THE FORT CHRISTIAN PSYCHIATRIC CENTER / SHAW WENDI FORTUCHANG, M.D., P.C.
SHAW WENDI FORTUCHANG, M.D., FAPA
P.O. BOX 1288, FAYETTEVILLE, GA 30214 (PHONE) 770-376-6726

PLEASE PROVIDE AN ANSWER FOR EVERY QUESTION!

ADULT FEMALE QUESTIONNAIRE

How did you hear about us? Word of mouth☐ Website☐ Internet☐ Radio☐ **Referred by**: _____
**Do you prefer a Christ-Centered, Bible-Based approach to treatment? Yes☐ No☐ Maybe☐

Briefly describe your current struggles and the reason(s) why you contacted us:

Name: F _____M_____ L_____

Age: _____ DOB: _____Race: _____ Email: _____
Would you like to receive email correspondence (superbill receipts, etc.)? Yes☐ No☐

Home Number: _____ Mobile Number: _____
May we leave messages for you at these numbers? Yes☐ No☐

Home Address: _____

City: _____ State: _____ Zip: _____

Are you currently a student? Yes☐ Full-Time student☐ Part-Time student☐ No☐

Name of school: _____ What year are you? _____
Type of school: 4-year college/university☐ 2-year community/junior college☐ Online☐ High School☐ Other☐
Major: _____ Grades: A☐ B☐ C☐ F☐ Passing☐ Failing☐ GPA: _____
Any academic challenges? No☐ Yes☐ Explain:

IF NO, name of last school attended: _____ Year graduated? _____
Highest earned: JD☐ MD☐ DO☐ MBA☐ PhD☐ PsyD☐ BA☐ BS☐ Master's☐ High School Diploma☐ GED☐
Major: _____GPA: _____ **Any academic challenges back then? No☐ Yes☐ Explain:**

Are you currently employed? Yes☐ No☐ Full-Time☐ Part-Time☐ Retired☐ Looking☐
If no, when and where was your last job? _____
What was your position / job title? _____

Current Employer: _____ Type of Work: _____
Work Phone: _____ How long have you worked here? _____
Any work-related issues? No☐ Yes☐ Explain:

Check all that apply: Married☐ Engaged☐ Separated☐ Divorced☐ Widowed☐ Dating☐ Single☐
Any relationship issues? No☐ Yes☐ Explain:

Spouse's Name: F:_____ M:_____ L:_____
Age: _____ Mobile Phone: _____ How long married? _____

EMERGENCY CONTACT Name: _____ Relationship: _____

Home_____Mobile_____Work_____

Current Primary Care Doctor (if none, indicate when and with whom you were last seen)
Name of doctor and practice: _____
Full Address: _____
Phone Number: _____ Fax Number: _____

Current Therapist or Other Mental Health Provider (if none, indicate N/A)
Name of Provider and Practice: _____
Full Address: _____
Phone Number: _____ Fax Number: _____

Pastor or Spiritual Leader (if none currently, indicate your last one)
Name: _____ Name of Church: _____
Full Address: _____
Phone Number: _____ Fax Number: _____

Name & Address of Your Church: _____
Do you attend on a regular basis? ☐Yes ☐No Do you pay tithes? ☐Yes ☐No Do you give offerings? ☐Yes ☐No

Preferred Pharmacy Information
Name & Address: _____ Phone Number: _____

Past & Current Psychiatric History

Are you currently seeing a THERAPIST / counselor (psychologist, LPC, LCSW, etc)? Yes☐ No☐
If no, have you ever seen a therapist / counselor? Yes☐ No☐
If yes, Who/Where? _____ When? _____ Why? _____
Name & location of current therapist: _____
How long have you been seeing this therapist? _____
Last appointment date: _____ **Next appointment date:** _____

Are you currently seeing a PSYCHIATRIST (medical doctor)? Yes☐ No☐
If no, have you ever seen a psychiatrist? Yes☐ No☐
If yes, Who/Where? _____ When? _____ Why? _____
Name & location of current psychiatrist:_____
When were you first seen by this doctor? _____ Last seen? _____
Why did you stop seeing this doctor? _____

Have you EVER been prescribed any psychiatric medication? Yes☐ No☐

Please circle all medications you have EVER been prescribed and taken:
Prozac, Paxil, Zoloft, Celexa, Lexapro, Luvox, Effexor, Pristiq, Cymbalta, Khedezla, Wellbutrin, Buspar, Remeron, Trazodone, Trintellix, Viibryd, Vistaril, Elavil, Xanax, Klonopin, Valium, Ativan, Restoril, Risperdal, Perseris, Rexulti, Vryalar, Invega, Saphris, Fanapt, Latuda, Clozaril, FazaClo, Zyprexa, Seroquel, Abilify, Geodon, Latuda, Haldol, Lithium, Lithobid, Eskalith, Depakote, Depakene, Stavzor, Tegretol, Trileptal, Lamictal, Neurontin, Topamax, Epitol, Ambien, Lunesta, Rozerem, Adderall, Concerta, Ritalin, Metadate, Methylin, Daytrana, Desoxyn, Adzenys, Aptensio, Evekeo, Mydayis, Quillivant XR, Quillichew ER, Zenzedi, Cotempla XR-ODT, Dynavel, Focalin, Vyvanse, Strattera, Intuniv, Clonidine, Guanfacine, Provigil, Namenda, Aricept, Halcion, Lyrica,

***What helped the MOST?** _____ ***What helped the LEAST?** _____
***What are you CURRENTLY TAKING, including the dose(s)**_____
****WHO IS PRESCRIBING this medication?** _____

