UB|MD PRIMARY CARE

ADULT MENTAL HEALTH HISTORY FORM

Marlon R. Koenigsberg, Licensed Psychologist

I see adults for individual counseling via telehealth video calls only. I participate with Highmark/BCBS of WNY, Independent Health, Univera, Medicare & Medicaid health insurances.

Please complete this form and send it to Dr. Koenigsberg prior to your first visit by fax 716.932.7465, by mail to Marlon Koenigsberg, PhD, 850 Hopkins Road, Williamsville, NY 14221, or by dropping it off at the office. Thank you.

Your Name: _____ **Today's Date:** _____

Cell Phone Number: _____ **Date of Birth:** _____

Address: _____

Email: _____ **Referred By:** _____

Check Health Insurance: ☐ **Highmark/BCBS of WNY)** ☐ **Independent Health** ☐ **Univera** ☐ **Medicare** ☐ **Medicaid**

CURRENT PROBLEMS *(Use your own words to describe the problems you are seeking help for.)*

PRIOR PROBLEMS *(List any previous periods in your life when you had this problem or another problem related to stress, mental health, addictions, alcohol or family difficulties.)*

TREATMENT GOALS *(What are you hoping to achieve from psychological treatment?)*

1.

2.

3.

Please Continue on Next Page ➔

If you have ever received mental health or addictions services before, please complete table below:

Professional's Name/Agency	Start/Stop Dates	Describe problem, treatment and effectiveness

Please list any psychiatric medications you have tried, and describe your response:

Please list any current health problems and/or physical limitations:

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PATIENT HEALTH QUESTIONNAIRE

Dr. Koenigsberg's Version

NAME: _____ DATE: _____

1. 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
a.	Little interest or pleasure in doing things	☐	☐	☐	☐
b.	Feeling down, depressed, or hopeless	☐	☐	☐	☐
c.	Trouble falling or staying asleep, or 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	☐	☐	☐	☐

2. Questions about anxiety.

		NO	YES
a.	In the last 4 weeks, have you had an anxiety attack—suddenly feeling fear or panic?	☐	☐

If you checked "NO," go to question 3.

b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue—that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

e. Check all items you experienced during your last bad anxiety attack:

- ☐ Short of breath
- ☐ Heart racing or pounding
- ☐ Chest pain or pressure
- ☐ Sweating
- ☐ Choking or trouble swallowing
- ☐ Hot flash or chills
- ☐ Nausea or upset stomach, or feeling you were about to get diarrhea
- ☐ Feeling dizzy, unsteady or faint
- ☐ Feeling numbness or tingling in parts of body
- ☐ Shaking or trembling
- ☐ Fear of dying
- ☐ Fear of losing control or going crazy
- ☐ Feeling things were not real, or you were distant from yourself

3 Over the last 4 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
a.	Feeling nervous, anxious, on edge, or worrying a lot about different things.	☐	☐	☐	☐

If you checked "Not at all", go to question 4 .

b.	Feeling restless so that it is hard to sit still.	☐	☐	☐	☐
c.	Getting tired very easily.	☐	☐	☐	☐
d.	Muscle tension, aches, or soreness.	☐	☐	☐	☐
e.	Trouble falling asleep or staying asleep.	☐	☐	☐	☐
f.	Trouble concentrating on things, such as reading a book or watching TV.	☐	☐	☐	☐
g.	Becoming easily annoyed or irritable.	☐	☐	☐	☐

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4 Questions about eating.	NO	YES
a. Do you often feel that you can't control what or how much you eat?	☐	☐
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
c. If you checked "YES" to either #a or #b, has this been as often, on average, as twice a week for the last 3 months?	☐	☐

5 In the last 3 months have you often done any of the following in order to avoid gaining weight?	NO	YES
a. Made yourself vomit?	☐	☐
b. Took more than twice the recommended dose of laxatives?	☐	☐
c. Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d. Near-Fasted --- eaten minimally (<500 cal) in 24 hours?	☐	☐
e Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐

6 If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	NO	YES
	☐	☐

7. In the past year, how often have you used the following?

	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a) Alcohol - For men, 5 or more drinks a day - For women, 4 or more drinks a day	☐	☐	☐	☐	☐
b) Tobacco Products	☐	☐	☐	☐	☐
c) Prescription Drugs for Non-Medical Reasons	☐	☐	☐	☐	☐
d) Illegal Drugs	☐	☐	☐	☐	☐

8. If you checked off any problems on this questionnaire so far, 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 difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**

9. In the last year . . .	No	Yes
a) Have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?	☐	☐
b) Have you ever been afraid to go home?	☐	☐

10. What is the most stressful thing in your life right now? _____

_____

_____

_____

Adapted from PHQ & PHQ-Brief, by Drs. Robert Spitzer, Janet Williams, Kurt Kroenke and colleagues. Published by Pfizer Inc.

