Dawna Gutzmann, MD & Associates

Offices in Skokie & Chicago Loop

Mailing Address: 5225 Old Orchard Road, Suite 36, Skokie, IL 60077
Phone: (312) 488-9599
E-mail: info@DGutzmannMD
Website: www.DGutzmannMD.com

Patient Name_____ Date of Birth_____

Legal Guardian_____Address_____

_____

City_____State_____ZipCode_____Email_____

Telephone #_____Alternate Phone#_____

INFORMED CONSENT TO TREATMENT AND/OR EVALUATION

I hereby authorize the psychiatric/psychological treatment and/or evaluation of myself (or the above named child) by Dr. Gutzmann (or her associate). I have discussed stated goals of psychological treatment and/or evaluation and I understand that I have the right to ask for information regarding diagnosis, goals for treatment, and estimated length of treatment.

I have read the Patient's Rights & Responsibilities document and understand my rights & responsibilities as a patient with Dawna Gutzmann, MD & Associates.

I have read the Privacy Practices document and the Limits of Confidentiality document and I understand these policies and legal requirements regarding confidentiality.

I understand that personal notes taken by Dr. Gutzmann (or her associate) represent the personal work product of my therapist and as such, remain her/his sole property. I understand and agree that Dr. Gutzmann (or her associate) may properly retain such documents in my file according to professional standards. She/he is not required to release personal notes about my care, since these represent work product, and are not part of the formal psychological record. Copies of actual records and/or typewritten reports about my care can be sent out if I provide proper written authorization, and this will be done according to professional standards. There may be a fee for preparing and sending records.

In the event of a life-threatening emergency, I can page Dawna Gutzmann, MD by calling (847) 610-0393 and **leaving a message.** Pages without messages will not be answered. I also understand that if a life is in imminent danger, I will not wait for Dawna Gutzmann, MD to respond. I will immediately call 911 or go to the nearest emergency room for assistance.

I have read the Financial Policies document and understand the policies of Dawna Gutzmann, MD & Associates.

I have read the Cancellation Policy document and understand the policies of Dawna Gutzmann, MD & Associates regarding cancellation of appointments. I understand that the cancellation fee must be paid before any further services are rendered, unless other arrangements are made. This fee will be charged directly to the client's credit card, if available.

I understand that this agreement becomes part of my psychological record, which is accessible to the parties at will, but to no other person without written consent.

Patient Signature_____
(or Legal Guardian)
Date_____

Confidential Personal History

Name_____Date_____

Parent/Guardian (if under 18 years)_____

How did you hear about us? _____

Occupation _____Do you enjoy your work? _____

What difficulties, if any, are you experiencing at work? _____

_____

Describe any difficulties in your level of motivation:_____

_____

Describe any difficulties in productivity & effectiveness: _____

_____

How many brothers & sisters do you have? _____

Where are you in the birth order of your family of origin? _____

Describe the family "atmosphere" in which your were raised: _____

_____

_____

Are you married or in a romantic relationship? _____ If so, for how long? _____

How satisfied are you with your relationship currently? _____

Do you give & receive affection frequently? _____ Describe any change in your sexual life: _____

_____

What type of contraception do you use?_____

Please list any children by first name & age _____

_____

Describe any difficulties you are currently having in your home life: _____

_____

What is your educational background?_____

Describe any challenges with learning. _____

Does it seem to be as easy as ever to make decisions? If not, please describe:_____

_____

What are your usual leisure pursuits, hobbies & keen interests?_____

_____

Are you able to derive as much pleasure from them as usual lately?_____

How do you typically like to socialize (a few close friends, numerous friends, one on one, in groups, etc.)?

_____

Have you had as much desire to socialize with friends and family as usual? _____

Do you have a close friend in whom you can confide? _____

Describe any social difficulties: _____

Describe any change in your attention to your appearance or hygiene: _____

Is your self-esteem/confidence as good as ever, better than ever or lower than usual lately?_____

What do you do to manage stress? _____

What are some of your greatest strengths? _____

_____

What habits, if any, do you have that might hinder your success? _____

_____

Do you organize your time effectively? _____

Do you have an adequate income for your needs? _____

What was your family's religion, if any, when you were a child? _____

Do you have a spiritual practice? _____ Do you get strength from spiritual beliefs? _____

Describe any major life stressors you have experienced in the past 2 – 3 years. _____

_____

_____

Describe three behaviors that concern you the most: _____

_____

How long have these problems persisted? _____

If no change occurs, what are you most concerned will happen? _____

_____

Health

How would you rate your current physical health? _____

When was your last complete physical exam? _____

Please indicate if you have a current or past history of disorders/illness of the following:

___Vision/eyes
___Hearing loss
___Sinus/throat
___Dental
___Headaches
___Seizures
___Concussions
___Lungs/breathing
___Heart Disease
___High Blood Pressure
___Anemia
___Thyroid
___Diabetes
___Skin
___Joint/back
___Bone fractures
___Urinary/kidney
___Liver
___Venereal disease
___Neurological condition(s)

Describe any current health problems: _____

_____

List any surgeries you have had: _____

List any other hospitalizations: _____

Has your weight increased or decreased by more than 10 pounds in the past 5 years? _____ Please explain:_____

_____

List the names & dosages of any medications you are taking. _____

_____

Have you been taking these medications as prescribed?_____

Describe any side effects that you are experiencing: _____

_____

List any supplements you are taking. _____

_____

List any medications to which you are allergic. _____

Describe your exercise routine. _____

Describe your usual eating habits. _____

Describe any change in your appetite: _____

How would you rate your sleeping habits? _____How many hours do you typically sleep each night? _____

Describe any sleep problems you have _____

Describe your energy level during the day: _____

How much caffeine do you have on average? _____

How much do you smoke & for how long, if at all? _____

How often and how much alcohol do you drink? _____

What is the most alcohol you have had to drink in 24 hours in the past year? _____

Was there ever a time when you felt you were, or someone told you, you were drinking too much? _____

If yes, under what circumstances? _____

Do you currently use any drugs such as marijuana, cocaine, ecstasy, heroin or others? _____

Describe any past drug use: _____

Women, are your periods regular? _____ Describe any symptoms of PMS. _____

_____

Family Health History

Do you have a family history of :

Depression	Y/N	Heart Disease	Y/N
Anxiety	Y/N	Seizures	Y/N
Drug or alcohol abuse	Y/N	Thyroid Disease	Y/N
Other Mental health problems	Y/N	Diabetes	Y/N
Domestic Violence	Y/N	Cancer	Y/N
Suicide attempts	Y/N	Dementia	Y/N

Who may we contact in case of an emergency?

Name: _____ Relationship: _____

Phone number(s): _____

Would you like to receive email announcements & newsletters from Dawna Gutzmann, MD & Associates? Y / N

Release of Information

I request and authorize Dawna Gutzmann, MD
5225 Old Orchard Rd., Suite 36
Skokie, IL 60077

To release the information specified to the healthcare professional, agency, hospital or medical center listed below:

Name (Your Therapist)_____ Street Address_____

_____

City _____State_____ Zip Code_____

Telephone number_____Fax number_____

Information or communication requested: Diagnosis, treatment recommendations, progress

_____

Regarding _____

Name _____ Date of Birth_____

Purpose of release of information: Coordination of care

The statues that govern this authorization include but are not limited to: Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), 735 ILCS 5/7 2001 (inspection and copying of hospital records and any relevant confidentiality code of any state, and the Employee Personnel Act, 820 ILCS 40/0.01.

I understand that I have a right to copy and inspect the information being disclosed. I have the right to revoke this authorization in writing, at any time by sending such written notification to my provider's office. Written revocation is effective upon receipt. However, my revocation will not be effective to the extent that my provider has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my provider may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. It has been explained to me that if I refuse to consent to this Release of Information specified above, the following are the consequences:

_____

Authorization: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I may have a copy of this form at any time that I choose to request it. The authorization will automatically **expire in one year from the date of signature** or, if I prefer, on

the date specified here:_____

_____

Printed name Signature Date

Release of Information

I request and authorize Dawna Gutzmann, MD
5225 Old Orchard Rd., Suite 36
Skokie, IL 60077

To release the information specified to the healthcare professional, agency, hospital or medical center listed below:

Name of your primary care physician _____Street Address_____

_____City _____State_____ Zip Code_____

Telephone number_____Fax number_____

Information or communication requested:
Diagnosis, treatment recommendations, progress

Purpose of release of information:
Coordination of care

The statues that govern this authorization include, but are not limited to: Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), 735 ILCS 5/7 2001 (inspection and copying of hospital records and any relevant confidentiality code of any state, and the Employee Personnel Act, 820 ILCS 40/0.01.

I understand that I have a right to copy and inspect the information being disclosed. I have the right to revoke this authorization in writing, at any time by sending such written notification to my provider's office. Written revocation is effective upon receipt. However, my revocation will not be effective to the extent that my provider has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my provider may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. It has been explained to me that if I refuse to consent to this Release of Information specified above, the following are the consequences:

_____

Authorization: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I may have a copy of this form at any time that I choose to request it. The authorization will automatically **expire in one year from the date of signature** or, if I prefer, on

the date specified here:_____

_____

Printed name Signature Date