Have you ever been **hospitalized for psychiatric reasons (including drug and/or alcohol)**? Yes□ No□

If YES, please describe when, where and why: _____

Have you been consistently depressed or down, most of the day, nearly every day for the past 2 weeks or longer? Yes□ No□ In the past 2 weeks or longer, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? Yes□ No□

Have you felt sad, low or depressed most of the time for at least 2 years? Yes□ No□

Have you ever had a period of time when you were totally sober (no alcohol or drugs) AND felt "up" or "high" or "so full of energy" or "so full of yourself" that you were impulsive and reckless and made poor decisions that got you into trouble, OR that other people thought you were not acting like your usual self? Yes□ No□

Have you ever been persistently irritable, for several days, resulting in arguments or verbal or physical fights, or shouted at people OTHER THAN your family members? Yes□ No□ With family members? Yes□ No□

Have you ever had an intense rush of anxiety, or what someone might call a "panic attack," and you suddenly felt very frightened or anxious or suddenly developed a lot of physical symptoms? Yes□ No□

Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people WOULD NOT feel that way? Yes□ No□

In the past 6 months, have you been very anxious about or afraid of situations like going out of the house alone, being in crowds, going to stores, standing in lines, or using public transportation? Yes□ No□

For the past 6 months or longer, have you been unable to stop worrying about RATIONAL things (ie: your future, finances, your family/children, your health, etc.), over which you have no control, to the point of it affecting your sleep, creating muscle tension, fatigue, poor concentration, irritability and making you feel on edge or keyed up? Yes□ No□

In the past 6 months, have you been extremely nervous in social situations, like having a conversation or meeting unfamiliar people OR in performance-related situations, with fear of humiliating yourself? Yes□ No□

In the past 6 months, is there anything you have been afraid to do or felt very uncomfortable doing in front of other people, like speaking, eating, writing or using a public restroom due to fear of humiliation? Yes□ No□

In the past month, have you been bothered by IRRATIONAL recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? For example, the idea that you were dirty, contaminated or had germs, or fear of contaminating others, or fear of harming someone even though you didn't want to, or fear you would act on some impulse or fear a superstition that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding/collecting or religious obsessions? Yes□ No□

In the past month, did you feel compelled to do something repeatedly without being able to resist it, like washing or cleaning excessively, counting or checking things over and over, collecting or arranging things or doing other superstitious rituals—even when you knew it didn't make sense? Yes□ No□

Have you ever experienced, witnessed IN PERSON (not on TV) or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? (Examples include serious accidents, sexual or physical assault, terrorist attack, being held hostage, kidnapping, fire, discovering a dead body, sudden death of someone close to you or war or natural disaster.) Yes□ No□

Looking back over your menstrual cycle for the past 12 months, have you had mood symptoms like anger, irritability, anxiety or depression that developed BEFORE your period and then went away during the week after your period? Yes□ No□ After your period began, did the problems disappear for at least 1 week? Yes□ No□

In the past 3 months, have you binge-eaten or eaten very large amounts of food in a short period of time, to the point of being uncomfortably full, followed by feelings of disgust and self-loathing? Yes□ No□

Have you ever binged on a large amount of food and then made yourself vomit it back up to avoid gaining weight? Yes□ No□

Have you ever starved yourself, taken laxatives, taken diuretics or excessively exercised in an effort to lose weight due to a fear of being fat, even though you were normal weight or underweight? Yes□ No□

Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you WITHOUT EVIDENCE to prove it? Yes□ No□

Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone else's mind or hear what another person was thinking? Yes□ No□

Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Yes□ No□
Have you ever felt that you were possessed? Yes□ No□

Have you ever believed that you were being sent special messages through the TV, radio or newspaper, or that a person you did not personally know was particularly interested in you in any way? Yes□ No□

Have your relatives or friends ever considered any of your beliefs to be strange or unusual? Yes□ No□

Have you ever heard things (sounds, voices) others couldn't hear? (Excluding religious experiences) Yes□ No□

Have you ever had visions when you were awake or have you ever seen things that other people couldn't see while totally sober (no alcohol or drugs)? (Excluding religious experiences). Yes□ No□

Suicide History
Are you having suicidal thoughts right now? Yes□ No□ Do you have a plan? Yes□ No□
Do you the have means (guns, weapons, lethal drugs, etc)? Yes□ No□

Have you ever had suicidal thoughts in the past? Yes□ No□ Did you have a plan? Yes□ No□
Have you ever attempted suicide? Yes□ No□ How many times? _____
If YES to any, please explain further: _____

Have you engaged in self-injurious behaviors like cutting, burning, etc.? Yes□ No□
If YES, when was the last time? _____

Injury to Others Have you ever thought seriously about harming or killing someone else? Yes□ No□
Did you have a plan? Yes□ No□
If YES, please describe further: _____

Recent Stressful Life Events **Please check all that are currently negatively impacting your life:**

□Recently engaged □Recently married □Marital discord □Recently divorced □Recent breakup
□Difficult family members □School changes or difficulties □Work changes □Work difficulties
□Personal injury □Personal illness □Sexual difficulties □Rape/sexual assault □Extramarital affair
□Special needs child □Birth of a child □Recent move □Legal difficulties □Custody battle
□Retirement □Financial issues □Lost Job □Let go from job □Fired □Slander □Gossip □Scandal
□Spiritual issues □Drugs □Robbery/Burglary □Mugging □Caring for an elderly relative □Bullied
□Restraining Order □Alcohol □Military □Serious health issues of a loved one □Death of a loved one
□Un-repented sin □Un-forgiveness □Other: _____ □I have not experienced any major life stressors

