

**Forsyth** MEDICAL CENTER
BEHAVIORAL HEALTH OUTPATIENT SERVICES

Remarkable People. Remarkable Medicine.

Forsyth Behavioral Health Outpatient
3821 Forrestdge Drive
Winston Salem, NC 27103

We are glad you have chosen Forsyth Behavioral Health for your Behavioral Health needs.

It is our desire that your experience with our staff would be an excellent and remarkable one. We are committed to making this happen for you.

If you are attending:	Arrive:
Mental Health or Substance Abuse Day Programs	By 8 am on your first day
Substance Abuse Evening Program	By 5.30 pm on your first day
Individual Counseling	15 minutes prior to your first appointment
DBT Skills Training Group	By 1 pm on your first day

Enclosed you will find a map to our office and registration forms which need to be completed before arriving for your appointment. We are also including paperwork for your review to be signed once you arrive for your appointment.

Please bring your insurance card(s) and a photo id such as your driver's license. Also bring with you the name of your Family physician, physician's practice name and phone number.

If you have any questions prior to your appointment or you need to reschedule, please call us at 336-277-1800. Please call 24 hours ahead of time if you need to cancel. Example: Monday appointments would need to be cancelled on Friday.

Thank you for taking the time to read this information and complete the appropriate forms.

We genuinely look forward to being of service.

Forsyth BH Outpatient Staff

FORSYTH BEHAVIORAL HEALTH OUTPATIENT REGISTRATION INFORMATION
3821 FORRESTGATE DRIVE
WINSTON SALEM, NC 27103

Today's Date: _____

PATIENT: Date of birth _____ SS# _____ Race _____ Sex _____ Marital Status: **M S D Sep WIDOWED**

Last Name _____ First Name _____ Middle Name _____

Maiden Name _____ Street Address _____ City _____

State _____ ZIP _____ Home Phone (____) _____ Cellular (____) _____

County that you live in _____

Are you an organ donor: [] Yes [] No Do you have a living will: [] Yes [] No
Do you have a medical power of attorney [] Yes [] No Do you refuse to receive blood products? [] Yes [] No

Please provide the first and last name of your Family Physician or Primary Care Physician _____

Physician practice name _____ Ph# _____

Were you born in the U.S.? [] Yes [] No If no, where were you born? _____

IF YOU ARE A FULL TIME COLLEGE STUDENT, DO YOU ATTEND – Circle one: Full Time Part Time
Circle one: Day Night

Name of College _____ City _____ State _____

Patient Employer (If **retired**, please give former employer) Name _____

Phone # () _____ Position _____

Street Address _____

City _____ State _____ Zip _____

Employment Status

Circle 1: Full Time Part Time
FMLA Retired Disabled
Disability Date _____

BILLING INFORMATION: If you are on your parent's or spouse's insurance policy we need the following information.

Spouse or Parent Name _____ Job Title _____

Spouse or Parent Employer _____ Phone () _____

Street Address _____ City _____ State _____ Zip _____

Spouse or Parent SS# _____

Employment Status

Circle 1: Full Time Part Time
Retired Disabled
Disability Date _____

Spouse /Parent Date of Birth _____

For security please provide the following information:

Year & Model of Car _____ Color _____ License Plate # _____

*****EMERGENCY CONTACT INFORMATION*****

Name _____ Relationship to Patient _____ Home PH (____) _____

Work PH (____) _____ Cellular (____) _____

Street Address _____ City _____ State _____ ZIP _____

Medications/Substances Brought From Outside the Hospital Consent

It is my request that I, _____ continue taking the

Patient's Name

Following medications/substances that I have been taking prior to admission.

I understand that this is contrary to Hospital Policy that requires all prescriptions administered at the Hospital be filled by the Hospital Pharmacy. Therefore, in consideration of the Hospital permitting me to use these medications/substances, I hereby waive and release this Novant Health Triad Region hospital and its employees, agents, officers, and trustees from any and all claims or demands which I may have arising out of the administration of the medications/substances listed below. This Release shall be binding upon undersigned, and any person claiming through, by or on my behalf.

Name of Medication/Substance	Dosage	Frequency

I understand that my physician will be notified of my intentions to take these medications/substances. I further understand that my physician must approve the use of these medications/substances.

Signature: _____ Date/Time: _____
Patient or Patient Representative

Witness: _____ Date/Time: _____

If limited English proficient or hearing impaired, offer interpreter:

Interpreter Accepted _____ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)



Medications/Substances Brought from Outside the Hospital Consent

BH Integrated Outpatient Assessment
(Psychosocial History Section IV)

Source of Information: Patient Family/Support System Agency

Other: _____

Patients' goal while hospitalized _____

DEMOGRAPHICS

Current living arrangements: _____

Current marital status:

Married Yes No, How long _____ # of Times _____ Widowed Yes No, how long _____

Divorced Yes No, how long _____ Partnered Yes No, how long _____

Briefly describe each marriage:

Age when first married: _____ Current Spouse's Name: _____

Occupation of spouse: _____

CURRENT FAMILY:

Children (including half & step)	Sex	Age	Supportive Y/N	Where Living



BH Integrated Outpatient Assessment
(Psychosocial History Section IV)

FAMILY OF ORIGIN:

Parents:	Mother	Step-Mother	Father	Step-Father
Name:				
Where Living:				
Supportive:				

Where were you raised? _____

Who raised you? _____

BROTHERS & SISTERS (including half & step, please specify)

Name	Where Living

How do you get along with your brothers and sisters? _____

DEVELOPMENTAL HISTORY

Were you ever seriously ill or have surgery? Yes No,
Explain _____

Please describe to the best of your ability, what your childhood was like for you: _____

EDUCATIONAL HISTORY

How far did you go in school? _____ If you dropped out of school, why? _____

Any special education? Yes No Describe: _____

Support Systems Patient has the following intact support systems: (Check all that apply)

Family Therapist Friends Community

HAVE YOUR FAMILY'S CIRCUMSTANCES CONTRIBUTED TO YOUR DIFFICULTIES AT ALL?



ARE THERE GRIEF/LOSS ISSUES THAT NEED TO BE ADDRESSED DURING YOUR TREATMENT?

Yes No _____

OCCUPATIONAL HISTORY

What is your job situation right now? Employed Unemployed/Seeking Work
 Unemployed/Not Seeking Work Disabled Retired

What special skills do you feel you have? _____

Would you like to change jobs or get more training? Yes No Explain: _____

MILITARY HISTORY

Have you ever been in the service? Yes No Branch: _____

Have you served a hostile fire tour of duty? _____

Type of discharge: Honorable Dishonorable Medical Explain: _____

SEXUAL HISTORY Age of first consensual sexual experience _____

Sexual orientation Homosexual Heterosexual Other _____

Denies current sexual activity Unwilling to provide information In a monogamous relationship

Had multiple sexual partners in past yr, # of partners _____ Uses birth control

Currently having unprotected sex Is sexually active single Admits to dysfunctional sexual relations

At risk to acting out sexually History of prostitution Has information regarding STD's including HIV

Needs information regarding STD's including HIV History of pornography

SPIRITUAL/CULTURAL NEEDS

What is your current religion? _____

How important is spirituality in your life? _____

Do you have any cultural beliefs/practices that we need to know about in order to provide you with support and respect for your beliefs? _____

ABUSE/NEGLECT/TRAUMA

History of Child Abuse? Yes No Explain: _____

History of Abuse/Trauma as Adult? Yes No Explain: _____

Does the patient need a referral for services regarding the abuse/neglect? Yes No

If yes, to where did you refer the patient to for services? _____

