



THE FORT CHRISTIAN PSYCHIATRIC CENTER / SHAW WENDI FORTUCHANG, M.D., P.C.  
 SHAW WENDI FORTUCHANG, M.D., FAPA  
 110 NORTH PARK DRIVE, FAYETTEVILLE, GA 30214 (PHONE) 770-376-6726

**PLEASE PROVIDE AN ANSWER FOR EVERY QUESTION!**

**ADULT MALE QUESTIONNAIRE**

**How did you hear about us?** Word of mouth  Website  Internet  Radio  Referred by: \_\_\_\_\_  
**Do you prefer a Christian-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 in school? \_\_\_\_\_

Type of school: 4-year college/university  2-year community/junior college  Associate degree  Online

Major: \_\_\_\_\_ Grades: A  B  C  F  Passing  Failing  GPA: \_\_\_\_\_

**Any academic challenges?** Yes  No

**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?** Yes  No  **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: future, finances, family/children, health, etc.), over which you have no control, to the point of it affecting sleep, causing 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, urges or images that were unwanted, 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

In the past 12 months, have you taken ANY pills to calm you down, help you relax or to help you sleep? Yes  No

In the past 12 months, have you found that once you start drinking you ended up drinking much more than intended to? Yes  No  What about drinking for a much longer time than intended? Yes  No

In the past 12 months, have you used ANY illegal drugs or marijuana? Yes  No

In the past 12 months, have you misused ANY prescription medication? 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 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 said any of your beliefs were 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

**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!

### 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-repent 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

**\*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 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
- Special Education
- Mispronounced words
- 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 affected BIOLOGICAL family members (except you). 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 waking  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

Anemia

Endocrine Problems (hormones)

High Blood Pressure

Heart Problems

Allergies

High Cholesterol

Pain Problems

Thyroid Problems

Neurological Problems /  Seizures

Joint Problems

Skin Problems

Liver Problems

Eye Problems

Kidney Problems

Headaches

Musculoskeletal Issues

Gynecologic Problems

Sinus Issues

Gastrointestinal Problems

Lung Problems

Dental Problems

Sexually Transmitted Diseases

**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 a 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:

### 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** \_\_\_\_\_



*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: MaleFemale 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

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*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. X\_\_\_\_\_

**HOURS:** Mon-Thu from 7am – 7pm. Appointments are scheduled on Tuesdays, Wednesdays and Thursdays. Monday is an administrative day. We are closed on Fridays and weekends. 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 Tuesdays, Wednesdays and Thursdays. If you choose to cancel your appointment, you must do so at least **48-business hours to the exact date and time of the appointment in order to avoid being charged the full cost. A cancellation made less than 48-business hours to the exact date and time of the appointment will be charged the full cost for the session.** **Because we are closed on Fridays, Friday is not counted as a business day.** 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:** We have 2 categories for appointment cancellations: **#1. Appointments scheduled for less than 12 weeks in the future.** These appointments must be canceled by **48 business hours to the date and exact time of the scheduled appointment,** otherwise patients will be charged the full cost for the session. **Because we are closed on Fridays, Friday is not counted as a business day.** For example, a 4 PM Monday appointment must be canceled by 4 PM on the previous Wednesday, and a 9 AM Tuesday appointment must be canceled by 9 AM on the previous Thursday. A 1:30 PM Wednesday appointment must be canceled by 1:30 PM on the previous Monday, and a 5:15 PM Thursday appointment must be canceled by 5:15 PM on the previous Tuesday. X\_\_\_\_\_

**#2. Appointments scheduled for 12 weeks or more in the future.** **This is calculated by counting 12 weeks ahead from the date of the scheduled appointment.** These appointments must be canceled by 1 week to the date of the appointment, **during or before business hours,** otherwise patients will be charged the full cost for the session. Therefore, a Monday appointment must be canceled by the previous Monday, a Tuesday appointment must be canceled by the previous Tuesday, a Wednesday appointment must be canceled by the previous Wednesday, and a Thursday appointment must be canceled by the previous Thursday. Additionally, these appointments **must be canceled before or during business hours (by 7 PM when we close)** otherwise patients will be charged the full cost. 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\_\_\_\_\_

**Appointment Cancellation Method:** All appointment cancellations must be made via email to [dr.fortuchang@thefortchristian.com](mailto:dr.fortuchang@thefortchristian.com) or [office@thefortchristian.com](mailto:office@thefortchristian.com), and/or through our website [www.thefortchristian.com](http://www.thefortchristian.com). Therefore, please do not call our office to cancel an appointment. X\_\_\_\_\_

**To cancel an appointment via email:** you may either write to us (you are solely responsible for ensuring that our email address is entered correctly) or you may reply to an email from us. 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. **We will not contact you to confirm receipt of the cancellation.** X\_\_\_\_\_

**To cancel an appointment via our website:** simply log onto it, go to the CONTACT page and submit the form. 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. **We will not contact you to confirm receipt of the cancellation.** X\_\_\_\_\_  
Appointment cancellations must be made during business hours. 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\_\_\_\_\_

**Telephone Policy:** To provide quality care to her patients, Dr. Fortuchang prefers to personally return their calls. Messages left between the hours of 7am and 7pm on Mon through Thurs will be returned within 24 hours. Messages left after 7pm on Thurs 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, which 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 (fax line) at 770-376-6727.** Your call will be routed to a private voicemail. 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 call back. Your call will be returned as soon as possible from a blocked number. **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\_\_\_\_\_

\*\*We charge \$25/medication for all medication refill requests made between appointments. A good way to avoid this is to either bring your medication bottles to every 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 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, over the weekend, or on holidays. X\_\_\_\_\_

\*\*Again, we strongly urge you to pay close attention to your medication supply. We encourage you to make prescription requests during your appointment in order to avoid being 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.    
Completion of forms (school, camp, work, jury duty, prior authorization): \$35/form.    
Requests for medication refills made between appointments: \$25/refill.    
Manual credit/debit card transaction for payment of services: \$2/use.    
Telepsychiatry services: \$10 fee + the cost of the session

**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.

**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.

**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.

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.

**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.

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.

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: \_\_\_\_\_)



**TFPCPC 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 (TFPCPC) / 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 TFPCPC 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 TFPCPC.
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 TFPCPC, 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.