Substance Use History

Alcohol Use:

How often do you drink? _____ **Do you drink alcohol to self-medicate?** Yes☐ No☐

Answer the following questions regarding your alcohol and drug consumption:

1. Has anyone ever told you that you were drinking too much? **Yes☐ No☐**
2. Have you ever tried to cut down on your drinking? **Yes☐ No☐**
3. Have you ever gotten annoyed at people telling you to cut down? **Yes☐ No☐**
4. Have you ever felt guilty about your drinking? **Yes☐ No☐**
5. Have you ever needed a drink in the morning to get you going? **Yes☐ No☐**
6. Have you ever been diagnosed with alcoholism OR drug dependence? **Yes☐ No☐**

Drug Use: Check the drugs you have EVER taken or tried (excluding medication prescribed to you):

☐Marijuana ☐Hashish ☐Medical MJ ☐Inhalants ☐Heroin ☐Mushrooms ☐PCP ☐Hallucinogens ☐Amphetamines ☐Speed ☐Meth ☐Ecstasy ☐Opiates (pain pills) ☐LSD ☐Barbiturates ☐Bath salts ☐Cocaine ☐Crack ☐K-2 ☐Spice ☐Kratom ☐Synthetic (man-made) drugs ☐Sedatives ☐Benzodiazepines (Valium, Xanax, Klonopin, etc) ☐Triple Cs ☐Other ☐NONE

If circled any of the above, please describe further: _____

***Have you ever taken prescription medication in an unauthorized manner? Yes☐ No☐**

If YES, explain: _____

Spirituality:

Do you believe that Jesus Christ died on the cross for our sins and rose again, giving Christians eternal life? Yes☐ No☐
Have you received Jesus Christ as your personal Lord and Savior? Yes☐ No☐
Do you believe that we were created as a spirit, we have a soul and live in a physical body? Yes☐ No☐
Are you aware that there are biological, spiritual and psychological aspects to mental health? Yes☐ No☐
Are you aware that unresolved spiritual issues can worsen or mimic many psychiatric disorders? Yes☐ No☐
Do you spend quiet, quality alone time with God in prayer and meditation? Yes☐ No☐
Do you believe in the power of prayer? Yes☐ No☐
Do you have difficulty fully trusting God and surrendering your will and/or way for His? Yes☐ No☐
Do you regularly pay your tithes at your local church? Yes☐ No☐
Are you aware that any act or thought that goes against The Word of God (The Holy Bible) is sin? Yes☐ No☐
Do you believe that our sins have already been paid for by Christ's sacrifice on the cross? Yes☐ No☐
Do you believe that sins must be confessed and repented in order to receive God's best for our lives? Yes☐ No☐
Are there any areas of unrepented sin and/or unforgiveness in your life? Yes☐ No☐
Are you aware that there are 4 major areas within which Satan gains access to our lives? Yes☐ No☐

Check ALL that you have ever participated, been affected by or were forced into doing:

1. FEAR: Prolonged worry/anxiety☐ Unbelief☐ Need for control☐ Certainty☐ Social isolation☐ Withdrawal☐

2. OCCULT: Astrology/Horoscopes☐ Fortune-telling☐ Tarot cards☐ Palm-reading☐ Seances☐ Lucky charms☐ Ouija board☐ Voodoo☐ Manipulation☐ Witchcraft☐ Spells/Curses☐ Hexes☐ Chanting☐ Yoga☐ Mediums☐

3. HATRED: Unforgiveness☐ Bitterness☐ Anger/Resentment☐ Gossip☐ Slander☐ Self-loathing☐ Revenge☐

4. SEXUAL: Adultery/Affair☐ Pornography☐ Fornication☐ Lewdness/Lust☐ Molestation☐ Incest☐ Rape/Assault☐ Homosexuality☐ Bisexuality☐ Same-sex "experimentation"☐ Prostitution/"Escort"☐

Your Social History What do you enjoy doing (hobbies)? _____

Are you physically active? Yes☐ No☐ Are you currently dating? Yes☐ No☐ N/A☐
Do you have close friends? Yes☐ No☐ Is it difficult for you to make friends? Yes☐ No☐
Do you enjoy social situations? Yes☐ No☐ Do you prefer solitary activities? Yes☐ No☐
Do you use substances to feel more comfortable socially? Yes☐ No☐
Are you sexually active? Yes☐ No☐ Sexual preference: Men☐ Women☐ Both☐ N/A☐
Are you involved in any groups or organizations? Yes☐ No☐ If yes, which ones and what is your role?

Your Birth History & Childhood

Mother's pregnancy was: normal□ abnormal□ Mother's delivery was: normal□ abnormal□
If abnormal, please explain: _____ I do not have this information□

Were there any delays in developmental milestones (walking, talking, toileting, etc)? No□ Yes□ Unsure□

Please CHECK all of the following issues that pertained to you during childhood/teen years:

□Afraid to go to school □Anxiety □Fear □Moodiness □Emotional problems □Inattention □Hyperactive
□Ran away from home □Juvenile detention □School expulsions □School detentions □School truancy
□Cruelty to animals □Cruelty to others □Fire-setting □Lying □Stealing □Cigarettes □Alcohol □Drugs
□Frequent accidents □Divorced parents □Step-parents □Disrespectful □Destruction of property
□Fear of the dark □Disturbed sleep □Nightmares □Night terrors □Bedwetting after age 5
□Oppositional to authority □Spiritual issues □Occult □Witchcraft □Voodoo □Dabbling in other religions
□Frequent Transitions (moves, school changes, etc) □Poor grades □IEP □504 Plan
□Difficulty With: □Reading □Writing □Mathematics □Psychological testing □Diagnosed learning disorder(s)
□Failed a grade/Repeated a grade □No Friends/loner □Peer pressure □Bullied by others □Bullied others
□Abuse □Incest □Promiscuity □Sexually active □Pregnancy □Abortion □Miscarriage
□Socially awkward □Mispronounced words □Special Education □Lisp □Stuttered/stammered speech
□Tics □Seizures □Chronic medical problems □Other:_____ ☐**None of these pertained to me**

