

# The New Mind: Whole Person Psychological Care

Dennis W. Wallstrom, Ph.D.

PSY 13058

114 N. Indian Hill Blvd., Suite B

Claremont, CA 91711

(909) 603-9300, (909) 603-9301 FAX

New Patient Registration—Adult

Welcome, and thank you for the opportunity to collaborate together for your mental, physical, spiritual, and social health. If you will take a few moments and provide information about yourself and your current concerns, it will help us focus your treatment most effectively. Your medical and family history is important because physical issues can often affect psychological issues. Please feel free to bring any questions to the attention of Dr. Wallstrom.

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone (OK to call?) \_\_\_\_\_ Driver's License \_\_\_\_\_ SS# \_\_\_\_\_

Work Phone (OK to call?) \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Gender: \_\_\_ Female \_\_\_ Male Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed

Education: \_\_\_ High School Grad \_\_\_ Some College/Technical \_\_\_ College Grad \_\_\_ Graduate/Professional Degree

Emergency Contact \_\_\_\_\_  
Name Relationship to Patient Phone

Primary Care Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Other Persons in Household (Relationship to Patient):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How were you referred to Dr. Wallstrom? \_\_\_\_\_

May we acknowledge contact? \_\_\_ Yes \_\_\_ No

Primary Insurance Plan \_\_\_\_\_ Payor/Health Plan \_\_\_\_\_

Policy/Group # \_\_\_\_\_ Psychiatric/Mental Health Plan \_\_\_\_\_

Insured Party \_\_\_\_\_ Insured Party SS# \_\_\_\_\_

Insured Party Birthdate \_\_\_\_\_ Patient's Relationship to Insured:  
\_\_\_ Self \_\_\_ Spouse \_\_\_ Dependent

Employer \_\_\_\_\_

What concerns bring you to see Dr. Wallstrom at this time? \_\_\_\_\_  
\_\_\_\_\_

What events or circumstances made these concerns surface? \_\_\_\_\_  
\_\_\_\_\_

Please rate any problems or concerns according to their severity (rate 1-5):

NO PROBLEM 1	MILD PROBLEM 2	MODERATE PROBLEM 3	SEVERE PROBLEM 4	EXTREME PROBLEM 5
___ Depressed Mood		___ Lack of Friends		___ Marriage/Relationship Issues
___ Anxiety		___ Loneliness		___ Sexuality/Sexual Issues
___ Stress		___ Coping Difficulties		___ Family Conflict
___ Loss of a Loved One		___ Abuse/Victimization	___ Behavioral Problems	
___ School Difficulties		___ Financial Difficulties	___ Drug/Alcohol Use	
___ Work Difficulties		___ Legal Matters	___ Controlling Impulses (gambling, over-spending, etc.)	
___ Anger		___ Attention/Concentration	___ Memory	
___ Unusual Experiences	_____			
	(Describe)			
___ Other	_____			
	(Please specify)			

Current Medications: \_\_\_\_\_  
(Name and Dosage) \_\_\_\_\_

Last Physical Exam? \_\_\_\_\_  
Date Doctor

Significant Findings? \_\_\_\_\_

Blood Test Results? \_\_\_\_\_  
(include date)

Medical Conditions \_\_\_\_\_  
Currently Being Treated: \_\_\_\_\_

Do you experience any of the following? (Check all that apply)

___ Double or Poor Vision	___ Excessive Thirst/Dry Mouth	___ Difficulty Hearing
___ Indigestion, Gas Heartburn	___ Fainting	___ Stomach Pain
___ Blackouts	___ Diarrhea or Constipation	___ Convulsions
___ Vomiting/Vomiting Blood	___ Blood in Stool	___ Paralysis
___ Dizziness	___ Change in Appetite/Eating Habits	___ Headaches
___ Sleep Difficulties	___ Thyroid Problems	___ Sexual Difficulties
___ Coughing or Wheezing	___ Difficulties with Memory, Attention, or Concentration	
___ Chest Paine	___ Weakness or Lack of Energy	___ Shortness of Breath
___ Joint Pain	___ Heart Palpitations or Irregularities	___ Lumps Anywhere in Body
___ Swelling	___ Weight Gain or Loss _____	
	(Number of pounds over what period of time)	

Describe your use of drugs or alcohol:

<u>Substance</u>	<u>Amount</u>	<u>Frequency</u>	<u>Last Use</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been in trouble with the law because of your use of substances? \_\_\_\_\_

Have you ever had family/relationship difficulties because of your use of substance? \_\_\_\_\_

Have you experienced blackouts, seizures, or withdrawal symptoms?

