Breakthrough
Mental Healthcare LLC

17304 Preston Rd, Suite 800, Frisco TX 75252
469-287-5505
214-975-2395
info@breakthroughmh.com

Personal Details

Date: _____ Name: _____DOB: _____ Age: _____

Address:

_____

SSN#: _____ Wk. Phone: _____Cell Phone: _____
Email Address: _____ Employer/School: _____
Sex: [ ] Male [ ] Female [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated [ ] Other:

Primary Insurance

Insurance: _____Policy/Member ID#:_____Group#: _____

Insurance Holder (Name):_____DOB: _____ SSN#: _____
Relationship to Patient: _____

Secondary Insurance

Insurance: _____ Policy/Member ID#: _____Group#: _____

Insurance Holder (Name):_____DOB: _____SSN#: _____
Relationship to Patient: _____

I, _____, have provided the above information accurately and to the best of my knowledge. It is my responsibility to notify Tonia Ajamu's office of any changes of insurance or demographic information. I understand that payment of co-pay/co-insurance, are due before any services are rendered. I certify that I, and/or my dependents have insurance coverage, and I assign directly to Tonia Ajamu, MSN, APRN, PMHNP-BC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named provider may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the signed below date.

Emergency Contact Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Address: _____

_____

Signature of Patient, Parent, Guardian, or Representative Date

Date: _____ Name: _____DOB: _____Age: _____

My Primary Care Physician is: _____My last physical was: _____

History of Past Illness:

[ ] Measles [ ] Rheumatic Fever or Heart Disease [ ] Mumps [ ] Congenital Abnormalities [ ] Chicken Pox [ ] None

Adult:

[ ] Asthma [ ] High Blood Pressure [ ] Cancer (Site):_____ [ ] Diabetes [ ] Ulcer or Gastritis [ ] Thyroid Problems [ ] Tuberculosis [ ] Kidney Problems [ ] Liver Problems [ ] Blood Problem [ ] Venereal Disease [ ] Heart Failure [ ] Heart Attack [ ] Abnormal Heart Rhythm [ ]Osteopenia [ ] Osteoporosis [ ] Fibromyalgia [ ] None

Allergies:

Do you have any allergies? [ ] Yes [ ] No

Allergen	Symptoms/Severity Operations

Operations:

Have you had any surgeries or operations? [ ] Yes [ ] No

Date	Procedure performed	For what problem?

Current Medications: Do you currently take any medication? [ ] Yes [ ] No If yes, please list:

Medication Dosage	First/Last time you took it	Effect of medication

Have you been on **PSYCHIATRIC** medication in the past? [ ] Yes [ ] No If yes, please list:

Medication Dosage	First/Last time you took it	Effect of medication

Past Psychiatric Care (List all Psychiatrist, Therapists, Counselors, and Hospitalizations)

Date(s) seen? By Whom?	For what problem?	What treatment (meds, TMS, ECT, therapy)?

Substance Abuse Please indicate for each drug listed below Drug

	Ever used?	Age at 1st use	Time since last use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Do you have a family history of diabetes [ ] Yes [ ] No

Has anyone in your family attempted or committed suicide? [ ] Yes [ ] No

Systemic Review:

Current weight: _____ Max weight: _____ Min weight: _____ Height: _____

Have you recently had: [ ] Weakness [ ] Fever [ ] Chills [ ] Fainting [ ] Problems Sleeping [ ] Night Sweats [ ] None

Respiratory:

Asthma or wheezing [ ] Yes [ ] No

Difficulty breathing [ ] Yes [ ] No

Pleurisy or Pneumonia [ ] Yes [ ] No

Cough up blood (ever) [ ] Yes [ ] No

Skin:

Skin Disease [ ] Yes [ ] No

Jaundice [ ] Yes [ ] No

Hives, eczema, rash [ ] Yes [ ] No

Head Eyes Ears Nose Throat:

Dry eyes or mouth [ ] Yes [ ] No

Bleeding gums [ ] Yes [ ] No

Blurred vision [ ] Yes [ ] No Date of last eye exam:_____

Nosebleeds – frequent [ ] Yes [ ] No

Chronic sinus trouble [ ] Yes [ ] No

Ear disease [ ] Yes [ ] No

Impaired hearing [ ] Yes [ ] No

Dizziness or room spinning [ ] Yes [ ] No

Frequent or severe headaches [ ] Yes [ ] No

Injuries:

Have you ever been in a serious motor vehicle accident? [ ] Yes [ ] No

Have you ever had any concussions or head injuries? [ ] Yes [ ] No

Have you ever been knocked unconscious? [ ] Yes [ ] No

Social History:

Are you employed? [ ] Yes [ ] No

What is your job? _____

Are you a student? [ ] Yes [ ] No Where? _____

Grade School [ ] College [ ] Postgraduate [ ]

Do you wear seatbelts? [ ] Always [ ] Sometimes [ ] Never

Foreign Travel within the past year? [ ] Yes [ ] No Country? _____

Coffee _____ Tea_____ Colas _____ per day

Ever used Alcohol? [ ] Yes [ ] No Drinks per week currently? _____

Ever used Tobacco? [ ] Yes [ ] No Packs per week currently? _____

Has a parent, sibling, child, grandparent ever had psychiatric problems, substance abuse, or treatment?

[ ] Yes [ ] No If so, what type of illness and treatment?

_____
_____

Sexual Orientation: [ ] Heterosexual [ ] Homosexual [ ] Bisexual [ ] Choose not to answer

Do you have any concerns regarding sexual function? [ ] Yes [ ] No

Please describe any other symptoms or experiences you have had problems with:

_____
_____
_____

Print Name: _____Signature: _____Date: _____