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INFORMED CONSENT FOR TELEPSYCHOLOGY

As my practice is now completely telehealth, I have taken steps to create a safe system we can use for "virtual visits". While this allows us to have psychotherapy sessions, telehealth requires some technical competence on both our parts, and not being in the same room has some inherent limitations and benefits.

Some practical issues:

- **Confidentiality.** On my end I have taken steps to ensure your privacy (I selected Doxy HIPAA-compliant encrypted video software, I am using a secure UBMD computer, I maintain up-to-date antivirus software, I am using an office with physical privacy). But it is important for you to (1) find a private place for our session where you can minimize interruptions, and (2) protect the privacy of our session on your device. While I have taken these steps, I cannot guarantee that our internet communication is secure and private. That is, there may be security and privacy risks associated with any Internet-based communications. All confidentiality protections granted by various state and federal laws also apply to my care during this appointment.
- **Reliability.** Technology may stop working during a session. If that happens, please disconnect from the session, close your browser, and try clicking the link again. Moving closer to your router or switching devices may help in certain circumstances. I may also be restarting the software, so it may be a moment before the "waiting room" is available again.
- **Emergency situations.** In an emergency, please call 911, or the local 24-Hour Crisis Hotline (Erie County: 716.834.3131; Niagara County: 716.285.3515; U.S. Suicide Prevention Lifeline: 800.273.8255) or go to your nearest emergency room.
- **Urgent situations.** If an urgent issue arises, you should feel free to attempt to reach me by phone at my office number (716.688.9641). I will return your call ASAP. If I am not available, the provider on call for my office may return your call.
- **Administrative communication between sessions.** You can call our office (716.688.9641) for most administrative issues such scheduling/rescheduling/cancelling appointments, changes in insurance, changes in contact info. If you choose to email or text me, be aware that such communication is not secure, and I cannot guarantee the confidentiality of such communication. If you choose to use such communication anyway, I recommend that it be limited to administrative matters (i.e. rescheduling appointments). Also, I do not continuously monitor my email or texts, nor can I always respond immediately, so these methods should not be used for emergent or urgent matters.
- **No Recording of Sessions.** Our communication is privileged and confidential, and we will not record the audio or video without first explicitly seeking the permission of the other. I will create a written progress note summary of the Tele-health appointment in the electronic health record.

Electronic Communications. Your communication device (computer, tablet, smartphone) will need to meet some basic requirements (i.e. compatible hardware and software, webcam, and microphone) to use telehealth services. You will need a good data connection to run the video effectively. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telehealth, and for your data costs, if applicable.

Fees. For most insurances, the same fee rates, copays, and deductibles will apply for telehealth psychotherapy as apply for in-person psychotherapy. As usual, you will be responsible for any portion not covered by your insurance. Please contact your insurance company prior to our engaging in telehealth sessions in order to determine their coverage for these sessions. Do not hesitate to contact me if you have questions about this.

THEREFORE, BY CONSENTING TO TELEHEALTH APPOINTMENTS WITH DR. KOENIGSBERG:

1. I desire to engage in remote audio-visual communication with my Healthcare Provider.
2. I understand the risks and benefits of using Internet-based communications and that no results can be guaranteed.
3. I acknowledge that if the Healthcare Provider believes that remote communication is insufficient for treatment, consultation, or evaluation, then I will be referred to alternate services or options.
4. I understand that I may be responsible for co-payments, deductibles, or other charges from my Healthcare Provider for services related to this appointment.
5. I have the ability to ask direct questions to my Healthcare Provider about this appointment, including details about the Healthcare Provider's privacy policy. If my questions are not answered to my satisfaction, I have the right to terminate the appointment.
6. I am at least 18 years of age.

_____ _____

Signature Date