses, shifts, hours per week.

Unemployed                       I am on disability

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**Military -**       Yes       No       Not Applicable

Active       Yes       No

Combat       Yes       No

Branch \_\_\_\_\_ Length \_\_\_\_\_

Type of Discharge \_\_\_\_\_ Disciplinary Action \_\_\_\_\_

**Legal History** – Note any legal difficulties including arrests, convictions, pending charges, guardianship, power of attorney.

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**Religion/Spirituality** – Please describe past and/or present religious affiliations.

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Are you active in a church that provides additional support?     Yes     No

**Violence/Abuse** – Please describe any history of violence or abuse as a child or adult.

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Form completed by: (check all that apply)

Patient       Staff       Family - Name of Family Member \_\_\_\_\_

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Staff Signature \_\_\_\_\_ Date \_\_\_\_\_



**HANCOCK COUNSELING & PSYCHIATRIC SERVICES**

**120 W. McKenzie Road, Suite F**

**Greenfield, Indiana 46140**

**(317) 468-6200 Fax: (317) 468-6201**

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

I authorize Hancock Counseling & Psychiatric Services to give and receive information concerning my treatment to and from:

Name to be released to/from: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

Information to be released: \_\_\_\_\_

\_\_\_\_\_

For the purpose of:

Diagnosis and Evaluation \_\_\_\_\_

Formulation of Treatment Plan \_\_\_\_\_

Assist in Rehab Efforts \_\_\_\_\_

Continuing Care \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please read the following waiver and charging information prior to signature:**

I knowingly and voluntarily waive the Indiana Law Provision that this consent expires in 60 days and specify that this consent remain in effect while I am in treatment or until revocation in writing has been received by the doctor(s) and/or therapist(s) who shall not be liable to the undersigned patient for any consequences of the disclosure by the doctor(s) and/or therapist(s) authorized above. I am aware that the records disclosed may include but are not limited to mental health treatment, substance use and HIV status. I understand that faxed and/or photo copies of this release are permissible.

I further agree to pay any fees involved in the preparation, copying and mailing of the requested information.

\_\_\_\_\_  
Patient, Guardian, Parent or Health Care Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship To Patient



## **HANCOCK COUNSELING AND PSYCHIATRIC SERVICES**

### **NO SHOW/CANCELLATION POLICY**

At Hancock Counseling and Psychiatric Services, it is our goal to provide the highest quality care with the best value for you.

It is our policy to require at least a 24 hour advance notice if you cannot keep a scheduled appointment.

Failure to notify us of your intent not to keep your appointment will result in a no show/short notice cancellation fee or you may be subject to suspension or termination from our services. The fee for no notification will be \$60.00.

There will be a fee (not more than \$60.00) determined by your provider for notification of cancellation less than 24 hours in advance. This determination will be based on your level of commitment in your treatment. A pattern of cancellations could result in the higher fee or could also result in suspension or termination from our services.

We appreciate your understanding and look forward to working with you. If you have any questions or concerns about this policy, please discuss it with one of our staff.

I have read the No Show/Late Cancellation policy and understand it will remain in effect throughout my treatment. Fees and conditions are subject to change upon written notification.

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Patient/Parent/Health Care Representative

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Date



**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

With my consent, Hancock Health Network may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Hancock Health Network's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Hancock Health Network reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: HHN Privacy Officer at 156 W. Muskegon, Greenfield, IN 46140.

With my consent, Hancock Health Network may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Hancock Health Network may mail to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Hancock Health Network restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Hancock Health Network's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, Hancock Health Network may decline to provide treatment to me.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Guardian (if not Patient)