(Describe) \_\_\_\_\_

What mental health or substance abuse treatment have you received previously? \_\_\_\_\_

Please respond to the following lifestyle questions:

	<u>Current Frequency</u>	<u>Highest Frequency</u>	<u>Last Use/Occasion</u>
Caffeinated drinks	_____	_____	_____
Tobacco	_____	_____	_____
Alcohol (drinks per day)	_____	_____	_____
Exercise (time and type)	_____	_____	_____
Work	_____	_____	_____
Vacation	_____	_____	_____
Religious Services	_____	_____	_____
Prayer/Meditation	_____	_____	_____

What kind of serious medical illness has been in your family? \_\_\_\_\_

What kind of mental health issues have been in your family? \_\_\_\_\_

What kind of substance use problems have been in your family? \_\_\_\_\_

## Policies and Agreements

Please read each item carefully and sign below. A copy of this agreement will be provided to you. Dr. Wallstrom will discuss with you any questions or concerns you may have.

### TREATMENT APPROACH

Dr. Wallstrom will be working closely with you to identify clearly areas on which your treatment will focus, as well as goals of treatment and modes of treatment (e. g., individual therapy, couple/family therapy, EEG neurofeedback). Alleviating distress and making progress toward optimal mental, physical, spiritual, and social functioning, are my highest concerns. If you are involving your health plan, a case manager may be collaborating with us and making certification decisions. Your active involvement in your treatment, including "homework" assignments, will be essential for the best outcome of treatment.

### CONFIDENTIALITY

All information disclosed by you to Dr. Wallstrom will be held in strictest confidence, unless court-ordered to release it, or:

- You authorize a release of information with your signature.
- You present a danger of physical harm to yourself or others.
- There is a reasonable suspicion of child or dependent adult abuse or neglect.

To protect others, law enforcement and potential victims may need to be contacted, according to the requirements of the law.

### FINANCIAL TERMS

You will be responsible for the financial obligations of your treatment. This will mean making payment for each session at the time of service (unless other arrangements are made), or fulfilling the applicable deductible amount and making co-payments. Co-payments must be made at the time of each session. If you are not eligible for benefits or your insurance company should not pay for any reason, you are responsible for full payment of services. Unpaid accounts may be sent to a collection agency, and a 40% service charge will be added to the balance assigned to the collection agency. INITIAL \_\_\_\_\_

### CANCELLED OR MISSED APPOINTMENTS

This practice relies upon your responsibility for arriving at your appointments at the designated times. Of course, schedule changes and emergencies are inevitably a part of life. When making changes to appointments, please allow at least **24 hours notice**. Notification within less than 24 hours or not showing for an appointment will result in a **\$70 fee**, which must be paid prior to your next appointment. Health plans do not cover charges for late cancellations or missed appointments. INITIAL \_\_\_\_\_

### EMERGENCY PROCEDURES

You may contact Dr. Wallstrom outside of session at 909-603-9300, and leave a message at any time. Every effort will be made to respond to non-urgent messages the same day. If it is an urgent matter, you may contact Dr. Wallstrom on his mobile phone: 909-560-3905. Any life-threatening emergency should be addressed by calling 911, or by going immediately to the nearest hospital emergency room.

### RELEASE OF INFORMATION TO YOUR HEALTH PLAN

If I am involving my health plan in my treatment, I authorize Dr. Wallstrom to release information regarding my care to my health plan for the payment of claims, certification and case management decisions, and other purposes related to the administration of my benefits.

### CONSENT FOR TREATMENT

I authorize and request Dr. Wallstrom to carry out the assessments, diagnostic procedures, and treatments necessary during the course of my treatment. I understand that the purpose of any facet of treatment will be explained to me and will be subject to my agreement. I also understand that the process of psychotherapy, while designed to facilitate my recovery to optimal mental, physical, spiritual, and social functioning, may be challenging and difficult at times.

### APPEALS AND GRIEVANCES

I acknowledge my right to request reconsideration in the event certification for my care is denied. To appeal, I understand I would request an appeal through Dr. Wallstrom, and that I risk nothing in exercising this right. I also acknowledge that I may submit a grievance to Dr. Wallstrom at any time to register a complaint about any aspect of my care. And at any time, if I am not satisfied with the response I receive from an appeal or grievance, I may submit the complaint directly to my health plan.

*I have read, understand, and agree to all of the above information.*

---

Patient (or Parent/Guardian)—PRINTED, then SIGNED

---

Date

Policies and Agreements—YOUR COPY

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Patient (or Parent/Guardian)—PRINTED, then SIGNED

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Date

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Claremont, CA 91711  
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I, \_\_\_\_\_, authorize my insurance company,  
\_\_\_\_\_, to send payment automatically to  
Dennis W. Wallstrom, Ph.D., 114 N. Indian Hill Blvd., Suite B, Claremont, CA 91711.

Signed \_\_\_\_\_ Date \_\_\_\_\_