Family History

Were you adopted? No□ Yes□ Were your parents married? No□ Yes□ Did you have step-parents? No□ Yes□

Name, age and gender of siblings: _____
Describe what it was like growing up in your home: _____
Check all that applied to the home: **Stable□ Chaotic□ Abusive□ Happy□ Scary□ Fun□ Safe□ Christian□**

Who lived in the home (including non-relatives)? _____
Who were you closest to in your family? _____ Who were you least close to? _____
What did your parents do for a living? Father: _____ Mother: _____

Family Psychiatric and Family Substance Abuse History

***Please list all BIOLOGICAL family members affected by the conditions below. Write N/A if none.**

Depression _____ Bipolar Disorder _____
ADHD _____ Anxiety Disorder _____
PTSD _____Obsessive Compulsive Disorder _____
Panic Disorder _____ Substance Use _____
Schizophrenia and other Psychotic Disorders _____
Learning Disorders _____ Eating Disorders _____

Psychiatric Hospitalizations? Yes□ No□ **Who and on which side of the family?** _____

ANY SUICIDE ATTEMPTS Yes□ No□ **or COMPLETED SUICIDES** Yes□ No□ **on either side of the family?**
If YES, who and on which side of the family? _____

Family Medical History **Check all of the following that apply to your family members:**

Diabetes□ Seizures/Epilepsy□ Heart Problems□ Obesity□ High Cholesterol□ High Blood Pressure□

Legal History **Have you ever been arrested for ANY reason?** Yes□ No□

If YES, please indicate the year(s), the charge(s): _____
If YES, did you spend any time in jail? Yes□ No□ **Prison?** Yes□ No□

Do you have any outstanding warrants? Yes□ No□ Are you currently on parole? Yes□ No□
Are you currently on probation? Yes□ No□ Do you have any current charges? Yes□ No□
If yes, please list ALL current charges: _____. N/A□

Your Medical History

When was your last physical exam? _____ Doctor: _____

Where? _____ Was blood work done / labs done? Yes□ No□

Sleep: Check all of the following that apply:
Difficulty falling asleep□ Difficulty staying asleep□ Feeling tired upon wakening□ Nightmares□
Bedwetting□ Sleepwalking□ **Do you take anything to help you sleep?** No□ Yes□ **What?**

Smoking:
Do you smoke cigarettes, cigars or other forms of tobacco? No□ Yes□ **Which ones?** _____

Caffeine: Do you consume caffeinated beverages daily? Yes□ No□
Coffee? Yes□ No□ Tea? Yes□ No□ Soda? Yes□ No□ Energy drinks? Yes□ No□

Current Non-Psychiatric Medications, Allergies and Medical Conditions

List ALL DRUG ALLERGIES: (if none, indicate "N/A"): _____

List ALL current medications, including over- the counter medications and herbal supplements:

Name_____ Dose_____ Reason taking_____
Name_____ Dose_____ Reason taking_____
Name_____ Dose_____ Reason taking_____

Name and title of person who prescribed your medication: _____

What medical conditions do you have currently? Please **CHECK all that apply**:

□Diabetes
□High Blood Pressure
□High Cholesterol
□Neurological Problems / □Seizures
□Liver Problems
□Headaches
□Sinus Issues
□Dental Problems
□Anemia
□Heart Problems
□Pain Problems
□Joint Problems
□Eye Problems
□Musculoskeletal Issues
□Gastrointestinal Problems
□Sexually Transmitted Diseases
□Endocrine Problems (hormones)
□Allergies
□Thyroid Problems
□Skin Problems
□Kidney Problems
□Gynecologic Problems
□Lung Problems
□**NONE OF THESE**

Other: _____

Are you seeing any medical specialists? Yes□ No□
If yes, which type? Why? _____

1. **Have you ever hit your head and lost consciousness?** Yes□ No□
   If yes, describe: _____

2. **Have you ever had a head CT scan?** Yes□ No□ If yes, explain:

3. **Have you ever had an MRI (brain)?** Yes□ No□ If yes, explain:

4. **Have you ever had an EKG (heart)?** Yes□ No□ If yes, explain

5. **Have you ever had an EEG (brain)?** Yes□ No□ If yes, explain:

6. **Have you ever had a seizure?** Yes□ No□ If yes, explain:

Reproductive History

What was your age at your first menstrual period? _____What grade were you in? _____
Do you have regular periods? Yes□ No□ Have you ever missed a period? Yes□ No□
Are you currently trying to get pregnant? Yes□ No□ Menopausal? Yes□ No□

Are you currently taking an oral contraceptive? Yes□ No□
Which one and for how long: _____
Does your oral contraceptive affect your mood in any way? Yes□ No□
If "yes," please indicate how _____

Please check all that apply in the WEEK prior to your period:

Extreme fatigue□ Food cravings□ Anger□ Extreme irritability□ Problems with family/friends□
Tearfulness□ Hopelessness□ Extreme anxiety□ Lack of interest□ Lack of motivation□
Poor concentration□ Extreme moodiness□ Major sleep changes□ Feeling out of control□

