

OAK STREET MEDICAL, P.C.

Date:

Patty Nadel, LCSW
71 East 15th Ave
Eugene, OR 97401
(541) 431-9416

Thank you for allowing us to become partners in your Health Care!

Enclosed you will find paperwork we need you to complete and bring with you for your appointment. If this is not completed when you come in it may delay your appointment time. Please arrive 20 minutes prior to your appointment time as additional paperwork will be needed at check in as part of the new patient registration process.

§ If your insurance is a managed care plan, a referral is required from your primary care physician in order to be seen by a specialist. With a managed care plan, please call to make sure the referral has been requested from your primary physician and received by the specialist.

§ As a courtesy, our office will contact your insurance company to verify coverage and benefits. Please call us if you have questions about the amount you will need to be prepared to pay at your first appointment. Co-payments, Co-insurance and Deductible amounts are payable at the time of service. We accept cash, checks made payable to Oak Street Medical, Visa, MasterCard or Discover.

Appointment Policy

Our office requires 24 hour notice if an appointment cannot be kept. If you are unable to make your scheduled appointment, please notify us as soon as possible. You can directly call the scheduler for Patty Nadel at 541-431-9416 to speak to them or leave a message if they are not available to the phone at the time of your call. Another number is Oak Street Medical main phone number of 541-431-0000. All no shows and late cancelations will be documented in the patient's medical record.

Subsequent to the 1st occurrence there will be a \$60 charge to the patient for no shows and late cancelations.

If there is another late cancelation or no show, the patient will need to call to speak to Patty before scheduling any further appointments.

Continued no shows and late cancelations will subject the patient's account for review of possible terminations from the practice.

Mailing Address: 1488 Oak Street, Eugene Oregon, 97401

Physical Address- **(Patty Nadel, LCSW) 71 East 15th Ave, Eugene Oregon 97401**

(A historic blue house on the corner of the alley between Oak and Willamette St)

If you have any questions, please feel free to call the office during regular business hours.
We look forward to meeting you soon.

Warmest regards,

The Office Staff
Oak Street Medical

Oak Street Medical
BEHAVIORAL HEALTH PATIENT INFORMATION
Patty Nadel, LCSW

Name: _____
Birth date: _____

Date: _____

A. The reason you're seeking counseling now?

Please describe the main concern(s) that have prompted you to see me now?

B. History:

Please indicate your major life stressors of the past 12 months? Serious illness or injury Death of a close friend/family member
 Major illness in family Gain of New Family Member Divorce/Separation Job Change
Other: _____

Have you ever received psychological or psychiatric counseling (specify if hospitalized) before? No Yes

If yes When, with whom, purpose and results?

Have you taken medication for a psychiatric or emotional problem in the past? No Yes When, What, for what and with what results?

C. Medical Information

Primary Care Physician: _____ Last Exam: _____

Current or Chronic Health Problems:

How would you characterize your overall health? Excellent Good Fair Poor

MEDICATIONS: (include dosage, frequency, effectiveness and who prescribed):

D. Alcohol/Drug

Do you consume any Alcohol? No Yes less than 1x month 1-3 x month 1x per week
 Several x's a week Everyday Wine Beer Hard Liquor (please check all that apply)

During the last year, has the use of alcohol or drugs:

- Placed you in a dangerous situation, such as driving a car under the influence?
- Gotten you arrested?
- Continued despite causing problems for you and/or your loved ones?

Name: _____

DOB: _____

History of alcohol abuse / treatment (where, how long, outcome?)

Do you smoke? ____ Yes ___ No Smoked in the past ____ Yes ____ No Packs per day _____

Do you drink caffeine (coffee, tea, soda?) ____ Yes ____ No Cups/cans per day? _____

Current or history of drug (street or prescription) abuse? ____ No ____ Yes If yes, Names of drug, frequency of use, treatment:

E. Social/Relationship Information

Relationship Status: Single ____ Married (how long) ____ Partnered (how long) ____ Divorced (how long) ____

This is my # _____ Marriage or partnership

How do you get along with your present spouse or partner?

Number of children, ages and with whom do they live if not on own?

How do you get along with your kids?

Were your parents: Divorced ____ (what age where you? ____) Never Married ____ Still Married ____

If you have siblings, where are you in the birth order? _____

How do you get along with your family of origin?

Mother: _____

Father: _____

Siblings: _____

Family history of: Depression _____ Suicide (or attempts) _____ Anxiety _____ Eating Disorders _____

Mental Illness _____ Violence _____ Sexual abuse _____ Emotional abuse _____ Alcohol/Drug Addiction _____

Other _____

Please indicate any of the following that you have experienced?

____ Death of Mother ____ Your age at occurrence ____ Death of Father ____ Your age at occurrence

____ Death of child ____ Your age at occurrence ____ Age of child

____ Death of sibling ____ Your age at occurrence ____ Age of sibling

____ Desertion by mother or father as a child ____ Your age at occurrence

Please list the first names of your significant friends and indicate how long you have had these relationships?

First Name	How Long?	How often do you see this person?

Name: _____

DOB: _____

F. Employment Information

What is the nature of your employment? _____
How long at current job? _____ How satisfied are you in this job? ___Not very ___Somewhat ___Comfortable ___Very
Are you satisfied that your income adequately covers your living expenses? ___Not very ___Somewhat ___Comfortable ___Very

G. Spiritual Resources

How significant a role does spirituality play in your life? _____None _____ somewhat important ___ Significant ___Very Important
Particular spiritual path/Religion? _____

H. Symptoms

Check those that are true for you.
Any recent changes in: ___ Sleep ___ Nightmares ___ Amount of exercise ___ Sexual Desire ___ Eating/Appetite ___Weight
Do you feel any of the following more days than not or more than usual for you?
___Sad or depressed
___Disinterested in Life
___Worthless or guilty
___Tired/Fatigue/or Agitated
___ Do you have recurrent thought of death, recurrent suicidal ideation or history of suicide attempts or plan for committing suicide?
Are you bothered by:
___ Restlessness, feeling keyed – up or on edge?
___ Being easily tired?
___ Problems concentrating?
___ Irritability?
___ Muscle tension?
___ Trouble falling asleep or staying asleep, or restless and unsatisfying sleep?
___ Do you have a history of manic or hypomanic episodes?
___ Do you have unreasonable worry about a number of events or activities, such as work or school and /or health?
___ Do you avoid open spaces, public places, bridges, or tunnels, traveling (buses, trains, cars, airplanes), situations in which escape is blocked or help may be difficult to obtain? Or if you do these things is it endured with intense anxiety?
___ Do you use a “safe person” to be able to do any of the above?
___ Do you worry about being humiliated or embarrassed in social or performance situations?
___ Are you unable to control the anxiety/worry?
___ Does your worry/anxiety interfere with your daily life?
___ Do you have or have you ever had hallucination or delusion with or without the depressed mood?
___ Do you have or have you had panic attacks?
___ Do these panic attacks happen only in the presence of a specific situation or stimulus?
___ Do you fear germs or contamination?
___ Do you have a history of a traumatic event or events?
___ Do you worry about the welfare of others or about being away from home?
___ Are your worries experienced as intrusive or excessive, and accompanied by urges, impulses, or compulsions?

Is there anything else you think I should know as we begin?

We look forward to meeting you soon.

Warmest regards,
The Office Staff
Oak Street Medical