Patient Name: _____ **Date: _____**

OV/CP: _____

Fulshear Family Health Consultants

Madiha Ghayas, M.D.

Psychiatric Review of Systems

Depression:

- Anergia (lack of energy)
- Hyperphagia (increased appetite)
- PM Agitation
- Self-injurious behavior
- Anhedonia (inability to feel pleasure)
- Hypersomnia (trouble staying awake)
- PM Retardation
- Suicidal Ideation
- Anorexia (lack of appetite for food)
- Insomnia (difficulty falling asleep)
- Poor concentration
- Worthless/Guilt
- Dysphoria (generalized dissatisfaction with life)
- Irritability

Manic:

- Distractibility
- Increased goal-directed activities
- Euphoria (state of intense excitement and happiness)
- Pressure of speech
- Flight of ideas
- Grandiosity (pretentiousness)

Psychosis:

- Disorganized speech/behavior
- Delusions
- Hallucinations
- Negative symptoms

Anxiety:

- Agoraphobia (extreme fear of entering crowded places)
- Excessive anxiety w/ somatic symptoms
- Poor Body Image
- Compulsions (being forced to do something)
- Flashbacks
- Nightmares
- Separation Anxiety
- Dissociation (state of being disconnected)
- Hypervigilance (increased anxiety which can cause exhaustion)
- Obsessions
- Social phobia
- Exaggerated Startle Response
- Intrusive Memories
- Panic Attacks
- Specific Phobia

Disruptive Behaviors:

- Aggression (violent behavior)
- Hyperactivity
- Property Destruction
- Deceitfulness/theft
- Inattention
- Serious Violation of rules
- Defiance
- Impulsivity
- Fire setting
- Oppositionality (the refusal to conform to the ordinary requirement of authority)

Other:

- Binge-eating
- Enuresis (involuntary urination)
- Paraphilia (abnormal sexual desires)
- Food Restricting
- Gender Identity Issues
- Sexual Acting Out
- Purging
- Learning Disorder(s)
- Sexual Dysfunction
- Encopresis (involuntary defecation)
- Mental Retardation
- Tics

Office use only:

BP_____ HR_____ RP_____ HGT_____ WGT_____

Fulshear Family Health Consultants

Madiha Ghayas, M.D.

PATIENT HISTORY **Today's Date** _____

Name _____ **SSN** _____ **Date of Birth** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone _____ **Cellular** _____ **Work** _____ **Email** _____

Race: Caucasian African American Asian Pacific Islander **Ethnicity**_____ **Language**_____

Gender : Male Female **Marital Status**: Single Partnered Married Divorced Widowed

Primary Insurance Name_____ **Policy Holder Name**_____

Insured Member Number_____ **Group Number**_____

Customer Service Phone Number_____ **Policy Holder Date of Birth**_____

Emergency Contact_____ **Phone**_____ **Relation**_____

Driver License #:_____

**This information is requested for the purpose of filing insurance claims, verification of information, and fraud prevention.

Occupation_____ **Business Phone**_____

Employer_____

Address_____ **City, State, Zip**_____

DRUG ALLERGIES **REACTION**

_____

_____

_____

CURRENT MEDICATIONS & DOSAGE

_____

_____

_____

_____

Fulshear Family Health Consultants
Madiha Ghayas, M.D.

Release of Information

I,_____, hereby give consent to Fulshear Family Health Consultants and her staff to access any and all medical records necessary for continuum of care. I understand that I may refuse, in writing, the release of any and all records per my right under HIPPA. I have been given the HIPPA information sheet and I understand when, where, and how the clinic may, in turn, release my information unless I specify otherwise.

_____ _____

Patient signature Date

I,_____, hereby give consent to the following persons to discuss my records, and/or results, with doctor and his staff if needed.

1. _____Relationship:_____Phone:_____
2. _____Relationship:_____Phone:_____
3. _____Relationship:_____Phone:_____
4. _____Relationship:_____Phone:_____

I understand that this authorization can be revoked, in writing, at any time and may apply to one or more of the persons.