Are you currently pregnant? Yes□ No□ Have you ever been pregnant? Yes□ No□
Number of pregnancies: _____ Did pregnancy affect your mood? Yes□ No□

Your Children

List your **biological** children's ages, gender, whether or not they have EVER been diagnosed with any major **medical and/or psychiatric** illnesses, and what medication they take:

Name _____Age____ Gender____ Diagnosis / Medication _____
Name _____Age____ Gender____ Diagnosis / Medication_____
Name _____Age____ Gender____ Diagnosis / Medication _____
Name _____Age____ Gender____ Diagnosis / Medication _____

Abuse/Trauma History

Have you ever been a victim of verbal/emotional abuse? Yes□ No□ Perpetrator? Yes□ No□
If yes to either, please explain: _____

Have you ever been a victim of physical abuse? Yes□ No□ Perpetrator? Yes□ No□
If yes to either, please explain: _____

Have you ever been a victim of sexual abuse? Yes□ No□ Perpetrator? Yes□ No□
If yes to either, please explain: _____

Have you ever been in a situation where you feared that your life, or someone else's life, was in imminent danger? Yes□ No□ **If "yes," please explain** _____

When you look over your life, which one or more of the following ways/patterns of being has been relatively stable over time (from childhood to present)?

☐Unjustifiable distrust of other people and suspecting them of being mean. Baseless persecution from others.
☐Detached from close relationships (neither wants nor enjoys them) and preferring not to express much emotion.
☐Extreme discomfort in close relationships and preferring activities that other people consider odd or eccentric.
☐Disregarding the rights of other people without concern for how it affects them; going against societal norms.
☐Extremely unstable mood, interpersonal relationships, sense of self and impulsivity; recurrent suicidal behavior.
☐Extreme emotionality and attention-seeking; uncomfortable unless center of attention; extremely dramatic.
☐Extreme arrogance, need for admiration from others and lack of empathy for others; believe you are superior.
☐Extreme social inhibition, inferiority and inadequacy; hypersensitive to negative evaluation; fear of rejection.
☐Excessive need to be taken care of resulting in clinging behaviors and fear of separation; poor decision-making
☐Preoccupation with perfectionism, details, rules, lists, and organization; miserly frugality; reluctant to delegate tasks for fear they won't get done right; rigidity and stubbornness—none of which you see as a problem!

DISCLAIMER: Completing these forms does NOT guarantee an appointment. A doctor-patient, provider-patient, or therapist-patient relationship is NOT established until the decision is made to create such a relationship at the conclusion of your initial psychiatric diagnostic appointment. Therefore, you will NOT be considered a patient of Shaw Wendi Fortuchang, M.D., PC / The Fort Christian Psychiatric Center or its associates until then. If we determine our services are not adequate to meet the level of care required, we will notify you within a reasonable time frame.

GUARANTOR INFORMATION (if not patient): **Relationship to Patient:** _____

Full Name: _____
(First) (MI) (Last)

Address: _____

City: _____ State:_____ Zip:_____

Date of Birth: _____ Gender: □Male□Female SSN: _____

Phone number:_____ Email address: _____

I, the undersigned, agree that I am financially responsible for all services provided by The Fort Christian Psychiatric Center. I am aware that office policy requires payment at the time of service. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% of the outstanding balance. I understand that outstanding balances over 90 days may be referred to a collection agency.

Patient / POA Signature: _____ Date: _____
***This must be the signature of the person signing. It is illegal in the state of Georgia to sign another person's name without Power of Attorney.**

GUARANTOR AGREEMENT:

This agreement will remain in effect until written notice of other payment arrangements are provided to The Fort Christian Psychiatric Center. The current guardian will be responsible for any and all charges incurred prior to receipt of notification of other arrangements. **If you wish to change your guarantor information, you must have the appointed guarantor complete a separate agreement with The Fort Christian Psychiatric Center.** Our "Change of Guarantor" forms are available upon request.

CONSENT FOR TREATMENT AT A CHRISTIAN PSYCHIATRIC FACILITY:

I fully understand that The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C. is a Bible-based, Christian psychiatric practice that purposefully uses The Bible, Scripture, and prayer as the foundation for treatment, as led by The Holy Spirit. Therefore, I agree to be treated by physicians and/or mental health professionals associated with The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C. I am fully aware that The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C. does not accept health insurance, and I agree that I am personally responsible for ensuring that all fees are paid at the time services are rendered. I authorize The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C. to provide information concerning my treatment to any referring physician or therapist, as well as to any physician/therapist to whom I may be referred following the initial consultative diagnostic evaluation.

Patient's Signature _____ Date: _____
***This must be the signature of the person signing. It is illegal in the state of Georgia to sign another person's name without Power of Attorney.**

Signature of POA: _____ Date: _____

The Fort Christian Psychiatric Center
Shaw Wendi Fortuchang, MD, FAPA
110 North Park Drive, Fayetteville, GA 30214 (Phone) 770-376-6726 (Fax) 770-376-6727

*DISCLAIMER: **A doctor-patient, provider-patient, or therapist-patient relationship is NOT established until the decision is made to create such a relationship at the conclusion of your initial psychiatric diagnostic appointment. Therefore, you will not be considered a patient of Shaw Wendi Fortuchang, M.D., PC / The Fort Christian Psychiatric Center or its associates until then.***

Please read each section very carefully before initialing where highlighted.

Insurance: The Fort Christian Psychiatric Center does not accept insurance. If you wish to be reimbursed by your insurance company, you will be responsible for filing the claim on your own. You will receive a superbill receipt from us via email containing all the information needed by your insurance company, but we cannot guarantee that your insurance company will reimburse for services rendered. **Therefore, it is your responsibility to find out which CPT procedural codes are reimbursable. Further, we do not submit any billing claims to insurance companies. We do not manage any billing-related insurance issues. All insurance company correspondence should be mailed directly to you, not to us! We reserve the right to charge administrative fees related to insurance claims, when applicable.** X_____

Appointments: Our office hours follow the Fayette County School calendar. When Fayette County schools are closed due to inclement weather, we will also be closed. **At least 1 parent must be present and/or available for feedback at some point during every child/adolescent patient appointment.** X____

HOURS: We are open Mon through Thu from 7am – 7pm. Appointments are on Tuesday, Wednesday & Thursday. Monday is an administrative day. We are closed on Friday, Saturday & Sunday. X____

Scheduling and Punctuality: To provide safe medical care, appointments are scheduled as frequently as the patient's clinical symptoms require. Patients are expected to arrive on time for their appointments. Arriving 10 minutes after your appointment time is considered late. As a courtesy, we will allow late arrivals to be seen up to 15 minutes after the scheduled appointment time, allowing for the remainder of the time to be used (this policy does NOT apply to 15-minute sessions). *Once 15 minutes have elapsed, the appointment will be automatically canceled. The patient's credit card on file will be charged the full cost for the canceled session + the $2 manual transaction fee. X_____

Missed Appointments: Patients who cancel 3 consecutive appointments are subject to termination. Additionally, if a patient has not been seen in 6 months or longer, they may be subject to termination. Patient safety is our top priority at The Fort Christian Psychiatric Center. Making and keeping regularly scheduled appointments, and adherence to the treatment plan are integral components of this safety process—especially when medication is prescribed. The frequency with which appointments are scheduled is an important and methodical medical decision, involving extensive clinical experience and wisdom, sound judgment and guidance from The Holy Spirit. Close adherence to our office policies and pearls of wisdom agreement is vitally important to us as a Christian-centered medical practice, which helps us to ensure the safety of the patients we have been called by God to treat. X_____

Appointment Reminders for Established Patients: It is always the patient's responsibility to remember the date and time of an appointment. However, as a courtesy we will provide an appointment reminder card at the conclusion of appointments. Also, at the bottom of the superbill receipt we send to patients via email, we will write the date, time and length of the next appointment. And, within the body of these emails, we will write the date, time and length of the next appointment. If you miss an appointment due to receiving an email with incorrect information, or because your email goes to junk/spam and never reaches your inbox, you will be held responsible and will be charged the full cost for that session. **Therefore, always write down the date and time of your next appointment**. X_____

Payment Options: We operate on a fee-for-service basis. We accept cash, checks, most major credit cards (American Express, Discover, MasterCard and Visa), debit cards and health savings / flex spending cards. Full payment is expected at the time services are rendered. A $35 fee will be assessed for any returned checks. More than 1 bad check will result in revocation of all check-writing privileges. X_____

Initial Diagnostic Evaluations & Consultations: Initial Diagnostic Evaluations and Consultations are typically conducted in the morning on Wednesday through Saturday. If you choose to cancel your appointment, you must do so exactly **48-hours to the date and time of the appointment in order to avoid being charged the full cost**. **Otherwise the appointment is considered late and will be charged the full cost for the session. Cancellations must be made via email or via our website.** All no-shows are charged the full cost for the session and *are not granted another appointment with us*. X____

The Initial Diagnostic Evaluation is always considered an evaluation, not a patient appointment. The decision of whether or not a doctor-patient relationship will be established and whether or not subsequent appointments are scheduled is a decision made by Dr. Fortuchang and The Fort Christian Psychiatric Center. In the event that the initial evaluation does not result in a doctor-patient relationship being formed, names of other mental health professionals will be provided. The individual or their designated guarantor will be responsible for the full payment at the time of the evaluation. X_____

Cancellation Policy for Established Patients: Appointments ***must be canceled electronically** (via email or website) within exactly **48 hours to the date & time of the appointment**, otherwise the cancelation is considered late and patients will be charged the full cost for the session. For example, a 4 PM Wed appointment ***must be canceled electronically** (via email or website) by 4 PM on the previous Mon (exactly 48 hours). *Electronic cancelations provide us with date/time stamped documentation, which is printed and placed in the patient's chart. **Do not cancel by calling our office.** X_____

Appointment Cancellation Method: **All appointment cancellations must be made electronically via email to** dr.fortuchang@thefortchristian.com or office@thefortchristian.com, **OR via our website** www.thefortchristian.com. Therefore, please do not call our office to cancel an appointment. X____

- To cancel an appointment via email: please only use the email address(es) you provided to us (you are solely responsible for ensuring that our email address is entered correctly). Please include the date and time of the appointment you are choosing to cancel in the body of the email and in the subject line. You will immediately receive an automatic reply to your email and should consider this your confirmation of our receipt of your appointment cancelation. **We will not contact you to confirm our receipt of your cancellation**. X____

- **To cancel an appointment via our website:** simply log onto it, go to the APPOINTMENT CANCELLATION page and submit the form. You will immediately receive an automatic reply to your submission and should consider this your confirmation of our receipt of your appointment cancellation. **We will not contact you to confirm our receipt of your cancellation.** X____

Rescheduling a Cancelled Appointment: You must call our office to reschedule a canceled appointment for a new date and time. All appointments are scheduled by telephone. X_____

No-Shows: No-shows occur when a patient does not contact us to cancel their appointment and does not show up for it. No-shows are always charged the full fee for the missed session and will jeopardize a patient's standing at The Fort Christian Psychiatric Center. Repeat no-shows will result in termination from the practice. Please note that insurance companies do not reimburse these fees. X____

Telephone Policy: To provide quality care to her patients, Dr. Fortuchang prefers to personally return their calls. Messages left during business hours (7am to 7pm on Mon through Thu) will be returned as soon as possible. Messages left after 7pm on Thu will be returned on the next business day (Mon). X___

After Hours, Urgent Matters and Emergencies: An urgent matter is anything requiring Dr. Fortuchang's attention that can be fully addressed in the office or via telephone (prescription refill, medication questions, a recent non-life-threatening stressor, etc.), but something that cannot wait until the next business day. In other words, it is not an emergency but not something that can wait. X____

An emergency is any life-threatening situation in need of immediate attention, typically requiring a call to 911 or a trip to the nearest emergency room. *Patients must be seen soon after any emergency. X___

During normal business hours, please call the office (770-376-6726) for any urgent matters. X_____

For urgent matters occurring after business hours that cannot wait until the next business day to be addressed, please call our after-hours line. Please leave a brief message including your name, the patient's name (if different), your telephone number, and the issues concerning you/the patient. If Dr. Fortuchang is unable to answer immediately, you must leave a message if you expect a return to your call. **Do not call the after-hours line for a medication refill.** X___

**Also available to you is the Georgia Crisis and Access Line 1-800-715-4225, and the National Suicide Prevention Lifeline at 800-273-8255. X____

**If you are experiencing a life-threatening emergency call 911 or go to the emergency room. X_____

**Patients are expected to contact us immediately AFTER contacting emergency services. X_____

Medication Refill Policy: While we make every effort during your appointment to provide enough medication refills to last until your next appointment, patients share the responsibility of monitoring their need for a medication refill. Patients should either bring their medication bottles to each appointment OR write down how many pills are left in each bottle AND whether or not any refills remain. X____

Medication Refill Policy, continued: **We charge $25/medication for all medication refill requests made between appointments. **To avoid this is to either bring your medication bottles to appointment, OR write down how many pills are in each bottle AND whether or not any refills remain.** X____

**Prescriptions are only "called in" for current patients of The Fort Christian Psychiatric Center who are in good standing and who maintain their regularly scheduled appointments. X____

WE WILL NOT HONOR MEDICATION REFILL REQUESTS FAXED TO US FROM YOUR PHARMACY. PATIENTS MUST CALL OUR OFFICE DURING NORMAL BUSINESS HOURS TO REQUEST MEDICATION REFILLS. X____

Medication refills will not be called in after hours, on days when we are closed, or on holidays. X____

Without exception, prescriptions that are lost in the mail, lost by the patient, or lost by the pharmacy will be charged a $25 fee. X___ ***Duplicate prescription refill requests are always charged a $25 fee. X___

Outside Food & Beverages: Because this is a physician's office, we do not allow outside food and beverages (excluding water) in our office. **Please do not bring these items with you.** X_____

Photocopies: I agree that photocopies and electronic copies of this form are as valid as the original. X_____

Email Policy: We use email to receive appointment cancellations and to send superbill receipts. Email containing clinical information is strictly prohibited and goes directly against our office policy. Clinical concerns and urgent matters are to be addressed via telephone by calling our office. X____
Note: By choosing to communicate via Email or Internet, you are assuming a certain degree of risk of breach of privacy. The Fort Christian Psychiatric Center cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. We will save email correspondence with you and they will be considered part of the medical record. Therefore, you should consider that any electronic communication may not be confidential and will be included in your medical chart. X_____

Policy for Termination of Treatment: Patients are under no obligation to continue services should they choose to terminate treatment. However, it is required that we be notified, *in writing*, in order to properly begin the termination process. Similarly, The Fort Christian Psychiatric Center reserves the right, under any circumstances (including choosing to go against medical advice, failure to adhere to the treatment plan, office policies and pearls of wisdom agreement, etc.) to terminate the doctor-patient relationship at the discretion of Dr. Fortuchang. Patients with inactive charts for 6 months and longer are subject to termination. A formal letter of termination will be mailed to the home address on file. X____.

Terminations occur for a reason. Therefore, it is our policy not to re-establish the doctor-patient relationship—regardless of how the termination process was initiated. **Please note that patients are fully responsible for any and all outstanding balances at the time of termination. X_____

Policy Changes: The Fort Christian Psychiatric Center reserves the right to change/modify/amend/update our office policies at any time. You will be notified of any changes. The updated version will always be available on our website and at our front desk for your review. X_____

Prior-Authorization, Records, Forms and Other Fees: Medical records: $25/request. X____
Completion of forms (school, camp, work, jury duty, prior authorization): $35/form. X____
Requests for medication refills made between appointments: $25/refill. X____
Manual credit/debit card transaction for payment of services: $2 convenience fee/transaction. X_____
Telepsychiatry services: $10 convenience fee + the cost of the session X_____
After-hours appointments: $50 convenience fee + the cost of the session X_____

Session Fees: Our fees are subject to change to keep pace with inflation, business overhead, and other factors to the discretion of Shaw Wendi Fortuchang, M.D, P.C. / The Fort Christian Psychiatric Center. X____

Consent for Treatment at a Christian-Centered Medical/Psychiatric Facility: I have read and initialed the office policies of The Fort Christian Psychiatric Center (TFCPC). I understand them and I agree to adhere to them. I understand that TFCPC is a Christian, Bible-based practice. I understand that The Bible, Scripture and prayer are used as the foundation for the treatment—as is dictated by The Holy Spirit. I hereby consent to be treated by physicians and/or mental health professionals associated with The Fort Christian Psychiatric Center and Shaw Wendi Fortuchang, M.D., P.C. I understand this consent does not constitute a guarantee about the results of my treatment. I understand that I can terminate this consent for treatment at any time. I also understand that my doctor, prescribing provider, therapist or counselor may terminate consent for treatment at any time, and will discuss the reasons with me if this should occur. Potential reasons include misuse of prescribed medications or mental health services, failure to reimburse for services rendered, failure to keep appointments or repeated cancellations of appointments, etc. I agree that I am personally responsible for ensuring that all charges for services rendered are paid by me, at the time services are rendered. X_____

Statement of Confidentiality: Under Georgia law communications between patients and psychiatrists are confidential, and under ordinary circumstances, only the patient may waive this privilege. However, there are three clear exceptions in which a psychiatrist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to him or herself, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, (3) actual or suspected incidents of child abuse. Although legally and ethically bound to break confidentiality under these circumstances, we will attempt to discuss with you first. X_____

I authorize The Fort Christian Psychiatric Center (TFCPC) to provide information concerning my treatment to any physician or therapist who referred me to TFCPC, as well as to my primary care physician for the sole purpose of collaborating fasting baseline lab work when needed. X_____

ACCEPTANCE OF THE OFFICE POLICIES OF TFCPC: We are committed to providing professional services of the highest quality and standards, and we consider it an honor to serve you. In order to provide our patients with the most efficient and responsible care, we require agreements be made to the policies stated above.

I have read and initialed the office policies of The Fort Christian Psychiatric Center (TFCPC) in their entirety. I understand them, I agree with them, and I will adhere to them. X_____

I have read and signed the Pearls of Wisdom of The Fort Christian Psychiatric Center (TFCPC) in their entirety. I understand them, I agree with them, and I will adhere to them. X_____

Signature of Patient/Guardian: _____
*This must be the signature of the person signing. It is illegal in the state of Georgia to sign another person's name without Power of Attorney (POA).
Printed Name of Patient/Guardian: _____ Date: _____
(POA Signature (if applicable): _____ Date: _____)

TFCPC Pearls of Wisdom Covenant Agreement

Please read the following pearls very closely and in entirety before signing…

1. I will immediately notify The Fort Christian Psychiatric Center (TFCPC) / Dr. Fortuchang if there are any significant changes in psychiatric symptoms and/or medical condition (pregnancy, etc.).

2. If I have thoughts of hurting myself, I will notify Dr. Fortuchang immediately. If I am suicidal or have a medical emergency requiring immediate action, I will call 911 or go to the nearest ER and then contact Dr. Fortuchang.

3. If I ever require emergent psychiatric treatment and/or hospitalization, I will make sure that Dr. Fortuchang is promptly notified. I will call TFCPC on the next business day to schedule an urgent follow-up appointment. I will inform Dr. Fortuchang of any medication changes made during hospital visit and/or hospitalization.

4. I will take medication as prescribed. If I want to increase, decrease, or discontinue medication, I will discuss with Dr. Fortuchang first. I understand that making changes without Dr. Fortuchang's permission and guidance is strictly prohibited, potentially dangerous and will impair my standing as a patient at TFCPC.

5. I understand that it is extremely important not to share my medication with anyone, and not to take any medication that has been prescribed to someone else. I understand that such actions are strictly prohibited.

6. I understand that obtaining psychiatric medications from any doctor(s) other than Dr. Fortuchang (except during hospitalization) violates the trust and open communication essential to a functional doctor-patient relationship. Such actions are strictly prohibited and may result in termination from The Fort Christian Psychiatric Center.

7. I understand that it is dangerous to misuse alcohol and prescription medication, or use illegal drugs— especially when taking psychiatric medication. I understand that substance abuse/dependence may result in termination of treatment with referral to an addictions specialist, as Dr. Fortuchang is not an addictions specialist.

8. **I will notify Dr. Fortuchang if there are any changes to my contact information and credit/debit card on file.**

9. I fully understand that The Fort Christian Psychiatric Center does not engage in email correspondence with patients and/or their families, other than under special circumstances or to send office-wide information. ***I will regularly check my email inbox. *I will reply to all emails (& phone messages) requesting a response!**

10. I will not expect to receive any response to any email(s) I choose to send, and I will not send any emails containing urgent/emergent/clinical questions or information regarding the treatment.

11. Because safety is extremely important, I will follow the treatment plan (medication, frequency of appointments, etc.) outlined by Dr. Fortuchang. I will ask questions whenever I do not understand something about the treatment.

12. I understand that it is my responsibility to keep track of my medication and request medication refills during my appointment. I am fully aware that refill requests made between appointments are subject to a $25 fee.

13. I agree not to take any over-the-counter supplements (diet pills, herbal supplements, etc)—especially if I'm being prescribed medication, without first discussing it with Dr. Fortuchang. Such supplements may have adverse effects, may interact with prescribed medication and could worsen certain psychiatric disorders.

14. I fully understand that signing this form does not create a doctor-patient relationship between me and Shaw Wendi Fortuchang, M.D., and that it is not until after the initial evaluation when it may be mutually agreed upon to create such a doctor-patient relationship.

15. I have read, understand, and agree with the above Pearls of Wisdom and the office policies for TFCPC, and I understand that failure to comply with them could result in termination of my treatment at The Fort Christian Psychiatric Center/Shaw Wendi Fortuchang, M.D., P.C., once becoming a patient.

Patient's Signature _____ Date _____

Patient's Printed Name _____ Date _____

***This must be the signature of the person signing. It is illegal in the state of Georgia to sign another person's name without Power of Attorney.**