illuminate
THERAPY & WELLNESS

Coordination of Care for Primary Care Physician and Health Information

Pursuant to Illinois Law and in order to provide you with the highest quality of care, we wish to inform you that it is desirable that you confer with your primary care physician (PCP), if you have one, about seeking and receiving mental health treatment at Illuminate Therapy & Wellness, LLC. If you have a PCP, it is required that your therapist share pertinent information regarding a mutual patient's prognosis and treatment, unless you waive such notification. We request that you complete this form if you wish to authorize your therapist to exchange information regarding your care at Illuminate Therapy & Wellness with your PCP. If signed, this authorization will remain in effect for one (1) year from the date signed.

Please choose one of the following:

_____ I do give permission to notify my PCP.

I agree to you notifying my PCP that I am receiving mental health treatment services. I agree to signing the attached Release of Information (ROI) form permitting you to communicate with my PCP.

Name of PCP: ______________________________

Address: ______________________________

Telephone: ______________________________

_____ I do *not* give permission to notify my PCP.

I waive notification of my PCP that I am receiving mental health services, and I direct you not to notify him/her.

_____ I do not have a PCP and do not wish to confer with one.

Client Signature ______________________________ Date: __________

(Client if 12 years or older)

Parent/Guardian Signature ______________________________ Date: __________

(Parent/Guardian if Client is Minor under 12 years of age/Personal Representative)

Witness Signature ______________________________ Date: __________

HEALTH AND MEDICAL INFORMATION

Date of your last physical exam (Month/Year): ______________________________

What is your current health status? Please note any pertinent history you believe is important for your therapist to know. ______________________________

Psychiatrist (if applicable):	Telephone:

Please list medical problems:

Type:	Date of Diagnosis:

Please list *all* current medications and/or supplements (include birth control, OTC medication, herbal remedies, vitamins).

Medications:	Dose:

FAMILY HISTORY

Check all that apply and list the family member.

Condition	Family Member:
☐ Attention-Deficit/Hyperactivity/Impulsivity (ADD/ADHD)	
☐ Addiction (Specify):	
☐ Autism Spectrum Disorder/Asperger's Disorder	
☐ Bipolar Disorder	
☐ Depression	
☐ Eating Disorders	
☐ Generalized Anxiety and/or Phobias	
☐ Learning Problems/Disabilities/Dyslexia/Speech	
☐ Obsessive-Compulsive Disorder (OCD)	
☐ Schizophrenia/Psychosis	
☐ Seizures/Other Neurological Disorder	
☐ Sleep Disorder	
☐ Other:	

NUTRITION SCREEN

Please give as much detail as you can for either yourself, or whom you are completing this form for.

1. Has there been any recent change in your appetite? ☐ Yes ☐ No

2. What is your Height: __________ Current Weight: _______ Average Weight: ______

3. Have you gained or lost weight in the past year? ☐ Yes ☐ No
   If so, how much? Gained _______ pounds *OR* Lost __________pounds

4. Please describe your diet: ____

4. Do you omit any foods because of health reasons? ☐ Yes ☐ No
If yes, what are they? ____

____

5. Do you omit any foods because of religious reasons? ☐ Yes ☐ No
If yes, what are they? ____

____

6. Do you include any food because of health benefits? ☐ Yes ☐ No
If yes, what are they? ____

____

7. Do you have difficulty with: ☐ Swallowing ☐ Chewing ☐ Diarrhea ☐ Constipation ☐ Vomiting ☐ Indigestion ☐ Heartburn

8. Do you use any purging methods: ☐ Laxatives ☐ Diuretics ☐ Diet Pills ☐ Vomiting

9. What type of exercise do you do and how often? ____

____