_____ _____

Patient's Signature Date

Fulshear Family Health Consultants
Madiha Ghayas, M.D.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices for Fulshear Family Health Consultant's office, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Printed Name	Date of Birth
Patients/Guardian Signature	Date
Relationship	Date

Acknowledgement of Review of Office Policies and Procedures

I have reviewed the Office Policies and Procedures to Fulshear Family Health Consultant's office. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by the late cancellation and missed appointment policy.

Patient Printed Name	Date of Birth
Patients/Guardian Signature	Date
Relationship	Date

Fulshear Family Health Consultants
Madiha Ghayas, M.D.

Controlled Substances

THIS AGREEMENT is effective as of 5/11/17, by and between Fulshear Family Health Consultants/Dr. Madiha Ghayas MD & _____.
Print Patient Name

This contract has been established due to several patients misplacing, having destroyed, or having controlled substance prescriptions taken/stolen.

It is the patients' sole responsibility to keep track of controlled substance prescriptions, and it is office policy that we do not provide early refill, nor do we re-write controlled prescriptions. This policy insures that there is no misuse or overuse of controlled substances.

This contract is only effective with receipt of damaged prescriptions to be verified & voided in our office.

_____, will be provided with a copy of this contract and it will be kept as record in your
Print Patient Name

chart as well.

_____ _____
Patients/Guardian Signature Patient Date of Birth

_____
Date

_____ _____
Relationship to Patient Date

Legal Disclosure Statement

If this visit, corresponds with any legal matters, and/or court proceedings, Fulshear Family Health Consultants' physician, Dr. Madiha Ghayas, must be made aware immediately. As she does not participate in any trials and/or depositions of any kind.

Acknowledgement of the Legal Disclosure Statement

I,_____, have reviewed the Legal Disclosure
Print Patient Name
Statement to Fulshear Family Health Consultant's, the office of Dr. Madiha Ghayas, M.D. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by acknowledgment of the legal disclosure statement.

_____	_____
Patient Printed Name	Date of Birth
_____	_____
Patients/Guardian Signature	Date
_____	_____
Relationship	Date

Fulshear Family Health Consultants

MADIHA GHAYAS, M.D.

19255 Park Row Dr. Ste 105
Houston, TX 77084
Phone: (346)251-5901 Fax: (832)321-3516

Physician Assistant (P.A.) Consent Form

This office has on staff P.A. to assist in the delivery of medical care. A Physician Assistant is not a doctor.

A Physician Assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a Physician, a Physician Assistant can diagnose, treat, and monitor acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical presence of the supervising physician, rather the overseeing of activities of and accepting responsibility for the medical services provided. A Physical Assistant may provide such medical services that are within his/her education, training, and experience.

These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions
- Making appropriate referrals

I, _____ have read the above, and hereby consent to the services of a P.A. for my health care needs.

_____ _____

Patient Signature Date

Fulshear Family Health Consultants

MADIHA GHAYAS, M.D.

19255 Park Row Dr. Ste 105
Houston, TX 77084
Phone: (346)251-5901 Fax: (832)321-3516

FMLA SHORT-LONG TERM/WORK PAPERWORK POLICY:

In regards to any paperwork that needs to be filled out by our practice, the patient needs to be established with us for at least 6 months before we can furnish the request.

I, _____ have read the above, and hereby understand that any paperwork that I needed to be filled out will be completed after I am established for at least 6 months.

_____ _____

Patient Signature Date

PLEASE READ THE POLICIES AND PROCEDURES.

It contains important information regarding your financial liability for services provided.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE REVIEWED THE AGREEMENT TITLED **"Policies and Procedures – Fulshear Family Health Consultants"** AND YOU AGREE TO ITS TERMS.

YOU MAY REQUEST A PRINTED COPY OF THE POLICIES AND PROCEDURES..

_____ _____

Signature of Client/Patient/or Patient's Legal Representative Date: