## TABLE OF CONTENTS

Introduction ................................................................. 2

What You Need to Know When Setting Up Your 80 Hour Practicum ............................................ 4

Sample Forms to be Used for 80 Hour Practicum ................................................................. 5-16

What You Need to Know When Setting Up Your 400 Hour Practicum .................................... 17
(when treating patients with psychotropics)

Sample Forms to be Used for 400 Hour Practicum ................................................................. 19-86

Everything You Need to Know Now that Your Coursework and Practica are Complete ............ 87

Final Form to be submitted to the Training Director ............................................................... 92

Checklist of Material to be Sent to the Training Director before Applying for Your Conditional License to Prescribe ................................................................. 97
POST-DOCTORAL TRAINING IN PSYCHOPHARMACOLOGY

INTRODUCTION
Congratulations on completing the physical assessment sequence of didactic training. The next sequence of training integrates didactic instruction and supervised experience. The Training Manual is intended to be a source of information and guidance for post-doctoral students in the supervised clinical experience (practicum).

Please take time to read through this training manual to orient you to important information regarding departmental policies and procedures as well as statutory guidelines. This manual will assist you as you progress through the series of administrative and regulatory factors of being an RxP. Please refer to this manual in case you have questions or concerns during your post-doctoral supervised clinical experience.

As professional psychologists, it is expected that you will comply with the APA’s Ethical Principles of Psychologists and Code of Conduct (www.apa.org/ethics/code.pdf). As post-doctoral students of New Mexico State University, it is also expected that you comply with the Student Code of Conduct (http://studenthandbook.nmsu.edu/student-code-of-conduct).

As an overview, you will be required to complete two (2) supervised clinical training applications (practica) in accordance with the Professional Psychologist Act (N.M.S.A. 61-9-1) and New Mexico Administrative Code (N.M.A.C. 16.22.1). In addition to the description and requirements of each practica, this manual will provide forms related to each practica.

Supervised Clinical Experience Sequence
1. Clinical Assessment and Pathophysiology- Eight (80) Hour Practicum
2. Psychopharmacology- Four-hundred (400) Hour Practicum

In order to qualify for a conditional and full prescriptive authority in the state of New Mexico, regulations and requirements of the Prescribing Psychologist Act must be followed. The program will provide you with information to assist you through the process of completing the supervised clinical experience. However, it is ultimately your responsibility to stay abreast of current regulations, requirements and statutes.

Useful Resources
NM Licensing and Regulation Department
http://www.rld.state.nm.us/boards/Psychologist_Examiners_Rules_and_Laws.aspx
NM RxP Law House Bill 170
http://cep.education.nmsu.edu/academic-programs/clinical-psychopharmacology/new-mexico-rxp-law/

The Director of Training will work closely with each student to ensure that all required documentation is completed. However, it is ultimately your responsibility to make sure that appropriate material is sent to the Training Director. A smooth progression through the academic and regulatory requirements is dependent upon multiple factors including:
1. Your Knowledge of the academic requirements
2. Regulatory requirements
3. Accuracy of documentation
4. Timely submission of required forms
LIABILITY COVERAGE

Activities related to curriculum and supervised clinical experience at the New Mexico State University need to be covered by your existing professional liability insurance. Any physical accidents that you incur or are caused by you to someone else are covered by the New Mexico State University insurance (FORM # 80-4). However, now is a good time for you to determine if your liability insurance carrier will cover you as a prescribing psychologist once you receive your conditional/unconditional prescribing license.

The Trust Sponsored Professional Liability Program (http://www.trustinsurance.com or toll-free (800) 477-120) is presently covering prescribing psychologists and has given their commitment to continue to do so. However, not all insurance carriers are willing to cover prescribing psychologists. If your insurance carrier is not open to covering you for the minimum of $100,000 / $300,000 liability, you will need to look into alternate coverage.

You will be completing two practica. The first practicum is eighty hours in a health setting to be supervised by a physician in which you will practice basic assessment skills.

The second practicum is your treatment of 100 patients for a minimum of 400 hours with psychotropic medication along with psychotherapy.

In the sections of this manual that follow, the description of the 80-hour practicum with a physician and forms related to it are discussed first followed by description of the 400-hour practicum and forms related to it.

There are many requirements within the Prescribing Psychologist Act and delineated in the regulations regarding the implementation of that Act that must be followed in order to qualify for a conditional and full prescribing psychologist license.

It is strongly recommended that you read the Law and regulations for implementing the Law, which are posted on the NMSU website at www.nmsu.edu/academic-programs/clinical-psychopharmacology. Further, if you will read the instructions within this manual, carefully use the materials provided for documenting your work, and forward those documents to the Training Director in a timely fashion, your progress through the steps will go smoothly.

While you are a prescribing psychology student in the New Mexico State University Master’s program, your activities will be covered by your existing liability insurance. Any physical accidents that you incur or are caused by you to someone else are covered by the New Mexico State University insurance (relevant forms to document this to your supervisors are provided in later sections of this manual). However, now is a good time for you to determine if your liability insurance carrier will cover you as a prescribing psychologist once you receive your conditional prescribing license and full prescribing license. The APA Insurance Trust is presently covering prescribing psychologists and has given their commitment to continue to do so. However, not all insurance carriers are willing to cover prescribing psychologists. If your insurance carrier is not open to covering you for the minimum of $100,000 / $300,000 liability, you will need to look into alternate coverage.
Upon completion of Unit 3 Pathophysiology for Psychologists, students may begin the 80-hour supervised clinical experience. The goal of the 80-hour practicum is to provide the student an opportunity to observe and demonstrate competence in physical and health assessment techniques within a medical setting under the supervision of a physician.

Each student is responsible for securing appropriate placement for the 80-hour practicum. A sample letter to the supervising physician is attached that describes the objectives of this eighty-hour practicum to aid you in setting up the appropriate experience.

REQUIREMENTS (Based on NMAC 16.22.23 Requirements for Education and Conditional Prescription Certificate)

SUPERVISION: The 80-hour practicum shall provide the opportunity for the applicant to observe and demonstrate competence in physical and health assessment techniques within a medical setting under the supervision of a physician. You may have a secondary supervisor; however, the primary supervisor must be a physician.

COMPLETION TIME:
The 80-hour practicum shall be completed in a time frame of full-time over two (2) weeks to thirty (30) weeks. If the applicant cannot complete the 80-hour practicum within the time frame designated because of illness or other extenuating circumstances, the student may request an extension from the Director of Training board explaining in writing the extenuating circumstances and the additional time requested.

EVALUATION AND VERIFICATION OF COMPLETION:
The supervising Physician and the Director of Training shall certify in writing that the student:
1. Assessed a diverse and significantly medically ill patient population
2. Observed the progression of illness and continuity of care of individual patients
3. Adequately assessed vital signs
4. Demonstrated competent laboratory assessment
5. Successfully completed the 80-hour practicum

The Physician and Director of Training must sign the final evaluation form. The Director of Training will keep a copy of the verification form. The student will retain the original verification form and submit to the New Mexico Board when applying for Conditional prescriptive Authority.

INFORMED CONSENT
With permission of the physician, the psychologist in practicum training and the physician identify the psychologist as _______ and request the patient’s permission to review protected health information and participation to the extent the physician deems appropriate.

The psychologist in practicum training is responsible for informing the patient (or the patient’s legal guardian) of their role unless there is a procedure already in place at the institution.

The name and role of the supervisor and sufficient information of the expectation and requirements of the practicum shall be provided to the patient or the patient’s legal guardian at the initial contact necessary to obtain informed consent and appropriate releases. The psychologist in practicum training shall provide additional information requested by the patient or the patient’s legal guardian concerning the applicant’s education, training and experience.
## SAMPLE FORMS TO BE USED FOR 80 HOUR PRACTICUM

<table>
<thead>
<tr>
<th>Form 80-1</th>
<th>Letter to Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A sample letter you may give to the physician explaining the purpose of the practicum.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Form 80-2</th>
<th>Evaluation Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Evaluation form to be completed by the supervising physician at completion on the 80-hour supervision. This evaluation form is the official form the New Mexico Board of Psychologist Examiners. A copy of this completed form must be returned to the Training Director. The student must retain a copy and submit the original to the Application Committee of the New Mexico Board of Psychologist Examiners when applying for the Prescribing Psychology License.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Form 80-3</th>
<th>Institution Contract</th>
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<tbody>
<tr>
<td></td>
<td>Some institutions require a contract between New Mexico State University and the institution (hospital, clinic, etc.). This form may be signed by the Director of Training, if necessary.</td>
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<tr>
<th>Form 80-4</th>
<th>New Mexico State University Insurance Coverage</th>
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<tbody>
<tr>
<td></td>
<td>This document may be utilized to provide institutions with documentation of insurance coverage through the New Mexico State University, if required by the institution.</td>
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FORM 80-1

Letter to the Supervising Physician
New Mexico State University
Psychopharmacology Training

Date: ______________________

Re: Introduction Letter about NMSU Program 80-hour Supervised Clinical Experience

Dear Medical Colleague:

Thank you so much for considering supervising one of the Post-Doctoral students in New Mexico State University’s Master of Arts which trains post-doctoral students in Psychopharmacology. New Mexico was the first state to pass a law in which psychologists with appropriate postdoctoral training and measured competency may prescribe psychotropic medications for their patients in consultation with the physicians.

The Prescribing Psychologists’ Act of New Mexico requires Post-Doctorate Students to have an 80-hour supervised clinical experience under the direction of a physician. The Psychologists complete this supervised clinical experience after a series of Master level courses, taught by physicians, in Pathophysiology and Physical Assessment.

The supervised clinical experience is similar to that of a first year medical student in which the Psychologist in training is offered the opportunity to shadow physicians for 80 hours. During this time, the student may review patient records and participate as deemed appropriate by the physician.

The Board of Psychologist Examiners requires the supervising physician to complete an evaluation form upon completion of the 80-hour supervision. Psychologists’ training in psychopharmacology should be able to demonstrate competence in the areas identified on the evaluation form attached to this letter.

Physicians that have participated in the clinical supervision have reported the experience to be quite helpful with their patients in addressing possible psychological concerns.

If you would consider being one of the supervisors in our program, New Mexico State University in conjunction with Southwestern Institute for the Advancement of Psychotherapy, provides continuing education credit for supervisory hours. We would greatly appreciate your participation in our program, which provides meaningful assistance to many underserved populations in New Mexico, as well as throughout the United States, in the Indian Health Service and all branches of the military.

Sincerely,

Psychopharmacology Training Staff
New Mexico State University
Las Cruces, NM 88004
(575) 646-2120
FORM 80-2

80-hour Practicum Evaluation Form
New Mexico State University  
Psychopharmacology Training  
Eighty-Hour Practicum

<table>
<thead>
<tr>
<th>Student</th>
<th>Site:</th>
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<tbody>
<tr>
<td>Evaluator:</td>
<td>Position:</td>
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<tr>
<td>Dates of Practicum:</td>
<td>Date of Evaluation:</td>
</tr>
</tbody>
</table>

I. **INTERVIEWING/HISTORY TAKING**
   Establishes good rapport with patient  
   Yes No
   
   Can interview patient skillfully about:
   - Chief complaint  Yes No
   - Present problems  Yes No
   - Symptom analysis of each present problem  Yes No
   - Past history  Yes No
   - Family history  Yes No
   - Review of System  Yes No

II. **PHYSICAL EXAMINATION/LABORATORY SKILLS**
   Observes and participates in physical examination as situation dictates  Yes No
   Recognizes range of symptoms and manifestations of abnormal findings  Yes No
   Demonstrates adequacy in assessing vital signs  Yes No

III. **EXPERIENCE IN ASSESSMENT**
   Differentiates relevant from irrelevant diagnostic cues  Yes No
   Formulates assessment at highest diagnostic level which data support  Yes No
   Formulates prioritized risk/health-maintenance-needs list  Yes No
   Can plan diagnostic studies judiciously  Yes No
   Can plan non-pharmacologic strategies when appropriate  Yes No
   Plan recommended follow-up/referral when appropriate  Yes No
   Demonstrates competent laboratory assessment  Yes No
   Demonstrates competency in physical and health assessment techniques  Yes No
   Assesses a diverse and significantly medically ill population  Yes No

IV. **GENERAL (appropriate to limits of practice)**
   Applies Current Theoretical Knowledge to Clinical Setting  Satisfactory Unsatisfactory
   Assumes Responsibility Appropriate To Current Knowledge/Skill Level  Satisfactory Unsatisfactory
   Seeks Assistance Appropriately  Satisfactory Unsatisfactory
   Takes a Patient’s Family Situation in Consideration Planning Care  Satisfactory Unsatisfactory
   Communicates Clinical Goals/Objectives Clearly To Supervisor  Satisfactory Unsatisfactory
   Retains Composure under Stress  Satisfactory Unsatisfactory
   Recognizes and Seeks to Remedy Weak Areas  Satisfactory Unsatisfactory

_________________________      ______________________
Supervisor        Date
FORM 80-3

AFFILIATION AGREEMENT
I. RECITALS

A. The purposes of this agreement are:
   1. To establish a practicum training program for doctoral level psychologists who have completed postdoctoral academic coursework towards obtaining a license as a prescribing psychologist.
   2. To ensure a close working relationship between New Mexico State University and the Institution.
   3. To benefit the University by providing a quality practicum experience for these psychologists in training.
   4. To benefit the Institution in providing high quality psychological expertise in diagnosis, testing, and treatment of mental disorders.
   5. To enable the participating psychologists to become knowledgeable about operational aspects of various types of health delivery systems.

II. RESPONSIBILITIES OF THE INSTITUTION

A. The Institution will:
   1. Accept for training the number of psychologists to be determined jointly by the Institution and the University, but no more than three psychologists will be supervised by an individual staff member at the Institution.
   2. Make available its clinical and related facilities and its personnel to provide quality learning experiences for the psychologists during their educational rotation at the Institution under the supervision of qualified Institutional personnel.
   3. Designate one or more clinical supervisors who will: (a) coordinate the psychologists’ clinical education experience with the appropriate university program director.
   4. Make patients aware that the psychologists from New Mexico State University are postdoctoral students training in psychopharmacology.
   5. Permit the University’s program director to work with the Institution’s clinical supervisors.

III. RESPONSIBILITIES OF THE UNIVERSITY

A. The University will:
   1. Identify specific psychologists who, with the agreement of the Institution, will be assigned part-time for training at the Institution in accord with a schedule agreed upon by the University, Institution, and the psychologist.
2. Require psychologists to conform the policies and procedures of the Institution, under the direction of the Institution’s designated clinical supervisors
3. Assure that psychologists are duly licensed as psychologists by the New Mexico Board of Psychologist Examiners

B. Psychologists will meet all reasonable health standards imposed by applicable Laws and regulations or imposed by the Institution.

C. The University Program Training Director responsible for the psychologists’ rotation at the Institution will send a letter to the Institution’s staff member responsible for the psychologists’ supervision at the Institution that provides the following specific information:
   1. The individual at the University who is designated to assume supervisor responsibilities for the psychologist; and
   2. The educational goals and objectives of the psychologist’s rotation at the Institution; and
   3. The period of assignment of the psychologist at the Institution
   4. The Institution’s responsibilities for supervision and evaluation of the psychologist’s performance; and
   5. The policies and procedures that govern the psychologist’s education while on rotation at the Institution; and
   6. An attestation by the program Training Director that the psychologist rotating at the Institution is in good standing in the program; and
   7. A delineation by the program Training Director of the minimum required level of supervision of the psychologist

IV. INSURANCE AND LIABILITY

A. As between the parties, each party acknowledges that it will be responsible for claims or damages arising from personal injury or damage to persons or property to the extent they result from negligence of that party’s employees or (in the case of University) program director. The University will provide professional liability insurance covering the program director and University employed faculty members for their activities at the Institution, in accordance with the provisions of the New Mexico Tort Claims Act, Sections 41-4-1 et seq. NMSA 1978, as amended. The liability of the faculty employed by the University will be subject in all cases to the limitations and immunities of the New Mexico Tort Claims Act.

B. If a complaint is made or otherwise involving a psychologist or University Employee, the Institution will immediately provide written notice to the Counseling and Educational Psychology Department at New Mexico State University. If a claim or suit is filed or initiated against the Institution, naming or otherwise involving alleged actions or omissions of a psychologist, the University will manage and control all aspects of the defense on behalf of the psychologist.

V. TERM AND TERMINATION
This agreement will become effective on ____________ and will continue through ____________ unless earlier terminated by their party by providing written notice of intent to terminate from the other party at least 60 days prior to the proposed date.
VI. REIMBURSEMENT
Unless otherwise specified, this relationship is based upon an exchange of services and not reimbursement through funds.

VII. HIPAA COMPLIANCE
A. The parties will comply with the applicable provisions of HIPAA and any current future regulations promulgated hereunder, including without limitation, the federal privacy regulations, the federal security standards, and the federal standards for electronic transactions (collectively the “HIPAA Requirements”). The parties will not use or further disclose any Protected Health Information or Individually Identifiable Health Information (such as terms are defined in the HIPAA regulations), other than as permitted by the HIPAA Requirements and the terms of this Agreement.
B. The University will ensure that psychologists have been provided training with regard to HIPAA Requirements. Additionally, the Institution may require each psychologist to sign a Confidentiality Agreement and an Acknowledgement that the psychologist has received Institution’s Notice of Privacy Practices.

VIII. MISCELLANEOUS
A. Entire Agreement: This Agreement and the Program Letters references in Section III-C of this of this Agreement represent the entire understanding between the parties and supersede any prior agreements or understandings with respect to the subject matter of this Agreement.
B. Waiver of Breach. The waiver by either party of a breach or violation of any provision of this Agreement will not operate as or be construed as a waiver of any subsequent breach of this Agreement.
C. Modifications. No changes, amendments, of alterations to this Agreement will be effective unless in writing and signed by both parties.
D. Non-Assignability. This Agreement will not be assigned by either party, nor will the duties imposed upon either party by this Agreement be delegated, subcontracted, or transferred by either party, in whole or in part, without the prior written consent of the other party.
E. Governing Law. This Agreement will be construed, interpreted, governed, and enforced in accordance with the statutes, judicial decisions, and other laws of the State of New Mexico.
F. Severability. The invalidity or unenforceability of any term or provision of this Agreement will in no way affect the validity or enforceability of any other term or provision to the extent permitted by Law.
G. Marketing Materials. Neither the University nor the Institution will use the other’s name in any publicity or advertising materials without prior written consent of the other party; provided, however, that either party may indicate to individual psychologists the existence and scope of the training program available at the Institution.
H. Confidentially
1. Patient and Psychologist Records. The confidentiality of patients’ medical records and psychologists’ academic records will be maintained by the parties in accordance with applicable federal and state laws and regulations.
I. Retention of Records. The Institution and University will maintain detailed records associated with the assignment of psychologists pursuant to this agreement for a period of five years.
J. Relationship of parties. Psychologists and employees of the University will not be considered employees of the Institution for any purpose including, but not limited to, workers’ compensation, insurance, bonding or any other benefits afforded to employees of the Institution.

K. Cooperation and Dispute Resolution. The parties agree that, to the extent and compatible with the separate and independent management of each, they will maintain effective liaison and close cooperation. If a dispute arises related to the obligations or performance of either party under this Agreement, representatives of the parties will meet in good faith to attempt to resolve the dispute.

L. Third parties. Nothing in this Agreement, express or implied, is intended to confer any rights, remedies, claims, or interests upon a person not a party to this agreement.

M. Eligibility for Participation in Government Programs. Each party represents that neither it, nor any of its management or any other employees or independent contractors who will have any involvement in the services or products supplied under this Agreement, have been excluded from participation in any government healthcare program, debarred from or under any other federal program (including but not limited to debarment under the Generic Drug Enforcement Act), or convicted of any offense defined in 42 U.S.C. Section 1320a-7, and that it, its employees, and independent contractors are not otherwise ineligible for participation in federal healthcare programs. Further, each party represents that it is not aware of any such pending action(s) (including criminal actions) against it or its employees or independent contractors. Each party shall notify the other party immediately upon becoming aware of any pending or final action in any of these areas.

N. Notices. Any notice required to be given pursuant to terms and provisions of this Agreement will be in writing and will be sent by certified mail, return receipt requested, postage prepaid, as follows:

To the University at: New Mexico State University  
College of Education  
Department of Counseling & Educational Psychology  
MSC 3CEP, P.O. Box 30001  
Las Cruces, NM 88003-8001

To the Institution: _________________________  
_________________________  
_________________________  

Signed this ______ day of __________________, 20___.

A staff member of Psychopharmacology Training for NMSU:

By ______________________________________________

Signed this ______ day of __________________, 20___.

FORM 80-4

New Mexico State University
Insurance Coverage
March 2, 2004

RE: Professional Liability Insurance

TO WHOM IT MAY CONCERN:

New Mexico State University students who are participating in supervised practicum are covered by the State of New Mexico Risk Management Division for professional/medical liability up to the limits of the New Mexico Tort Claims Act. Coverage limits are:

$300,000 Each Person for Bodily Injury
$100,000 Property Damage
$500,000 Aggregate
$2,000,000 Excess Coverage (Out of State or Federal)

Should you have any questions, I may be reached by phone at (575) 646.2916 or by electronic mail at MABERNET@NMSU.EDU.

Sincerely,

Michael J. Abernethy
Director of Purchasing
& Risk Management
What You Need To Know When Setting Up Your 400-Hour Practicum
In Which You Treat Patients With Psychotropics

The following steps are required by State Law and are being carefully monitored by the Application Committee (comprised, at the minimum, of one member of the Board of Psychologist Examiners, someone recommended by the Board of Medical Examiners, and a public member) when you apply for a conditional prescribing license. Later sections of this manual offer forms for completing each requirement. The forms created by the NMSU Program may not exactly meet the needs of your Institution, and you may modify them as is appropriate. However, it is very important that, if you modify the forms, you carefully study the Law and regulations to make sure that your forms will provide documentation of all factors that you need in order to apply for a prescribing license.

I. You must develop a practicum plan and send a copy of that plan, signed by yourself and your primary supervisor, to the Training Director. A model plan is attached as FORM 400-1. Your plan should demonstrate that you will be working with:
   A. A minimum of 100 separate patients
   B. For at least 400 hours which are patient-only hours
   C. For both evaluation and treatment with psychotropics
   D. For a range of disorder, and a diversity of patients (including gender, ages throughout the lifecycle, various ethnicities, sociocultural background, various economic backgrounds) as much as possible within your area of expertise
   E. A primary or secondary supervisor who is on site
   F. And will obtain one hour of supervision from each eight hours of patient contact

II. In addition to the practicum plan, you must also keep records that would document:
   A. Dates and times of contact with patients and dates and times of supervision
   B. FORM 400-3 and FORM 400-4 can be used for this purpose and will also serve to document requirements in the Law that: the practicum is completed in no less than six months and no more than three years; and that the practicum was completed within the last five years preceding the request from the Board for an application for a conditional prescribing license

III. The Law and regulations require that you inform all patients of your training status. A copy of a form that can be used is included (FORM 400-5). Please feel free to modify this form if it does not fit your particular Institution. However, make sure that you do have a form you are using and send a copy of that to the Training Director

IV. In addition to your regular case notes and the form to be used in that regard, you must keep a summary log with coded patient IDs which includes, for each of the 100 patients: (see FORM 400-6)
   A. Birthdate/age
   B. Gender
   C. Diagnosis
   D. Dates and time spent in pharmacotherapy
These logs must be submitted to the Training Director of the NMSU Program upon completion of the 400-hour practicum. A copy of these logs may be requested by the Application Committee when you apply for your conditional prescribing license.

V. You must forward to the program written evaluations by your supervisor at least at the midpoint and at the end of completing your 400-hour practicum (FORMS 400-6).

VI. In addition to this extensive evaluation requested by the law and by the New Mexico Board of Psychologist Examiners requires a special form be completed by your physician at the end of the practicum. For your convenience, it is also included under (FORM 400-6), an additional form required by the New Mexico Board of Psychologist Examiners.

VII. In addition, you must forward an evaluation completed at the end of practicum for every secondary supervisor (FORM 400-6).

VIII. The Law and the regulations also require you to keep very careful and extensive records of your work with each patient. These extensive case notes are in addition to the basic log mentioned in paragraph IV but are not submitted to the Training Director. Your extensive notes should be reviewed by your supervisors. It is also possible that the Board of Psychologist Examiners could request copies of these notes to see that you have included all of the information listed in the Prescribing Psychologist Act and the regulations. This manual contains the forms to assist you in maintaining all required information. These forms include:
   A. 400-Hour Practicum initial intake forms for adults and children that include a review of symptoms
   B. 400-Hour Practicum for Prescribing Psychologists follow-up forms for adults and children
   C. Initial and follow-up symptom checklists to be completed by adults and parents/children
SAMPLE FORMS FOR THE 400-HOUR PRACTICUM

The following are forms and letters that you will need (you may use them as they are or modified according to your Institutional Directors), to meet the requirements of the Prescribing Psychologist Act.

Forms 400-1 through 400-5 were developed as a part of your setting up your 400 hour practicum plan. A letter from the Training Director explaining the nature of the practicum is included, as well as a form you, your supervisor, and the Training Director must sign and keep in your University and personal file.

**FORM 400-1:** 400-Hour Model Practicum Plan
**FORM 400-2:** Contract with Institution
**FORM 400-3:** 400-Hour Practicum form to log time spent with patient
**FORM 400-4:** 400-Hour Practicum form to log contact times with supervisor
**FORM 400-5:** 400-Hour Practicum Letter to patient Regarding Student Status

Form 400-6 is an evaluation form that your practicum supervisor should fill out when you have worked with 50 patients and 100 patients.

**FORM 400-6a&b:** 400-Hour Performance Evaluation of Prescribing Psychologist (to be completed by supervisor at mid-point of practicum and form required by New Mexico Board of Psychologist Examiners) in addition to this extensive evaluation by the law.

Forms 400-7 through 400-11 are for your use while you are working with patients. Depending on the site where you are placed, you may be able to use these forms directly. You may modify them somewhat, or you may be in an institution where you need to use the institution’s forms. If you use these forms you can be assured that you will have documented with each patient all of the information that is required by the Prescribing Psychologists’ law. If you are not using these forms, you need to carefully look at the law to make sure that your forms include all of the information required by the Prescribing Psychologists’ law. You will see that included in this series are forms to be completed by the patient and forms to be completed by you.

Forms 400-7 and 400-8 are to be completed by the patient at the initial interview.

**FORM 400-7:** 400-Hour Practicum Patient Intake Form to be completed by adult patients
**FORM 400-8:** 400-Hour Practicum Initial Patient Intake form to be completed by child patients

Form 400-9 is one that you can use to record all pertinent information about a patient after initial contact.

**FORM 400-9:** Sample 400-Hour Practicum Initial Patient Chart form to be completed by prescribing psychologist student

Form 400-10 is a form to be used to record pertinent information on your follow-up sessions.

**FORM 400-10:** 400-Hour Practicum form for Patient follow-up sessions to be completed by prescribing psychologist student

Form 400-11 and 400-12 are to be completed by the patient before the beginning of each follow-up session

**FORM 400-11:** Symptom Checklist to be completed by adult patients at initial before the beginning of each follow-up session.

**FORM 400-12:** Symptom Checklist to be completed by child patients (with parent if help is necessary) at initial and follow-up sessions.
FORM 400-1

400-hour Practicum Model Plan
New Mexico State University
Psychopharmacology Training

400 HOUR PRACTICUM PLAN FOR REVIEW BY THE BOARD OF PSYCHOLOGIST EXAMINERS

Name of applicant: _____________________________________________________

Date at which applicant will finish the 450 didactic hour training program of NMSU _________________

Information about the primary supervisor.

Name of supervisor:____________________________________________________

Summary of supervisor’s medical training:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Supervisor’s area of specialization:

_____________________________________________________________________

Information about 1st secondary supervisor

Name of supervisor:

_____________________________________________________________________

Summary of supervisor’s medical training:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Supervisor’s area of specialization:

_____________________________________________________________________

Information about 2nd secondary supervisor

Name of supervisor:

_____________________________________________________________________

Summary of supervisor’s medical training:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Supervisor’s area of specialization:

_____________________________________________________________________
Information on additional supervisors should be included on an attached sheet.

Sites of practicum placement:

<table>
<thead>
<tr>
<th>Location</th>
<th>Type of Facility</th>
<th>Time to be spent in Facility</th>
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Description of the 80 hour practicum in a setting treating the acutely ill or seriously mentally ill in which the level of care is more restricted than in an outpatient setting (such as an acute mental health treatment program, a residential treatment center, a general hospital, an inpatient mental health facility, a substance abuse treatment center, day or residential geriatric treatment center, or center for the homeless):

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Explanation of how the supervisee will gain experience with a diverse patient population, including patients of different genders, ages, disorders, ethnicity, sociocultural, and economic background:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

This plan has been reviewed and agreed upon by:

_________________________                  ________________________
Applicant                                      Date

_________________________                  ________________________
Supervising Physician                Date

_________________________                  ________________________
Director of Psychopharmacology Training            Date
New Mexico State University
Dear Medical Colleague:

Thank you so much for considering supervising one of the postdoctoral students in New Mexico State University’s postdoctoral Master’s program. As you are probably aware, New Mexico was the first state to pass a law in which psychologists with appropriate postdoctoral training and measured competency may prescribe psychotropic medications for their patients in consultation with the physicians.

The Prescribing Psychologists’ Act of New Mexico requires students to complete several practica. The psychologist is asking for your assistance in the practicum that involves working with 100 patients for a minimum of 400 hours in the evaluation and treatment with psychotherapy and possible psychotropic medication. The psychologist does not have a license to prescribe at the point of this practicum, so much of the experience involves shadowing the supervisor’s work and then assisting the supervisor in conducting evaluations, follow up therapy, follow up phone calls, and other activities as the preceptor and student deem as appropriate. The student is to have one hour of supervision for every eight hours of seeing patients. However, this supervision time can include the time that the student spends with you in a session with the patient, as well as time in between sessions discussing cases, along with concentrated one on one time.

Attached to this letter is the evaluation form that the Board of Psychologist Examiners requires the 400 hour supervisors to complete. A review of this form should help explicate the specific skills that the psychologist should practice and demonstrate.

If you would consider being one of the supervisors in our program, we want you to know that the New Mexico State University program, in conjunction with the Southwestern Institute for the Advancement of Psychotherapy, provides continuing education credit for being a supervisor that perhaps will be useful to you in maintaining your license CE requirements. We would greatly appreciate your participation in our program, which provides meaningful assistance to many underserved populations in New Mexico, as well as throughout the United States, in the Indian Health Service and all branches of the military.

Please feel free to contact me at any time.

Sincerely,

Director of Psychopharmacology Training
New Mexico State University
MSC 3 C EP, PO Box 30001
Las Cruces, NM  88003-8001
(575) 646-2120
FORM 400-2

Contract between Your Institution and
New Mexico State University
PREScribing Psychologist Practicum
Affiliation Agreement
400-hour Practicum

The Regents of New Mexico State University for its operation of the postdoctoral prescribing psychologist program, specifically through its department of Counseling and Educational Psychology and the ___________________________ (the “Institution”), a health Institution, agree:

IX. RECITALS

A. The purposes of this agreement are:
   1. To establish a practicum training program for doctoral level psychologists who have completed postdoctoral academic coursework towards obtaining a license as a prescribing psychologist
   2. To ensure a close working relationship between New Mexico State University and the Institution
   3. To benefit the University by providing a quality practicum experience for these psychologists in training
   4. To benefit the Institution in providing high quality psychological expertise in diagnosis, testing, and treatment of mental disorders
   5. To enable the participating psychologists to become knowledgeable about operational aspects of various types of health delivery systems

X. RESPONSIBILITIES OF THE INSTITUTION

A. The Institution will:
   1. Accept for training the number of psychologists to be determined jointly by the Institution and the University, but no more than three psychologists will be supervised by an individual staff member at the Institution.
   2. Make available its clinical and related facilities and its personnel to provide quality learning experiences for the psychologists during their educational rotation at the Institution under the supervision of qualified Institutional personnel
   3. Designate one or more clinical supervisors who will: (a) coordinate the psychologists’ clinical education experience with the appropriate university program director
   4. Make patients aware that the psychologists from New Mexico State University are providing services to patients in the Institution’s facilities
   5. Permit the University’s program director to work with the Institution’s clinical supervisors

XI. RESPONSIBILITIES OF THE UNIVERSITY

A. The University will:
   1. Identify specific psychologists who, with the agreement of the Institution, will be assigned part-time for training at the Institution in accord with a schedule agreed upon by the University, Institution, and the psychologist
2. Require psychologists to conform the policies and procedures of the Institution, under the direction of the Institution’s designated clinical supervisors
3. Assure that psychologists are duly licensed as psychologists by the New Mexico Board of Psychologist Examiners

B. Psychologists will meet all reasonable health standards imposed by applicable Laws and regulations or imposed by the Institution. Copies of Institutional standards will be provided by the Institution to the University and the House officers.

C. The University Program Director responsible for the psychologists’ rotation at the Institution will send a letter to the Institution’s staff member responsible for the psychologists’ supervision at the Institution that provides the following specific information:
   1. The individual at the University who is designated to assume supervisor responsibilities for the psychologist; and
   2. The educational goals and objectives of the psychologist’s rotation at the Institution; and
   3. The period of assignment of the psychologist at the Institution
   4. The Institution’s responsibilities for supervision and evaluation of the psychologist’s performance; and
   5. The policies and procedures that govern the psychologist’s education while on rotation at the Institution; and
   6. An attestation by the program director that the psychologist rotating at the Institution is in good standing in the program; and
   7. A delineation by the program director of the minimum required level of supervision of the psychologist

XII. INSURANCE AND LIABILITY

A. As between the parties, each party acknowledges that it will be responsible for claims or damages arising from personal injury or damage to persons or property to the extent they result from negligence of that party’s employees or (in the case of University) program director. The University will provide professional liability insurance covering the program director and University employed faculty members for their activities at the Institution, in accordance with the provisions of the New Mexico Tort Claims Act, Sections 41-4-1 et seq. NMSA 1978, as amended. The liability of the faculty employed by the University will be subject in all cases to the limitations and immunities of the New Mexico Tort Claims Act.

B. If a complaint is made or otherwise involving a psychologist or University Employee, the Institution will immediately provide written notice to the Counseling and Educational Psychology Department at New Mexico State University. If a claim or suit is filed or initiated against the Institution, naming or otherwise involving alleged actions or omissions of a psychologist, the University will manage and control all aspects of the defense on behalf of the psychologist.

XIII. TERM AND TERMINATION

This agreement will become effective on ___________ and will continue through ______________ unless earlier terminated by their party by providing written notice of intent to terminate from the other party at least 60 days prior to the proposed date.
XIV. REIMBURSEMENT
Unless otherwise specified, this relationship is based upon an exchange of services and not reimbursement through funds.

XV. HIPAA COMPLIANCE

A. The parties will comply with the applicable provisions of HIPAA and any current future regulations promulgated hereunder, including without limitation, the federal privacy regulations, the federal security standards, and the federal standards for electronic transactions (collectively the “HIPAA Requirements”). The parties will not use or further disclose any Protected Health Information or Individually Identifiable Health Information (such as terms are defined in the HIPAA regulations), other than as permitted by the HIPAA Requirements and the terms of this Agreement.

B. The University will ensure that psychologists have been provided training with regard to HIPAA Requirements. Additionally, the Institution may require each psychologist to sign a Confidentiality Agreement and an Acknowledgement that the psychologist has received Institution’s Notice of Privacy Practices.

XVI. MISCELLANEOUS

A. Entire Agreement: This Agreement and the Program Letters references in Section III-C of this of this Agreement represent the entire understanding between the parties and supersede any prior agreements or understandings with respect to the subject matter of this Agreement.

B. Waiver of Breach. The waiver by either party of a breach or violation of any provision of this Agreement will not operate as or be construed as a waiver of any subsequent breach of this Agreement.

C. Modifications. No changes, amendments, of alterations to this Agreement will be effective unless in writing and signed by both parties.

D. Non-Assignability. This Agreement will not be assigned by either party, nor will the duties imposed upon either party by this Agreement be delegated, subcontracted, or transferred by either party, in whole or in part, without the prior written consent of the other party.

E. Governing Law. This Agreement will be construed, interpreted, governed, and enforced in accordance with the statutes, judicial decisions, and other laws of the State of New Mexico.

F. Severability. The invalidity or unenforceability of any term or provision of this Agreement will in no way affect the validity or enforceability of any other term or provision to the extent permitted by Law.

G. Marketing Materials. Neither the University nor the Institution will use the other’s name in any publicity or advertising materials without prior written consent of the other party; provided, however, that either party may indicate to individual psychologists the existence and scope of the training program available at the Institution.

H. Confidentially
   1. Patient and Psychologist Records. The confidentiality of patients’ medical records and psychologists’ academic records will be maintained by the parties in accordance with applicable federal and state laws and regulations.
I. Retention of Records. The Institution and University will maintain detailed records associated with the assignment of psychologists pursuant to this agreement for a period of five years.

J. Relationship of parties. Psychologists and employees of the University will not be considered employees of the Institution for any purpose including, but not limited to, workers’ compensation, insurance, bonding or any other benefits afforded to employees of the Institution.

K. Cooperation and Dispute Resolution. The parties agree that, to the extent and compatible with the separate and independent management of each, they will maintain effective liaison and close cooperation. If a dispute arises related to the obligations or performance of either party under this Agreement, representatives of the parties will meet in good faith to attempt to resolve the dispute.

L. Third parties. Nothing in this Agreement, express or implied, is intended to confer any rights, remedies, claims, or interests upon a person not a party to this agreement.

M. Eligibility for Participation in Government Programs. Each party represents that neither it, nor any of its management or any other employees or independent contractors who will have any involvement in the services or products supplied under this Agreement, have been excluded from participation in any government healthcare program, debarred from or under any other federal program (including but not limited to debarment under the Generic Drug Enforcement Act), or convicted of any offense defined in 42 U.S.C. Section 1320a-7, and that it, its employees, and independent contractors are not otherwise ineligible for participation in federal healthcare programs. Further, each party represents that it is not aware of any such pending action(s) (including criminal actions) against it or its employees or independent contractors. Each party shall notify the other party immediately upon becoming aware of any pending or final action in any of these areas.

N. Notices. Any notice required to be given pursuant to terms and provisions of this Agreement will be in writing and will be sent by certified mail, return receipt requested, postage prepaid, as follows:

To the University at: New Mexico State University  
College of Education  
Department of Counseling & Educational Psychology  
MSC 3CEP, P.O. Box 30001  
Las Cruces, NM 88003-8001

To the Institution at: ________________________  
________________________  
________________________  
________________________

Signed this ______ day of ________________, 20__.

_________________________________________________  
Director of Psychopharmacology Training  
New Mexico State University

An agent for the Institution:

By _________________________________________________  
Title________________________________________________
Log of Contact Hours with the Patient
PATIENT LOG

(Note: This will be easiest to follow if you keep a separate log sheet for each of the 100 patients)

400-HOUR PRACTICUM FOR PRESCRIBING PSYCHOLOGISTS
LOG OF CONTACT HOURS WITH PATIENT

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Patient DOB</th>
<th>Working Diagnosis</th>
<th>Date(s) Seen</th>
<th>Time(s) Seen</th>
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FORM 400-4

Log of Contact Times with Supervisor
**SUPERVISORY LOG**

**400-Hour PRACTICUM FOR PRESCRIBING PSYCHOLOGISTS**

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Supervisor</th>
<th>Method of Supervision</th>
<th>Patients Reviewed</th>
<th>Hours</th>
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FORM 400-5

Letter to Patients
SAMPLE LETTER FOR PATIENTS

Dear Patient or Legal Guardian:

This letter is to inform you of my status as a doctor of psychology participating in a postdoctoral program training psychologists to prescribe psychotropic medications for their patients. My program at New Mexico State University Program, leads to a post-doctoral Master’s Degree.

In order to obtain a license as a prescribing psychologist, I must complete 450 hours of postdoctoral coursework in basic biological sciences, pathophysiology, physical assessment, and advanced coursework in the treatment of medical and mental disorders. In addition, I must also complete an eighty-hour practicum with a physician in which I have learned about medical illnesses, interpretation of lab tests, and appropriate drug treatment. My work with you is part of a practicum in psychopharmacology in which I work with _______ (names of preceptors) to treat one hundred patients with psychotropic medication.

As a part of my ongoing learning experience, it is important that I keep very careful records of the medications prescribed, your progress in reaching your mental health goals, and your views of how your treatment is progressing. This may necessitate my requesting you to complete a number of forms as well as to sign off on some forms as we progress through your treatment. I believe that this monitoring will increase my effectiveness but also assures you the highest quality of care, and so I hope you will not feel encumbered by it. In signing this letter of which we will each keep a copy, you are indicating your understanding of the level of my training and the procedures involved.

______________________  __________________________
RxP Student’s Signature  Patient’s Signature

______________________               __________________________
Date       Date
FORM 400-6a

Performance Evaluation Form
PERFORMANCE EVALUATION FOR PRESCRIBING PSYCHOLOGIST 400 HOUR PRACTICUM

Date: ____________________________

Psychologist’s name: _______________________________________

Preceptor’s name: ___________________________________________

Midpoint and Final Evaluation - please indicate:  50 patients_____        100 patients_____  

Please use the following to guide your evaluation:

1. Has failed to demonstrate expected level of performance  
2. Performs satisfactorily at times, has specific deficiencies  
3. Meets expected level of performance  
4. Exceeds expected level of performance  
5. Exceptional performance  

If a student receives a one or a two, please include any comments about what would improve his/her performance.

1) Obtains appropriate psychological and medical history:

   1  2  3  4  5

Comments:
_____________________________________________________________________________________
_____________________________________________________________________________________

2) Uses appropriate processes to establish diagnostic criteria to determine primary and alternate diagnoses:

   1  2  3  4  5

Comments:
_____________________________________________________________________________________
_____________________________________________________________________________________

3) Recommends referral for medical evaluation when necessary:

   1  2  3  4  5

Comments:
_____________________________________________________________________________________
_____________________________________________________________________________________.
4) Initial goals are appropriate for patient’s diagnosis:

   1   2   3   4   5

Comments:________________________________________________________________________________
__________________________________________________________________________________________.

5) Is knowledgeable about when tests (laboratory, psychometric, and/or radiological) should be ordered:

   1   2   3   4   5

Comments:________________________________________________________________________________
__________________________________________________________________________________________.

6) Demonstrates appropriate knowledge in interpreting tests (laboratory, psychometric, and/or radiological):

   1   2   3   4   5

Comments:________________________________________________________________________________
__________________________________________________________________________________________.

7) Demonstrates an ability to explain a drug’s benefits, side effect profile, and risk to patients in a thorough and clear manner:

   1   2   3   4   5

Comments:________________________________________________________________________________
__________________________________________________________________________________________.

8) Is responsible in monitoring psychotropic drug effectiveness and recommending appropriate changes:

   1   2   3   4   5

Comments:________________________________________________________________________________
__________________________________________________________________________________________.
9) Is systematic in checking for drug interactions:

1 2 3 4 5

Comments:
________________________________________________________________________________
_________________________________________________________________________________.

10) Is systematic in assuring that drug selection is not contraindicated with patient’s medical condition or other medical treatment:

1 2 3 4 5

Comments:
________________________________________________________________________________
_________________________________________________________________________________.

11) Gives patients written information when appropriate:

1 2 3 4 5

Comments:
________________________________________________________________________________
_________________________________________________________________________________.

12) Using all available data, identifies the most appropriate treatment alternatives including medication, psychosocial, and combined treatments:

1 2 3 4 5

Comments:
________________________________________________________________________________
_________________________________________________________________________________.

13) Sets appropriate long term goals:

1 2 3 4 5

Comments:
________________________________________________________________________________
_________________________________________________________________________________.

14) Keeps timely and thorough notes:

1 2 3 4 5

Comments:
________________________________________________________________________________
_________________________________________________________________________________.

15) Is an active participant in the learning process by asking appropriate questions, reading recommended material, etc.:

   1  2  3  4  5

Comments:
________________________________________________________________________________
_________________________________________________________________________________

16) Demonstrates proficiency in writing valid and complete prescriptions:

   1  2  3  4  5

Comments:
________________________________________________________________________________
_________________________________________________________________________________

17) Demonstrates an ability to work with others in an advisory fashion when appropriate:

   1  2  3  4  5

Comments:
________________________________________________________________________________
_________________________________________________________________________________

18) Demonstrates an ability to work with others in a collaborative manner when appropriate:

   1  2  3  4  5

Comments:
________________________________________________________________________________
_________________________________________________________________________________

19) In your professional opinion, this psychologist is ready to assume the responsibility for prescribing psychotropic medications for his/her patients in an independent manner?  □ YES  □ NO

   ___________________________________________  ________________
   Signature         Date

PLEASE RETURN TO:
New Mexico State University
Department of Counseling & Educational Psychology
Director of Psychopharmacology Training
MSC 3CEP, P.O. Box 30001
Las Cruces, NM 88003-8001
FORM 400-6b

Additional Form Required by the New Mexico Board of Psychologist Examiners
New Mexico Regulation and Licensing Department
BOARDS AND COMMISSIONS DIVISION
Board of Psychologist Examiners
Toney Anaya Building • 2550 Cerrillos Road • Santa Fe, New Mexico 87505
(505) 476-4960 • Fax (505) 476-4665 • www.rld.state.nm.us/psychology

SUPERVISOR VERIFICATION OF 80-HOUR PRACTICUM IN PRIMARY HEALTH CARE

Applicant Name: ______________________________________________________________________

Mailing Address: ______________________________________________________________________

City, State Zip: ________________________________________________________________________

Telephone No. ________________________________________________________________________

To be completed by the supervisor

SUPERVISOR

Name: _______________________________________________________________________________

Mailing Address: ______________________________________________________________________

City, State Zip: ________________________________________________________________________

Telephone No. ________________________________________________________________________

Describe the area of practice in which you are formally trained and/or certified/licensed? If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications:

NEW MEXICO LICENSURE

Is your license current and unrestricted? Yes No

Date New Mexico medical license was issued: _______________________________________________

License Number and Type of License: _____________________________________________________

If you hold any other professional licenses in this or any other jurisdiction list below:

______________________________________________________________
License No. Type State Status (Active/Inactive)

Name and Address of Applicant’s Training Director: _________________________________________

______________________________________________________________

Date Practicum Began: __________________________________________________________________

Date Practicum Ended: __________________________________________________________________
Have you sent an evaluation form about this applicant to the Director of Training discussing the student’s adequate development of skills in:

a. Assessing a diverse and significantly ill medical population?  
   [ ] Yes  [ ] No

b. Observing the progression of illness and continuity of care of individual patients?  
   [ ] Yes  [ ] No

c. Adequately assessing vital signs?  
   [ ] Yes  [ ] No

d. Demonstrating competent laboratory assessment?  
   [ ] Yes  [ ] No

e. Demonstrating competence in physical and health assessment techniques?  
   [ ] Yes  [ ] No

Has the student successfully completed the eighty-hours of supervised experience with you as specified in the Prescribing Psychologist Act?  
   [ ] Yes  [ ] No

The Board would appreciate any comments you might have regarding this applicant’s practicum. Please include any information you consider relevant regarding this applicant.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

As the Clinical Supervisor of the 80-Hour Practicum, I certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

___________________________________
Signature of Clinical Supervisor

___________________________________
Date
State Board of Psychologist Examiners

CONDITIONAL PRESCRIBING PSYCHOLOGIST CERTIFICATE APPLICATION

VERIFICATION BY SUPERVISOR OF 400-HOUR PRACTICUM TREATING A MINIMUM OF 100 PATIENTS WITH PHARMACOTHERAPY

PLEASE NOTE: To be completed by the supervisor

PRIMARY SUPERVISOR 400-HOUR/100-PATIENT PRACTICUM

The Board of Psychologist Examiners has received an application for a conditional certificate as a prescribing psychologist from the applicant named below. (To be filled out by Applicant and forwarded on to the Director of the training program)

Applicant:__________________________
Address:__________________________
City & State:________________________
Telephone No._______________________

We would appreciate you providing the Board with the information requested and return this form directly to the Board office at the above address.

SUPERVISOR

Name:______________________________
Address:____________________________
City & State:________________________
Telephone No._______________________

Please describe the area of practice in which you are formally trained and/or certified/licensed. If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications:

____________________________________

NEW MEXICO LICENSURE

Is your medical license current and unrestricted? Yes □ No □
Date New Mexico medical license was issued:______________________________
License Number and Type of License:______________________________
Do you hold any other professional licenses in this or any other jurisdiction? Please list below:

<table>
<thead>
<tr>
<th>License No.</th>
<th>Type</th>
<th>State</th>
<th>Status (Active/Inactive)</th>
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Name and Address of Applicant’s Training Director: ________________________________

SECONDARY SUPERVISOR

Name: ________________________________

Address: ________________________________

City & State: ________________________________

Telephone No. ________________________________

Is your license current and unrestricted? Yes ☐ No ☐

Date New Mexico license was issued: ________________________________

Do you hold any other professional licenses in this or any other jurisdiction? Yes ☐ No ☐

Please list below:

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<tr>
<th>License No.</th>
<th>Type</th>
<th>State</th>
<th>Status (Active/Inactive)</th>
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Please describe the area of practice in which you are formally trained and/or certified/licensed.

________________________________________________________

1. Was the 400-Hour Practicum part of the psychopharmacology training program from which the applicant obtained his/her certification or degree? Yes ☐ No ☐

2. Did the practicum meet the following requirements?
   a. A minimum of 100 separate patients? Yes ☐ No ☐
   b. A range of disorders listed in the DSM? Yes ☐ No ☐
   c. Both acute and chronic conditions? Yes ☐ No ☐
   d. Did the 400 hours include only time spent with patients to provide evaluation and psychopharmacotherapy and time spent in collaboration with treating healthcare providers? Yes ☐ No ☐
   e. Was there diversity including gender, ages throughout the life-cycle, various ethnicities, socio-cultural backgrounds, & various economic backgrounds, as much as possible within the psychologist’s area of practice? Yes ☐ No ☐
3. Was the primary or secondary supervisor onsite? [Yes □ No □]

4. Did the applicant consult with your or any secondary supervisors, as appropriate, before making decisions about the pharmacological treatment of patients? [Yes □ No □]

5. Did the primary/secondary supervisor(s) review the charts & records? [Yes □ No □]

6. Was there at least one hour of supervision for every eight hours of Patient contact? [Yes □ No □]

7. Did the applicant keep a log of the dates & times of supervision? [Yes □ No □]

8. Was the practicum completed in no less than 6 months and no more than three years? [Yes □ No □]

9. Was the practicum completed within the 5 years preceding this application? [Yes □ No □]

10. Did the applicant, during the initial contact with patients or legal guardians, adequately explain his/her status as a licensed psychologist receiving specialized training in psychopharmacology and being under supervision? (Please enclose copies of any printed material) [Yes □ No □]

11. Did the applicant maintain a log, without patient ID, which included basic identifying data? [Yes □ No □]

12. Did you, as a supervisor, write at least two formal evaluations of the applicant, preferably at the midpoint and at the end of the practicum, assessing progress, competence, and description of any deficiencies where competency had not been achieved? [Yes □ No □]

13. Did you, as supervisor, submit copies of these evaluations to the applicant & Training Director? [Yes □ No □]

14. Were you and any secondary supervisors in consultation regarding the applicant’s progress, competence, and any deficiencies? [Yes □ No □]

15. Do you, as primary supervisor, certify that the applicant has successfully completed the 400-Hour/100-Patient practicum, as specified in the Prescribing Psychologist Act and is competent to obtain a conditional prescription certificate, all other requirements being satisfactorily completed? [Yes □ No □]

As the primary clinical supervisor of the 400-Hour/100-Patient practicum, I certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge.

________________________________________  __________________________
Signature of Clinical Supervisor                      Date

Please mail to:
New Mexico State Board of Psychologist Examiners
P.O. Box 25101
Santa Fe, NM 87505
FORM 400-7

400-hour Practicum Patient Intake Forms
FOR ADULTS
FOR ADOLESCENTS

(These are sample forms. You may use the following forms or another of your choosing as long as all necessary information is recorded.
Please see the New Mexico RxP regulations)
Please Use Ink

**INTAKE FORM (Adolescent 12-17)**

Name ___________________________ Sex: □ Male □ Female DOB ___________________________
Age ________ Social Security# __________________________
Address ___________________________ City _____________ State _______ Zip Code ___________
Home telephone ___________________________ Emergency contact ___________ Relationship _______ Telephone ___________
School _______________ Grade _____ Teacher’s Name _______________ Telephone ___________

**Information about Mother:**
Name ___________________________ DOB ___________ Age __ SS# ___________________________
Address: ___________________________ City _____________ State _______ Zip Code ___________
Home telephone _______________ Work Phone _______________ Cell Phone _______________
Years of School Completed ______ Place of Employment _____________________________
Type of Work ______________________ E-mail address _________________________________
Marital Status _______________ Number of Marriages ______ Religion _______________________

**Information about Father:**
Name ___________________________ DOB ___________ Age __ SS# ___________________________
Address: ___________________________ City _____________ State _______ Zip Code ___________
Home telephone _______________ Work Phone _______________ Cell Phone _______________
Years of School Completed ______ Place of Employment _____________________________
Type of Work ______________________ E-mail address _________________________________
Marital Status _______________ Number of Marriages ______ Religion _______________________

**OTHERS IN THE HOME:**
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<thead>
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<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>Relationship</th>
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**NEUROLOGICAL**

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<td>Head injury</td>
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<td>Stroke</td>
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<td>Convulsions/ seizures</td>
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**REPRODUCTIVE**

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<td>Gallbladder problems</td>
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<td>Hernia</td>
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**CARDIOVASCULAR**

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<tr>
<td>Heart attack</td>
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**EYE/EARS/NOSE/THROAT**

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<th>Past</th>
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<th>Who</th>
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<tbody>
<tr>
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<td>Other eye problems</td>
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<td>Ear infection</td>
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<tr>
<td>Deafness or decreased hearing</td>
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<tr>
<td>Allergies or hay fever</td>
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<tr>
<td>Frequent nosebleeds</td>
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<tr>
<td>Difficulty swallowing</td>
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<tr>
<td>Strep throat</td>
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**KIDNEY/RENAL**

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<th>Family Hx</th>
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<tbody>
<tr>
<td>Kidney or bladder disease</td>
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**ENDOCRINE/METABOLIC**

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<tr>
<td>Diabetes (Type I or Type II)</td>
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(Note: Please check what applies to yourself. If there is a family history of the condition, please check FAMILY HX, then specify who on the line provided, such as paternal uncle, maternal grandmother, etc.)

**HT:** ___________  **Wt:** _______________
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<th>Condition</th>
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<td>Gynecologic problem (females)</td>
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<td>Anemia</td>
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<td>Bleeding</td>
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<td>Food allergies</td>
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<td>Other allergies, excluding ENT</td>
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<td>Tumor(s), cancerous or benign</td>
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<td>Other:</td>
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<td>INFECTIONS</td>
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<td>German measles/Rubella</td>
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<td>Polio</td>
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<td>Scarlet fever</td>
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<td>Mononucleosis</td>
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<td>Coping skills for stress</td>
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<td>Wake up rested most mornings</td>
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<td>troubled or upset</td>
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</table>
Please list all medications (include over-the-counter) and their doses that you are currently taking:

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<td>9.</td>
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<td>10.</td>
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</tbody>
</table>

Have you ever been hospitalized for a psychiatric reason?  Yes  No
Please list all hospitalizations, medical and psychiatric:

<table>
<thead>
<tr>
<th>Dates of hospitalization</th>
<th>Place</th>
<th>Reason</th>
<th>Psychiatric medications prescribed, if any</th>
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</table>

Your answers to this questionnaire can help me to quickly and accurately understand your concerns.

Yes  Yes

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks, or longer? (If YES, continue with next question; if NO, skip to Question 5.)

2. Have you become less interested in things you used to enjoy most of the time?

3. When something good happens, do you feel better, even if only temporarily?

4. Have you felt sad, low, or depressed most of the time for the last two years?

5. Other than when intoxicated on drugs or alcohol, have you ever felt so “up” or “high” that other people thought you were not your usual self?

6. Have you ever gone for days at a time without feeling the need for much sleep?

7. Are you currently feeling “up,” “high,” or full of energy?

8. Have you been frequently irritable, over-reacting to setbacks that you or others would consider relatively minor?

9. Have you had anxiety attacks, i.e., become intensely frightened, uncomfortable, or uneasy, for no apparent reason?

10. Do you feel anxious or uneasy in particular places or situations?

11. In the past month, have you been repeatedly bothered by unwanted thoughts or images?

12. In the past month, have you done something repeatedly without being able to resist doing it?

13. Have you ever experienced or witnessed serious injury or threat to yourself or another person, or an actual death?

14. Have you ever re-experienced a distressing event through dreams, flashbacks, or physical reactions?

15. In the past 12 months, have you had three or more alcoholic drinks within a three hour period on more than three occasions?
16. In the past 12 months, did you drink alcohol or take a drug, more than once, to get high, feel better, or change your mood?

If so, which of the following did you use?

- Stimulants, amphetamines, Speed, crystal meth, Dexedrine, Ritalin, diet pills.
- Narcotics, heroin, morphine, methadone, painkillers.
- Hallucinogens: LSD (‘acid’), mescaline, peyote, PCP (“Angel dust,” “Peace Pill”), psilocybin, STP, mushrooms, Ecstasy, MDA, or MDMA.
- Inhalants: glue, ethyl chloride, nitrous oxide (“laughing gas”), amyl or butyl nitrate (“Poppers”).
- Marijuana: hashish, THC.
- Tranquilizers or downers.
- Miscellaneous: steroids, nonprescription sleep aides, diet pills, other.

17. In the past three months, have you ever eaten a huge amount of food within a two-hour period?

18. Would people who know you well describe you as a worrier?

19. Have you ever felt that you should cut down on your drinking/drug use?

20. Has anyone annoyed you by telling you to cut down on your drinking/drug use?

21. Have you ever felt guilty or bad about your drinking/drug use?

22. Do you ever wake up in the morning wanting to have an alcoholic drink or take drugs (eye opener)?

23. Has anyone ever criticized you or told you that you have a gambling problem?

24. Have you ever had to lie to family members, friends, or therapists about your gambling practices?

25. In the past month, have you wanted to harm yourself?

26. In the past month, did you have suicidal thoughts (e.g., wished you were dead or would be better off dead)?

27. Have you ever made a suicide plan?

28. Have you ever attempted suicide?

**FAMILY MENTAL HEALTH HISTORY**

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age, if still living</th>
<th>Mental health or substance abuse problems, if any*</th>
<th>If deceased, age at death</th>
<th>If deceased, cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
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</tr>
<tr>
<td>Father</td>
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<tr>
<td>Sister/Brother (circle one)</td>
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<tr>
<td>Sister/Brother (circle one)</td>
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<tr>
<td>Sister/Brother (circle one)</td>
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<td>Sister/Brother (circle one)</td>
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</tr>
<tr>
<td>Sister/Brother (circle one)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Maternal Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandfather</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandfather</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Such as: alcoholism, drug addiction, depression, bipolar disorder, schizophrenia, ADHD, anxiety/panic, obsessive-compulsive disorder (OCD), learning disability, sleep disorder, violent tendencies.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost</th>
<th>Always</th>
<th>SD</th>
<th>IR</th>
<th>SR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I get along with others.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I tire quickly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>I feel no interest in things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>I feel stressed at work/school/housework/volunteering.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>I blame myself for things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I feel irritated.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>I feel unhappy in my marriage/significant relationship.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I have thoughts of ending my life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>I feel weak.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I feel fearful.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
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</tr>
<tr>
<td>11.</td>
<td>After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark “never”)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I find my work/school/ housework/volunteering satisfying.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>I am a happy person.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>I work/study too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>I feel worthless.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>I am concerned about family troubles.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>I have an unfulfilling sex life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>I feel lonely.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>I have frequent arguments.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>I feel loved and wanted.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
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</tr>
<tr>
<td>21.</td>
<td>I enjoy my spare time.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>I have difficulty concentrating.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>I feel hopeless about the future.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>I like myself.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Disturbing thoughts come into my mind that I can’t get rid of.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
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</tr>
<tr>
<td>26.</td>
<td>I feel annoyed by people who criticize my drinking (or frequent drug use). (If not applicable, mark “never”)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
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</tr>
<tr>
<td>27.</td>
<td>I have an upset stomach.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
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</tr>
<tr>
<td>28.</td>
<td>I am not working/studying housework/volunteering as well as I used to.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>My heart pounds too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
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</tr>
<tr>
<td>30.</td>
<td>I have trouble getting along with my friends and close acquaintances.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>I am satisfied with my life.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>I have trouble at work/school housework/volunteering because of drinking or drug use. (If not applicable, mark “never”)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>I feel that something bad is going to happen.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>I have sore muscles.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>I feel afraid of open spaces, or driving, or being on buses, subways, and so forth.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>I feel nervous.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>I feel my love relationships are full and complete.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>I feel that I am not doing well at work/school.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39.</td>
<td>I have too many disagreements at work/school.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40.</td>
<td>I feel something is wrong with my mind.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41.</td>
<td>I have trouble falling asleep or staying asleep.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>I feel blue.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43.</td>
<td>I am satisfied with my relationships with others.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44.</td>
<td>I feel angry enough at work/school housework/volunteering to do something I may regret.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45.</td>
<td>I have headaches.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46.</td>
<td>I feel restless &amp; can’t sit still.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47.</td>
<td>I hear or see things that may not be there.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>48.</td>
<td>I do impulsive things (spending/gambling/dangerous driving)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49.</td>
<td>My thoughts race.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL:**
Do you need a refill on any of your medications? Yes/No. If yes, please list with current dosage.

Experienced side effects at home, school, or work? Yes/No. If yes, explain.

Are tests, shops, or changing the dosage of any medication, diet, supplement, caffeine, or nicotine affecting you? Yes/No. If yes, explain.

Have you attempted to contact your doctor or pharmacist? Yes/No. If yes, explain.

Noted any new medication side-effects? Yes/No. If yes, explain.

Noted any new medical problems? Yes/No. If yes, explain.

Lost or gained weight? Yes/No. If yes, explain.

Since the last session have you...

Pain/Symptoms/Discomfort

Instructions: On the diagram below, please mark the areas where you are experiencing pain:

1. Head
2. Neck
3. Shoulders
4. Back
5. Hips
6. Lower back
7. Legs
8. Feet
9. Other

If you have pain...

We'll bring questionnaires...

Directions: Please circle any of the following that apply to you:

- Headache
- Migraine
- Fatigue
- Insomnia
- Nausea
- Anorexia
- Appetite increase
- Constipation
- Diarrhea
- Weight gain
- Weight loss
- Drowsiness
- Fatigue
- Decreased interest in activities
- Changes in mood
- Changes in energy levels
- Changes in concentration
- Changes in appetite
- Changes in sleep
- Changes in sexual function
- Changes in memory
- Changes in concentration
- Changes in mood
- Changes in energy levels
- Changes in concentration
- Changes in appetite
- Changes in sleep
- Changes in sexual function
- Changes in memory
- Changes in concentration
- Changes in mood
- Changes in energy levels
- Changes in concentration
- Changes in appetite
- Changes in sleep
- Changes in sexual function
- Changes in memory
- Changes in concentration
- Changes in mood
- Changes in energy levels
- Changes in concentration
- Changes in appetite
- Changes in sleep
- Changes in sexual function
- Changes in memory
- Changes in concentration
- Changes in mood
- Changes in energy levels
- Changes in concentration
- Changes in appetite
- Changes in sleep
- Changes in sexual function
- Changes in memory
- Changes in concentration
- Changes in mood
- Changes in energy levels
- Changes in concentration
- Changes in appetite
- Changes in sleep
- Changes in sexual function
- Changes in memory
- Changes in concentration
- Changes in mood
Even though we will ask to make a copy of your child’s insurance card, we would appreciate if you would fill in the following information:

**PRIMARY INSURANCE COMPANY**
Name of Insurance Company______________ Policy#____________ Group#__________
Authorization or Referral Number________________________
Name of Insured Person____________________ DOB _________ SS#________________________
Address, Phone Numbers and Place of Employment for Insured (if different from first page):
Address:______________________________City___________ State______ Zip Code________
Home telephone______________ Cell Phone______________
Place of Employment__________ Work Phone______________

**SECONDARY INSURANCE COMPANY**
Name of Insurance Company______________ Policy#____________ Group#__________
Authorization or Referral Number________________________
Name of Insured Person____________________ DOB _________ SS#________________________
Address, Phone Numbers and Place of Employment for Insured (if different from first page):
Address:______________________________City___________ State______ Zip Code________
Home telephone______________ Cell Phone______________
Place of Employment__________ Work Phone______________

**PATIENT OR AUTHORIZED PERSON’S SIGNATURE:** I authorize the release of any medical or other information necessary to process insurance claims:
☐ Yes  ☐ No

I authorize payment of medical benefits to (Prescribing Psychology Student Name) for services rendered:
☐ Yes  ☐ No

**SIGNED:** _________________________ **DATE:** ________________________________

Name of person who referred you to this office________________
Why are you seeking treatment for your child now? _________________________________

______________________________________________________________________________

Has your child ever seen a therapist or counselor before? ☐ Yes  ☐ No
If yes, what was the name of therapist? ____________________________________________
Dates and reason for therapy___________________________________________________________________
For each item, below, please check your preference and provide your initials; then sign below:

______ ☐ Yes ☐ No I grant permission for (Prescribing Psychology Student Name) to speak with my child’s physician about my child’s psychological and medical status.

______ ☐ Yes ☐ No I grant permission for (Prescribing Psychology Student Name) to speak about my child’s psychological and/or medical status with (other healthcare provider’s name, address, and phone number):

______ ☐ Yes ☐ No I grant permission for (Prescribing Psychology Student Name) to speak with my child’s teacher and other school personnel at (name of school) about how my child is doing in school.

______ ☐ Yes ☐ No I grant permission for (Prescribing Psychology Student Name) to release medical or other information about my child’s care to my child’s insurance company, in order to process insurance claims.

______ ☐ Yes ☐ No I authorize payment of medical benefits to (Prescribing Psychology Student Name) for services rendered.

_all questions on your account should be directed to:_

_____________________________

I have read (Prescribing Psychology Student Name) ☐ Yes ☐ No practice and privacy policies, and consent to this patient-psychologist agreement on behalf of my child.

_____________________________    ________________________
Parent or Guardian’s Signature    Date
INTAKE FORM (Adult)

PLEASE USE INK

Today's Date_________________
Name____________________ DOB_______ Age______ Social Security#__________
Address:_____________________ City___________ State_______ Zip Code__________
Home telephone______________ Work Phone__________ Cell Phone_______________
Years of School Completed____ Place of Employment__________________________
Type of Work________________ E-mail address_______________________________
Marital Status___________ Number of Marriages____ Religion__________________

Information about Spouse/Partner:
Name____________________ DOB_______ Age______ Social Security#__________
Address:_____________________ City___________ State_______ Zip Code__________
Home telephone______________ Work Phone__________ Cell Phone_______________
Years of School Completed____ Place of Employment__________________________
Type of Work________________ E-mail address_______________________________
Marital Status___________ Number of Marriages____ Religion__________________

OTHERS IN THE HOME:

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________</td>
<td>______</td>
<td>______</td>
<td>____________</td>
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</tbody>
</table>
**Present** | **Past** | **Uncertain** | **None** | **Family Hx** | **Who**
---|---|---|---|---|---
HEADACHE | ☐ | ☐ | ☐ | ☐ | ☐
Dizziness | ☐ | ☐ | ☐ | ☐ | ☐
Fatigue | ☐ | ☐ | ☐ | ☐ | ☐
Blackouts | ☐ | ☐ | ☐ | ☐ | ☐
Head injury | ☐ | ☐ | ☐ | ☐ | ☐
Convulsions/seizures | ☐ | ☐ | ☐ | ☐ | ☐
Other: | ☐ | ☐ | ☐ | ☐ | ☐

**REPRODUCTIVE**
Hepatitis | ☐ | ☐ | ☐ | ☐ | ☐
Genital herpes | ☐ | ☐ | ☐ | ☐ | ☐
Liver problems | ☐ | ☐ | ☐ | ☐ | ☐
Gallbladder problems | ☐ | ☐ | ☐ | ☐ | ☐
Hernia | ☐ | ☐ | ☐ | ☐ | ☐
Breast disease | ☐ | ☐ | ☐ | ☐ | ☐
Other: | ☐ | ☐ | ☐ | ☐ | ☐

**ADDICTIONS**
Alcohol | ☐ | ☐ | ☐ | ☐ | ☐
Drugs | ☐ | ☐ | ☐ | ☐ | ☐
Nicotine | ☐ | ☐ | ☐ | ☐ | ☐
Caffeine | ☐ | ☐ | ☐ | ☐ | ☐
Other: | ☐ | ☐ | ☐ | ☐ | ☐

**PULMONARY/LUNGS**
Asthma | ☐ | ☐ | ☐ | ☐ | ☐
Bronchitis | ☐ | ☐ | ☐ | ☐ | ☐
Emphysema | ☐ | ☐ | ☐ | ☐ | ☐
Pneumonia | ☐ | ☐ | ☐ | ☐ | ☐
Tuberculosis | ☐ | ☐ | ☐ | ☐ | ☐
Other: | ☐ | ☐ | ☐ | ☐ | ☐

**EYE/EARS/NOSE/THROAT**
Dental/oral problem | ☐ | ☐ | ☐ | ☐ | ☐
Eye or eyelid infection | ☐ | ☐ | ☐ | ☐ | ☐
Other eye problems | ☐ | ☐ | ☐ | ☐ | ☐
Ear infection | ☐ | ☐ | ☐ | ☐ | ☐
Deafness or decreased hearing | ☐ | ☐ | ☐ | ☐ | ☐
Allergies or hay fever | ☐ | ☐ | ☐ | ☐ | ☐
Frequent nosebleeds | ☐ | ☐ | ☐ | ☐ | ☐
Difficulty swallowing | ☐ | ☐ | ☐ | ☐ | ☐
Strep throat | ☐ | ☐ | ☐ | ☐ | ☐

**CARDIOVASCULAR**
High or low blood pressure | ☐ | ☐ | ☐ | ☐ | ☐
High cholesterol | ☐ | ☐ | ☐ | ☐ | ☐
Arteriosclerosis | ☐ | ☐ | ☐ | ☐ | ☐
Heart attack | ☐ | ☐ | ☐ | ☐ | ☐
Chest pain | ☐ | ☐ | ☐ | ☐ | ☐
Irregular heartbeat | ☐ | ☐ | ☐ | ☐ | ☐
Heart murmur | ☐ | ☐ | ☐ | ☐ | ☐
Other: | ☐ | ☐ | ☐ | ☐ | ☐

**DIGESTIVE (GI)**
Stomach/duodenal ulcer | ☐ | ☐ | ☐ | ☐ | ☐
Nausea or vomiting | ☐ | ☐ | ☐ | ☐ | ☐
Weight loss and/or gain | ☐ | ☐ | ☐ | ☐ | ☐
Diverticulosis | ☐ | ☐ | ☐ | ☐ | ☐
Colitis | ☐ | ☐ | ☐ | ☐ | ☐
Blood in stools | ☐ | ☐ | ☐ | ☐ | ☐
Constipation or diarrhea | ☐ | ☐ | ☐ | ☐ | ☐
Other: | ☐ | ☐ | ☐ | ☐ | ☐

**KIDNEY/RENAL**
Kidney or bladder disease | ☐ | ☐ | ☐ | ☐ | ☐

**ENDOCRINE/METABOLIC**
Thyroid problems | ☐ | ☐ | ☐ | ☐ | ☐
Diabetes (Type I or Type II) | ☐ | ☐ | ☐ | ☐ | ☐
<table>
<thead>
<tr>
<th>Condition</th>
<th>Present</th>
<th>Past</th>
<th>Uncertain</th>
<th>None</th>
<th>Family Hx</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate problem (males)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Gynecologic problem (females)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hemorrhoids</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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**HEMATOLOGIC**

<table>
<thead>
<tr>
<th>Condition</th>
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<th>Past</th>
<th>Uncertain</th>
<th>None</th>
<th>Family Hx</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Bleeding</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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**MUSCULOSKELETAL**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Present</th>
<th>Past</th>
<th>Uncertain</th>
<th>None</th>
<th>Family Hx</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis or other stiffness</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Gout</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Muscle weakness</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Muscle pain</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Bone fracture</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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**CURRENT HEALTH HABITS**

<table>
<thead>
<tr>
<th>Habit</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Daily aerobic exercise</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stable weight</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stable sleep</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Coping skills for stress</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Wake up rested most mornings</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Have someone to turn to when troubled or upset</td>
<td>☐</td>
<td>☐</td>
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</table>

**INFECTIONS**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Present</th>
<th>Past</th>
<th>Uncertain</th>
<th>None</th>
<th>Family Hx</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>German measles/Rubella</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Polio</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Mumps</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Scarlet fever</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Chicken pox</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Mononucleosis</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Other:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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**DERMATOLOGIC/SKIN**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Present</th>
<th>Past</th>
<th>Uncertain</th>
<th>None</th>
<th>Family Hx</th>
<th>Who</th>
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</thead>
<tbody>
<tr>
<td>Eczema</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Psoriasis</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Skin rash</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Open wound(s)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>
Please list all medications (include over-the-counter) and their doses that you are currently taking:

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>MEDICATION</th>
<th>DOSE</th>
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<tbody>
<tr>
<td>1.</td>
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<td>6.</td>
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<td>2.</td>
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<td>7.</td>
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<td>3.</td>
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<td>4.</td>
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<td>9.</td>
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<tr>
<td>5.</td>
<td></td>
<td>10.</td>
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</tbody>
</table>

Have you ever been hospitalized for a psychiatric reason?  
☐ Yes  ☐ No

Please list all hospitalizations, medical and psychiatric:

<table>
<thead>
<tr>
<th>Dates of hospitalization</th>
<th>Place</th>
<th>Reason</th>
<th>Psychiatric medications prescribed, if any</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Your answers to this questionnaire can help me to quickly and accurately understand your concerns.

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks, or longer? (If YES, continue with next question; if NO, skip to Question 5.)  
☐ Yes

2. Have you become less interested in things you used to enjoy most of the time?  
☐ No

3. When something good happens, do you feel better, even if only temporarily?  
☐ Yes

4. Have you felt sad, low, or depressed most of the time for the last two years?  
☐ Yes

5. Other than when intoxicated on drugs or alcohol, have you ever felt so “up” or “high” that other people thought you were not your usual self?  
☐ Yes

6. Have you ever gone for days at a time without feeling the need for much sleep?  
☐ Yes

7. Are you currently feeling “up,” “high,” or full of energy?  
☐ Yes

8. Have you been frequently irritable, over-reacting to setbacks that you or others would consider relatively minor?  
☐ Yes

9. Have you had anxiety attacks, i.e., become intensely frightened, uncomfortable, or uneasy, for no apparent reason?  
☐ Yes

10. Do you feel anxious or uneasy in particular places or situations?  
☐ Yes

11. In the past month, have you been repeatedly bothered by unwanted thoughts or images?  
☐ Yes

12. In the past month, have you done something repeatedly without being able to resist doing it?  
☐ Yes

13. Have you ever experienced or witnessed serious injury or threat to yourself or another person, or an actual death?  
☐ Yes

14. Have you ever re-experienced a distressing event through dreams, flashbacks, or physical reactions?  
☐ Yes
15. In the past 12 months, have you had three or more alcoholic drinks within a three hour period on more than three occasions?

16. In the past 12 months, did you drink alcohol or take a drug, more than once, to get high, feel better, or change your mood?

If so, which of the following did you use?

Stimulants, amphetamines, Speed, crystal meth, Dextedrine, Ritalin, diet pills.


Narcotics, heroin, morphine, methadone, painkillers.

Hallucinogens: LSD (“acid”), mescaline, peyote, PCP (“Angel dust,” “Peace Pill”), psilocybin, STP, mushrooms, Ecstasy, MDA, or MDMA.

Inhalants: glue, ethyl chloride, nitrous oxide (“laughing gas”), amyl or butyl nitrate (“Poppers”).

Marijuana: hashish, THC.

Tranquilizers or downers.

Miscellaneous: steroids, nonprescription sleep aids, diet pills, other____________________

17. In the past three months, have you ever eaten a huge amount of food within a two-hour period?

18. Would people who know you well describe you as a worrier?

19. Have you ever felt that you should cut down on your drinking/drug use?

20. Has anyone annoyed you by telling you to cut down on your drinking/drug use?

21. Have you ever felt guilty or bad about your drinking/drug use?

22. Do you ever wake up in the morning wanting to have an alcoholic drink or take drugs (eye opener)?

23. Has anyone ever criticized you or told you that you have a gambling problem?

24. Have you ever had to lie to family members, friends, or therapists about your gambling practices?

25. In the past month, have you wanted to harm yourself?

26. In the past month, did you have suicidal thoughts (e.g., wished you were dead or would be better off dead)?

27. Have you ever made a suicide plan?

28. Have you ever attempted suicide?

FAMILY MENTAL HEALTH HISTORY*Such as: alcoholism, drug addiction, depression, bipolar disorder, schizophrenia, ADHD, anxiety/panic, obsessive-compulsive disorder (OCD), learning disability, sleep disorder, violent tendencies

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age, if still living</th>
<th>Mental health or substance abuse problems, if any*</th>
<th>If deceased, age at death</th>
<th>If deceased, cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Sister/Brother (circle one)</td>
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<td>Sister/Brother (circle one)</td>
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<tr>
<td>Sister/Brother (circle one)</td>
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<tr>
<td>Sister/Brother (circle one)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandmother</td>
<td></td>
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<tr>
<td>Maternal Grandfather</td>
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<tr>
<td>Paternal Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandfather</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. I get along with others. 4 3 2 1 0  +  +
2. I tire quickly. 0 1 2 3 4  +  +
3. I feel no interest in things. 0 1 2 3 4  +  +
4. I feel stressed at work/school/housework/volunteering. 0 1 2 3 4  +  +
5. I blame myself for things. 0 1 2 3 4  +  +
6. I feel irritated. 0 1 2 3 4  +  +
7. I feel unhappy in my marriage/significant relationship. 0 1 2 3 4  +  +
8. I have thoughts of ending my life. 0 1 2 3 4  +  +
9. I feel weak. 0 1 2 3 4  +  +
10. I feel fearful. 0 1 2 3 4  +  +
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark “never”) 0 1 2 3 4  +  +
12. I find my work/school/housework/volunteering satisfying. 4 3 2 1 0  +  +
13. I am a happy person. 4 3 2 1 0  +  +
14. I work/study too much. 0 1 2 3 4  +  +
15. I feel worthless. 0 1 2 3 4  +  +
16. I am concerned about family troubles. 0 1 2 3 4  +  +
17. I have an unfulfilling sex life. 0 1 2 3 4  +  +
18. I feel lonely. 0 1 2 3 4  +  +
19. I have frequent arguments. 0 1 2 3 4  +  +
20. I feel loved and wanted. 4 3 2 1 0  +  +
21. I enjoy my spare time. 4 3 2 1 0  +  +
22. I have difficulty concentrating. 0 1 2 3 4  +  +
23. I feel hopeless about the future. 0 1 2 3 4  +  +
24. I like myself. 4 3 2 1 0  +  +
25. Disturbing thoughts come into my mind that I can’t get rid of. 0 1 2 3 4  +  +
26. I feel annoyed by people who criticize my drinking (or frequent drug use). (If not applicable, mark “never”) 0 1 2 3 4  +  +
27. I have an upset stomach. 0 1 2 3 4  +  +
28. I am not working/studying housework/volunteering as well as I used to. 0 1 2 3 4  +  +
29. My heart pounds too much. 0 1 2 3 4  +  +
30. I have trouble getting along with my friends and close acquaintances. 0 1 2 3 4  +  +
31. I am satisfied with my life. 4 3 2 1 0  +  +
32. I have trouble at work/school housework/volunteering because of drinking or drug use. (If not applicable, mark “never”) 0 1 2 3 4  +  +
33. I feel that something bad is going to happen. 0 1 2 3 4  +  +
34. I have sore muscles. 0 1 2 3 4  +  +
35. I feel afraid of open spaces, or driving, or being on buses, subways etc. 0 1 2 3 4  +  +
36. I feel nervous. 0 1 2 3 4  +  +
37. I feel my love relationships are full and complete. 4 3 2 1 0  +  +
38. I feel that I am not doing well at work/school. 0 1 2 3 4  +  +
39. I have too many disagreements at work/school. 0 1 2 3 4  +  +
40. I feel something is wrong with my mind. 0 1 2 3 4  +  +
41. I have trouble falling asleep or staying asleep. 0 1 2 3 4  +  +
42. I feel blue. 0 1 2 3 4  +  +
43. I am satisfied with my relationships with others. 4 3 2 1 0  +  +
44. I feel angry enough at work/school housework/volunteering to do something I may regret. 0 1 2 3 4  +  +
45. I have headaches. 0 1 2 3 4  +  +
46. I feel restless & can’t sit still. 0 1 2 3 4  +  +
47. I hear or see things that may not be there. 0 1 2 3 4  +  +
48. I do impulsive things (spending/gambling/dangerous driving) 0 1 2 3 4  +  +
49. My thoughts race. 0 1 2 3 4  +  +

**TOTAL:**
Even though we will ask to make a copy of your child’s insurance card, we would appreciate if you would fill in the following information:

**PRIMARY INSURANCE COMPANY**
Name of Insurance Company__________________ Policy#_____________ Group#__________
Authorization or Referral Number________________________
Name of Insured Person____________________ DOB __________ SS#________________________
Address, Phone Numbers and Place of Employment for Insured (if different from first page):
Address:___________________________City___________ State_______ Zip Code__________
Home telephone_____________ Cell Phone_____________
Place of Employment___________ Work Phone_____________

**SECONDARY INSURANCE COMPANY**
Name of Insurance Company__________________ Policy#_____________ Group#__________
Authorization or Referral Number________________________
Name of Insured Person____________________ DOB __________ SS#________________________
Address, Phone Numbers and Place of Employment for Insured (if different from first page):
Address:___________________________City___________ State_______ Zip Code__________
Home telephone_____________ Cell Phone_____________
Place of Employment___________ Work Phone_____________

**PATIENT OR AUTHORIZED PERSON’S SIGNATURE**: I authorize the release of any medical or other information necessary to process insurance claims:
☐ Yes ☐ No

I authorize payment of medical benefits to (Prescribing Psychology Student Name) for services rendered:
☐ Yes ☐ No

**SIGNED**: _________________________ **DATE**: __________________________
Name of person who referred you to this office____________________
Why are you seeking treatment now? __________________________________________
________________________________________
________________________________________

Have you ever seen a therapist or counselor before? ☐ Yes ☐ No
If yes, what was the name of therapist? __________________________________________
Dates and reason for therapy____________________________________________________
For each item, below, please check your preference and provide your initials; then sign below:

______  Yes  No  I grant permission for (Prescribing Psychology Student Name) to speak with my physician about my psychological and medical status.

______  Yes  No  I grant permission for (Prescribing Psychology Student Name) to release medical or other information about my care to my insurance company, in order to process insurance claims.

______  Yes  No  I authorize payment of medical benefits to (Prescribing Psychology Student Name) for services rendered.

All questions on your account should be directed to:

__________________________

I have read (Prescribing Psychology Student Name)  Yes  No practice and privacy policies, and consent to this patient-psychologist agreement on behalf of myself.

___________________________________ _________________
Patient’s Signature Date
FORM 400-8

400-hour Practicum Initial Patient Intake Form
To Be Completed by Child Patients
(with parental assistance)

(May use the following form or another of your choosing as long as all necessary information is recorded.
Please see the New Mexico RxP regulations)
INTAKE FORM
(Child)

Today's Date ________________________

Information about Child:
Name ___________________________ Sex: ☐ Male ☐ Female DOB _____________
Age ________ Social Security# __________________________
Address __________________________ City ___________ State ______ Zip Code ______
Height ___________________________________ Weight _________________
Home telephone ______________________ Emergency contact __________ Relationship _______ Telephone __________
School _______________ Grade ______ Teacher's Name ___________ Telephone __________

Information about Mother:
Name ________________________ DOB ________ Age ______ SS# ______________
Address: __________________________ City ___________ State ______ Zip Code ______
Home telephone ______________ Work Phone ___________ Cell Phone __________
Years of School Completed ____ Place of Employment __________________________
Type of Work ____________________ E-mail address ______________________
Marital Status ____________ Number of Marriages ____ Religion ____________

Information about Father:
Name ________________________ DOB ________ Age ______ SS# ______________
Address: __________________________ City ___________ State ______ Zip Code ______
Home telephone ______________ Work Phone ___________ Cell Phone __________
Years of School Completed ____ Place of Employment __________________________
Type of Work ____________________ E-mail address ______________________
Marital Status ____________ Number of Marriages ____ Religion ____________

OTHERS IN THE HOME:
Name DOB Age Relationship
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
_________________________________________ __________________________
Your child’s physician (name, phone, address):__________________________________________

Does your child have any allergies to medications?  ☐ Yes  ☐ No
If so, to which ones?:______________________________________________________________

To Foods?  ☐ Yes  ☐ No  If so, to which ones?:__________________________________________

Has your child ever had any of the following medical problems? Circle yes or no

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid problem</td>
<td></td>
<td></td>
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<tr>
<td>Endocrine disorder</td>
<td></td>
<td></td>
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<tr>
<td>Seizures or other</td>
<td></td>
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<tr>
<td>neurological disorder</td>
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<tr>
<td>Substance abuse</td>
<td></td>
<td></td>
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<tr>
<td>Headaches</td>
<td></td>
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<tr>
<td>Dizziness</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Bronchitis</td>
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<tr>
<td>Tuberculosis</td>
<td></td>
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<tr>
<td>Colitis</td>
<td></td>
<td></td>
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<tr>
<td>Chest pain</td>
<td></td>
<td></td>
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<tr>
<td>Frequent nosebleeds</td>
<td></td>
<td></td>
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<tr>
<td>Strep throat</td>
<td></td>
<td></td>
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<tr>
<td>Kidney/bladder disease</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes (Type I or Type II)</td>
<td></td>
<td></td>
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<tr>
<td>Venereal Disease</td>
<td></td>
<td></td>
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<tr>
<td>Anemia</td>
<td></td>
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<tr>
<td>Bleeding</td>
<td></td>
<td></td>
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<tr>
<td>Chemical sensitivities</td>
<td></td>
<td></td>
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<tr>
<td>Frequent infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent nausea and vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent constipation or diarrhea</td>
<td></td>
<td></td>
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<tr>
<td>Vision problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained, severe pains</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other unusual sensations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle weakness or fatigue</td>
<td></td>
<td></td>
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<tr>
<td>Other medical illness</td>
<td></td>
<td></td>
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<tr>
<td>Tumor(s), cancercous or benign</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>German Measles/Rubella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
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<tr>
<td>Mumps</td>
<td></td>
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<tr>
<td>Scarlet Fever</td>
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<tr>
<td>Chicken Pox</td>
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<tr>
<td>Mononucleosis</td>
<td></td>
<td></td>
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<tr>
<td>Muscle pain</td>
<td></td>
<td></td>
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<tr>
<td>Bone fracture</td>
<td></td>
<td></td>
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<tr>
<td>Eczema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin rash</td>
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<td></td>
</tr>
</tbody>
</table>

Has your child ever been referred to a psychiatrist or other prescriber for an evaluation for psychiatric medication?  ☐ Yes  ☐ No

Please list all medications and their doses (medical, psychiatric, non-prescription, herbal) that your child is currently taking:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Medication</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>4.</td>
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<tr>
<td>2.</td>
<td></td>
<td>5.</td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
<td>6.</td>
<td></td>
</tr>
</tbody>
</table>

Has your child ever been hospitalized for a psychiatric reason?  ☐ Yes  ☐ No

Please list all hospitalizations, medical and psychiatric:

<table>
<thead>
<tr>
<th>Dates of hospitalization</th>
<th>Place</th>
<th>Reason</th>
<th>Psychiatric medications prescribed, if any</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Has your child ever had any of the following problems?

<table>
<thead>
<tr>
<th>Sleep problems: i.e., resists going to bed, interferes with parents’ sleep, has trouble getting up in the morning</th>
<th>Family HX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nightmares, night terrors, or sleep walking</td>
<td>Huge Problem</td>
</tr>
<tr>
<td>Finicky eating</td>
<td></td>
</tr>
<tr>
<td>Eating too much</td>
<td></td>
</tr>
<tr>
<td>Eating too little</td>
<td></td>
</tr>
<tr>
<td>Dramatic changes in energy</td>
<td></td>
</tr>
<tr>
<td>Up or Down?</td>
<td></td>
</tr>
<tr>
<td>Frequent crying spells</td>
<td></td>
</tr>
<tr>
<td>Anxiety, panic, nervousness</td>
<td></td>
</tr>
<tr>
<td>Worry, intense shyness</td>
<td></td>
</tr>
<tr>
<td>Depressed, sad, or hopeless</td>
<td></td>
</tr>
<tr>
<td>Voiced thoughts of harming self</td>
<td></td>
</tr>
<tr>
<td>Engaged in self-injury</td>
<td></td>
</tr>
<tr>
<td>Attempted suicide</td>
<td></td>
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<tr>
<td>Concerns about personal appearance</td>
<td></td>
</tr>
<tr>
<td>Does purposeless things over and over</td>
<td></td>
</tr>
<tr>
<td>Cannot get certain thoughts out of his/her head</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unusual behavior or beliefs that seem strange to others</th>
<th>Family HX</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Huge Problem</td>
</tr>
<tr>
<td>Easily irritated or frustrated</td>
<td></td>
</tr>
<tr>
<td>Argues or becomes aggressive</td>
<td></td>
</tr>
<tr>
<td>Has voiced thoughts of harming someone else</td>
<td></td>
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<tr>
<td>Physically assaulted someone</td>
<td></td>
</tr>
<tr>
<td>Risky behavior __________</td>
<td></td>
</tr>
<tr>
<td>Behavior problems at school</td>
<td></td>
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<tr>
<td>Academic problems</td>
<td></td>
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<tr>
<td>Smokes cigarettes</td>
<td></td>
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<tr>
<td>Acts without thinking</td>
<td></td>
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<tr>
<td>Cannot stay focused</td>
<td></td>
</tr>
<tr>
<td>Restless, fidgety, or hyper</td>
<td></td>
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<tr>
<td>Breaks family or school rules</td>
<td></td>
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<tr>
<td>Lies or steals</td>
<td></td>
</tr>
<tr>
<td>Involvement in correctional system</td>
<td></td>
</tr>
<tr>
<td>Alcohol problems</td>
<td></td>
</tr>
<tr>
<td>Drug problems</td>
<td></td>
</tr>
<tr>
<td>Past/present drug or alcohol problems?</td>
<td></td>
</tr>
<tr>
<td>Other: ________________</td>
<td></td>
</tr>
</tbody>
</table>
Your answers to this questionnaire can help me to quickly and accurately understand your concerns. If adolescent, please complete. If parent, complete with child.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.) Has your child been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks or longer? (If YES, continue with the next question; if NO, skip to Question 5)</td>
<td>☐</td>
<td>☐</td>
<td>12.) In the past month, has your child done something repeatedly without being able to resist doing it?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2.) Has your child become less interested in things you used to enjoy most of the time?</td>
<td>☐</td>
<td>☐</td>
<td>13.) Has your child ever experienced or witnessed serious injury or threat to yourself or another person, or an actual death?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3.) When something good happens, does your child feel better, even if only temporarily?</td>
<td>☐</td>
<td>☐</td>
<td>14.) Has your child ever re-experienced a distressing event through dreams, flashbacks, or physical reactions?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4.) Has your child felt sad, low, or depressed most of the time for the last 2 years?</td>
<td>☐</td>
<td>☐</td>
<td>15.) In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on more than 3 occasions?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5.) Other than when intoxicated on drugs or alcohol, has your child ever felt so “up” or “high” that other people thought you were not your usual self?</td>
<td>☐</td>
<td>☐</td>
<td>16.) In the past 12 months, did your child drink alcohol or take a drug, more than once, to get high, feel better, or change your mood?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6.) Has your child ever gone for days at a time without feeling the need for much sleep?</td>
<td>☐</td>
<td>☐</td>
<td>If so, which of the following did your child use? (below)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7.) Is your child currently feeling “up” “high”, or “full of energy”?</td>
<td>☐</td>
<td>☐</td>
<td>Hallucinogens: LSD (“acid”), mescaline, peyote, PCP (“Angel Dust”, “Peace Pill”), Psilocybin, STP, Mushrooms, Ecstasy, MDA, or MDMA.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8.) Has your child been frequently irritable, over-reacting to setbacks that you or others would consider relatively minor?</td>
<td>☐</td>
<td>☐</td>
<td>Inhalants: Glue, Ethyl Chloride, Nitrous Oxide (“laughing gas”), Amyl or Butyl Nitrate (“Poppers”).</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9.) Has your child had anxiety attacks, i.e. become intensely frightened, uncomfortable, or uneasy, for no apparent reason?</td>
<td>☐</td>
<td>☐</td>
<td>Cocaine: snorting, freebase, crack, IV, or “Speedball”. Narcotics, Heroin, Morphine, Methadone, Painkillers.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10.) Does your child feel anxious or uneasy in particular places or situations?</td>
<td>☐</td>
<td>☐</td>
<td>Marijuana: Hashish, THC</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11.) In the past month, have you been repeatedly bothered by unwanted thoughts or images?</td>
<td>☐</td>
<td>☐</td>
<td>Tranquilizers or Downers. Miscellaneous: Steroids, Non-prescription Sleep Aides, Diet Pills, Other: ______________________</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>17.) In the past 3 months, has your child ever eaten a huge amount of food within a 2-hr period?</td>
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<tr>
<td>18.) Would people who know your child well describe him/her as a worrier?</td>
<td></td>
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<tr>
<td>19.) Has your child ever felt that he/she should cut down on drinking or drug use?</td>
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<td></td>
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<tr>
<td>20.) Has anyone annoyed your child by telling him/her to cut down on drinking or drug use?</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>21.) Has your child ever felt guilty or bad about drinking or drug use?</td>
<td></td>
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<tr>
<td>22.) Does your child ever wake up in the morning wanting to have an alcoholic drink or take drugs (eye opener)?</td>
<td></td>
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<tr>
<td>23.) Has anyone ever criticized your child or told him/her that he/she has a gambling problem?</td>
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<tr>
<td>24.) Has your child ever had to lie to family members, friends, or therapists about his/her gambling practices?</td>
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<tr>
<td>25.) In the past month, has your child wanted to harm himself/herself?</td>
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<tr>
<td>26.) In the past month, did your child have suicidal thoughts (i.e., wished he/she were dead or would be better off dead?)</td>
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<tr>
<td>27.) Has your child ever made a suicide plan?</td>
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<tr>
<td>28.) Has your child ever attempted suicide?</td>
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</tr>
</tbody>
</table>
### FAMILY MENTAL HEALTH HISTORY

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age, if still living</th>
<th>Mental health or substance abuse problems, if any*</th>
<th>If deceased, age at death</th>
<th>If deceased, cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sister/Brother (circle one)</td>
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<tr>
<td>Sister/Brother (circle one)</td>
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<td>Sister/Brother (circle one)</td>
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<tr>
<td>Sister/Brother (circle one)</td>
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<tr>
<td>Maternal Grandmother</td>
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<tr>
<td>Maternal Grandfather</td>
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<tr>
<td>Paternal Grandmother</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandfather</td>
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</tbody>
</table>

*Such as: alcoholism, drug addiction, depression, bipolar disorder, schizophrenia, ADHD, anxiety/panic, obsessive-compulsive disorder (OCD), learning disability, sleep disorder, violent tendencies.

Even though we will ask to make a copy of your child’s insurance card, we would appreciate if you would fill in the following information:

### PRIMARY INSURANCE COMPANY
Name of Insurance Company________________________ Policy#________________ Group#_________
Authorization or Referral Number________________________
Name of Insured Person________________________ DOB _______ SS# __________
Address, Phone Numbers and Place of Employment for Insured (if different from first page):
Address:_________________________City___________ State_______ Zip Code_________
Home telephone___________ Cell Phone______________
Place of Employment__________ Work Phone___________

### SECONDARY INSURANCE COMPANY
Name of Insurance Company________________________ Policy#________________ Group#_________
Authorization or Referral Number________________________
Name of Insured Person________________________ DOB _______ SS# __________
Address, Phone Numbers and Place of Employment for Insured (if different from first page):
Address:_________________________City___________ State_______ Zip Code_________
Home telephone___________ Cell Phone______________
Place of Employment__________ Work Phone___________
PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process insurance claims:

☐ Yes  ☐ No

I authorize payment of medical benefits to __________________ for services rendered:

☐ Yes  ☐ No

SIGNED: _________________________ DATE: ________________________________

Name of person who referred you to this office___________________________

Why are you seeking treatment for your child now? ________________________________

________________________________________________________________________

Has your child ever seen a therapist or counselor before? ☐ Yes  ☐ No

If yes, what was the name of therapist? ________________________________

Dates and reason for therapy ________________________________

________________________________________________________________________

For each item, below, please check your preference and provide your initials; then sign below:

_____ ☐ Yes  ☐ No I grant permission for (Prescribing Psychology Student Name) to speak with my child’s physician about my child’s psychological and medical status.

_____ ☐ Yes  ☐ No I grant permission for (Prescribing Psychology Student Name) to speak about my child’s psychological and/or medical status with (other healthcare provider’s name, address, and phone number): ________________________________

_____ ☐ Yes  ☐ No I grant permission for (Prescribing Psychology Student Name) to speak with my child’s teacher and other school personnel at ________________________________ (name of school) about how my child is doing in school.

_____ ☐ Yes  ☐ No I grant permission for (Prescribing Psychology Student Name) to release medical or other information about my child’s care to my child’s insurance company, in order to process insurance claims.

_____ ☐ Yes  ☐ No I authorize payment of medical benefits to (Prescribing Psychology Student Name) for services rendered.

I have read ___________________’s practice and privacy policies, and the HIPPA information, and consent to this patient-psychologist agreement.

________________________________________  __________________________  ____________
Parent/Guardian Name (printed)            Parent/Guardian Signature             Date
FORM 400-9

400-hour Sample
Practicum Initial Patient Chart Form
To Be Completed by the Psychologist
**INITIAL PATIENT DATA**

Supervisee: __________________________

Patient Name: __________________________
Patient Date of Birth: _____________

Date: ____________
Gender: ________________

Weight: _______
Height: _______

Ethnic Cultural Background: _______
Medical History Form Completed Yes ___ No___

Presenting Symptoms and History of Symptoms:

---

**Review of Systems:**

<table>
<thead>
<tr>
<th>CONST:</th>
<th>Fever</th>
<th>Chills</th>
<th>Fatigue</th>
<th>Dizziness</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT:</td>
<td>Sore Throat</td>
<td>Nasal Drainage</td>
<td>Nasal Congestion</td>
<td></td>
</tr>
<tr>
<td>PULMONARY:</td>
<td>Cough</td>
<td>Sputum</td>
<td>Trouble Breathing</td>
<td>Chest Pain</td>
</tr>
<tr>
<td></td>
<td>Asthma</td>
<td>Bronchitis</td>
<td>Emphysema</td>
<td>Pneumonia</td>
</tr>
<tr>
<td></td>
<td>Allergies</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVS:</td>
<td>High Cholesterol</td>
<td>Heart Disease</td>
<td>Atherosclerosis</td>
<td>Stroke</td>
</tr>
<tr>
<td></td>
<td>High Blood Pressure</td>
<td>Irregular Heartbeat</td>
<td>Foot Swelling</td>
<td>Anemia</td>
</tr>
<tr>
<td></td>
<td>Heart Attack</td>
<td>Heart Blockage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUS/SKEL:</td>
<td>Arthritis</td>
<td>Muscle Pain</td>
<td>Leg Pain</td>
<td>Fracture</td>
</tr>
<tr>
<td></td>
<td>Back Pain</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSTEO:</td>
<td>Arthritis</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GI:</td>
<td>Abdominal Pain</td>
<td>Nausea</td>
<td>Vomiting</td>
<td>Diarrhea</td>
</tr>
<tr>
<td></td>
<td>Constipation</td>
<td>Black/Bloody Stools</td>
<td>Liver Problems</td>
<td>Hemorrhoids</td>
</tr>
<tr>
<td></td>
<td>Hernia</td>
<td>Hepatitis Ulcer</td>
<td>Kidney Disease</td>
<td>Bladder Disease</td>
</tr>
<tr>
<td>GU:</td>
<td>Problems Urinating</td>
<td>Frequent Urination</td>
<td>Hemorrhoids</td>
<td></td>
</tr>
<tr>
<td>SKIN:</td>
<td>Skin Rash</td>
<td>Eczema</td>
<td>Psoriasis</td>
<td>Open Wounds</td>
</tr>
<tr>
<td>NEURO/EYES:</td>
<td>Headaches</td>
<td>Difficulty Walking</td>
<td>Blackouts</td>
<td>Difficulty w/Speech</td>
</tr>
<tr>
<td></td>
<td>Double Vision</td>
<td>Stroke</td>
<td>Head Injury</td>
<td>Seizures/Convulsions</td>
</tr>
<tr>
<td></td>
<td>Eye Infections</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENDOCRINE:</td>
<td>Postmenopausal</td>
<td>Hysterectomy</td>
<td>Abnormal Discharge</td>
<td>Abnormal Bleeding</td>
</tr>
<tr>
<td></td>
<td>Diabetes Hypothyroid</td>
<td>Prostate</td>
<td></td>
<td>Venereal</td>
</tr>
</tbody>
</table>

**Hospitalizations and Surgeries:**

**Use of Alcohol, Drugs, Caffeine and Tobacco:**

**Significant Family History Including Medical and Mental Conditions:**
**Mental Status:**

<table>
<thead>
<tr>
<th>APPEARANCE:</th>
<th>Appropriate</th>
<th>Unclean</th>
<th>Disheveled</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEHAVIOR:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td>Person</td>
<td>Place</td>
<td>Situation</td>
</tr>
<tr>
<td>ORIENTATION:</td>
<td>Asthma</td>
<td>Bronchitis</td>
<td>Emphysema</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>SPEECH/LANGUAGE:</td>
<td>Organized</td>
<td>Disorganized</td>
<td>Rate NL</td>
<td>Slow</td>
</tr>
<tr>
<td></td>
<td>Soft</td>
<td>Loud</td>
<td>Tone NL</td>
<td>Monotone</td>
</tr>
<tr>
<td>MOOD/AFFECT:</td>
<td>Euthymic</td>
<td>Depressed</td>
<td>Irritable</td>
<td>Tearful</td>
</tr>
<tr>
<td>THOUGHT PROCESS:</td>
<td>Hypervigilant</td>
<td>Linear</td>
<td>Tangential</td>
<td>Loose</td>
</tr>
<tr>
<td></td>
<td>Inattentive</td>
<td>Circumstantial</td>
<td>Coherent</td>
<td>Trouble Concentrating</td>
</tr>
<tr>
<td>THOUGHT CONTENT:</td>
<td>Obsessional</td>
<td>Grandiosity</td>
<td>Hallucinations</td>
<td>Delusions</td>
</tr>
<tr>
<td>SUICIDE:</td>
<td>Ideation</td>
<td>Plan</td>
<td>IS w/o Means</td>
<td>Prior SA</td>
</tr>
<tr>
<td>HOMICIDE:</td>
<td>Ideation</td>
<td>Plan</td>
<td>HI w/o Means</td>
<td>HI w/Means</td>
</tr>
</tbody>
</table>

**Vegetative Symptoms:**

| S - SLEEP:        | Nightmares | Flashbacks | Hypnopompic | Hrs of Sleep | Hypnagogic |
|                   |            |            | Hallucinations | Hyperarousal | Hallucinations |
| A - APPETITE CHANGE: | None       | Decrease   | Increase    | Severe       | Weight Change Loss |
| M - MEMORY:       | Intact     | Poor       |            |             |             |
| C - CONCENTRATION:| High       | Decrease   | Low         | Intact       | Slight Impairment |
| E - ENERGY:       | High       | Moderate   | Low         |             |             |
| L - LIBIDO:       | Increase   | Decrease   | Same        | Other:       |

**Diagnosis:**

| AXIS I:          |             |             |
| AXII:            |             |             |
| AXIII:           |             |             |

**AXIS IV – Psychosocial and Environmental Problems** *(check all that apply)*

- [ ] None
- [ ] Legal System Interaction
- [ ] Primary Support Group
- [ ] Economic
- [ ] Occupational
- [ ] Housing
- [ ] Educational
- [ ] Social Environmental
- [ ] Access to Healthcare
- [ ] Other

Comments:

Patient’s motivation for treatment:  ___low  ___ moderate  ___ high

Patient’s strength:

Patient’s obstacles to recovery:

Food allergies:

Drug allergies:
Conditions for which psychotropic drugs are contraindicated:

Primary symptoms to be targeted by the psychotropic medication:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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</thead>
<tbody>
<tr>
<td>Depressed Mood</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Decreased Energy</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Grief</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Worthlessness</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Guilt</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Panic Attacks</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Obsessions/Compulsions</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Elevated Mood</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Irritability</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Disruption of Thought-Process/Content</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Delusions</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Paranoia</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Dissociative State</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Oppositionalism</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Somatic Complaints</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Impulsiveness</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>PTSD Symptomology</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Sexual Trauma Perpetrator Symptomology</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
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<tr>
<td>Substance Use</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.__________________________</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
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<tr>
<td>b.__________________________</td>
<td>1.__</td>
<td>2.__</td>
<td>3.__</td>
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</table>

Relevant Findings from lab tests:
Discussion with PCP:
Discharge Criteria:

For Medical Conditions (prescription and over-the-counter):

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Dosage</th>
<th>Prescribed By</th>
<th>Taken For</th>
<th>Date Started</th>
<th>Date Discontinued</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Psychotropic Medications:

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Dosage</th>
<th>Prescribed By</th>
<th>Taken For</th>
<th>Date Started</th>
<th>Date Discontinued</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
PSYCHOTHERAPY PLAN:

Data –

Assessment –

Plan –

Or

Subjective –

Objective –

Assessment –

Plan -
FORM 400-10

FORM 400-11

400-hour Practicum Symptom Outcome Questionnaire
To Be Completed by Adult Patients and Adolescent Patients at Initial Appointment and Before Each Follow-up Appointment (Directions on how to score this outcome questionnaire follow)

Note: you do not need to use this outcome questionnaire but you are strongly encouraged to have your patients complete an objective measure at each session.
<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
<th>SD</th>
<th>IR</th>
<th>SR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I get along with others.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I tire quickly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>3. I feel no interest in things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>4. I feel stressed at work/school/housework/volunteering.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>5. I blame myself for things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>6. I feel irritated.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>7. I feel unhappy in my marriage/significant relationship.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>8. I have thoughts of ending my life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>9. I feel weak.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>10. I feel fearful.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark “never”)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>12. I find my work/school/housework/volunteering satisfying.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>13. I am a happy person.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>14. I work/study too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>15. I feel worthless.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>16. I am concerned about family troubles.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>17. I have an unfulfilling sex life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>18. I feel lonely.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>19. I have frequent arguments.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>20. I feel loved and wanted.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>21. I enjoy my spare time.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>22. I have difficulty concentrating.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>23. I feel hopeless about the future.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>24. I like myself.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>25. Disturbing thoughts come into my mind that I can’t get rid of.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>26. I feel annoyed by people who criticize my drinking (or frequent drug use). (If not applicable, mark “never”)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>27. I have an upset stomach.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>28. I am not working/studying housework/volunteering as well as I used to.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>29. My heart pounds too much.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>30. I have trouble getting along with my friends and close acquaintances.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>31. I am satisfied with my life.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>32. I have trouble at work/school housework/volunteering because of drinking or drug use. (If not applicable, mark “never”)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>33. I feel that something bad is going to happen.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>34. I have sore muscles.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>35. I feel afraid of open spaces, or driving, or being on buses, subways</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>36. I feel nervous.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>37. I feel my love relationships are full and complete.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>38. I feel that I am not doing well at work/school.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>39. I have too many disagreements at work/school.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>40. I feel something is wrong with my mind.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>41. I have trouble falling asleep or staying asleep.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>42. I feel blue.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>43. I am satisfied with my relationships with others.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>44. I feel angry enough at work/school housework/volunteering to do something I may regret.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>45. I have headaches.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>46. I feel restless &amp; can’t sit still.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>47. I hear or see things that may not be there.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>48. I do impulsive things (spending/gambling/dangerous driving)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>49. My thoughts race.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL:**
Directions for Scoring the Outcome Questionnaire

This description of the Outcome Questionnaire 45 is written by John Drozd, Ph.D., who completed the Master’s Degree in Psychopharmacology Training at NMSU.

**Purpose:** Global outcome measure that assesses patient progress in therapy (not a diagnostic instrument). Assesses patient progress along 3 dimensions:

1) subjective discomfort or symptom distress (SD subscale, heavily loaded for depression and anxiety),
2) interpersonal relationship (IR subscale)
3) social role performance (SR subscale)

**Overall Description:** The OQ45.2 is a brief 45 item self-report outcome/tracking instrument designed for repeated measurement of client progress throughout the course of therapy and at termination. The OQ45.2 is the result of a unique partnership between behavioral health care administrators, practitioners, and academic researchers in response to the changing mental health arena and the accompanying demands for cost containment, quality care, reliable monitoring, and accountability for services provided. As continuous monitoring of outcome may be achieved by standardized data, Dr. Burlingame, Lambert, and Reisinger et al, set out to design an instrument that would meet the needs of both providers and payers.

**Normative Sample:** Normative data from community mental health and private freestanding outpatient clinics, EAP participants, and asymptomatic community and undergraduate populations are available. These normative samples (N=1,000+) were collected from sites in seven different states and reflect both gender (female = 60%) and age (from 17-80 years of age) diversity. Current analyses do not reflect any reliable normative differences by gender and age.

**Psychometric Properties:** The OQ45.2 is a standardized instrument with empirical support. It is based on normative data. Validity and reliability exceed industry standards.

**Scoring and Interpretation:** Total score is sum of 3 subscale scores (i.e. all 45 items) and yields a total score range from 0 – 180. The higher the score the more disturbed the individual.

**Risk Assessment:**

- Item 8 is a suicide potential screening item
- Items 11, 26, and 32 are substance abuse screening items
- Item 44 screens for violence at work.

Any rating on above Items other than 0 should be investigated further

**Cutoff Score:** When a patient scores a total score of 63 or higher, it is more likely that they are part of the clinical rather than the non-clinical (“normal”) standardization sample. Cutoff scores for subscales are:

- Symptom Distress – 36,
- Interpersonal Relations – 15,
- Social Role – 12
**Reliable Change Index:** Total score changes of 14 points or more in either direction suggest reliable change (i.e., not due merely to measurement error)

**FOR FURTHER INFORMATION**


FORM 400-11

400-hour Practicum Symptom Checklist To Be Completed by Child Patient (with parent’s assistance if needed) Before Each Follow-up Session

Note: you do not need to use this outcome questionnaire but you are strongly encouraged to have your patients complete an objective measure at each session.
**CHILD FOLLOW-UP CHECKLIST**

Name: _______________________________  Date: ____________

Please rate the degree to which you experienced each of the following since the last session:

<table>
<thead>
<tr>
<th>Sleep problems: i.e., resists going to bed, interferes with parents’ sleep, has trouble getting up in the morning</th>
<th>Easily irritated or frustrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nightmares, night terrors, or sleep walking</td>
<td>Argues or becomes aggressive</td>
</tr>
<tr>
<td>Finicky eating</td>
<td>Has voiced thoughts of harming someone else</td>
</tr>
<tr>
<td>Eating too much</td>
<td>Physically assaulted someone</td>
</tr>
<tr>
<td>Eating too little</td>
<td>Risky behavior ____________</td>
</tr>
<tr>
<td>Dramatic changes in energy</td>
<td>Behavior problems at school</td>
</tr>
<tr>
<td>Up or Down?</td>
<td>Academic problems</td>
</tr>
<tr>
<td>Frequent crying spells</td>
<td>Smokes cigarettes</td>
</tr>
<tr>
<td>Anxiety, panic, nervousness</td>
<td>Acts without thinking</td>
</tr>
<tr>
<td>Worry, intense shyness</td>
<td>Cannot stay focused</td>
</tr>
<tr>
<td>Depressed, sad, or hopeless</td>
<td>Restless, fidgety, or hyper</td>
</tr>
<tr>
<td>Voiced thoughts of harming himself/herself</td>
<td>Breaks family or school rules</td>
</tr>
<tr>
<td>Engaged in self-injury</td>
<td>Lies or steals</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>Involvement in correctional system</td>
</tr>
<tr>
<td>Concerns about personal appearance</td>
<td>Alcohol problems</td>
</tr>
<tr>
<td>Does purposeless things over and over</td>
<td>Drug problems</td>
</tr>
<tr>
<td>Cannot get certain thoughts out of his/her head</td>
<td>Past/present drug or alcohol problems?</td>
</tr>
<tr>
<td>Unusual behavior or beliefs that seem strange to others</td>
<td>Other: _____________________</td>
</tr>
</tbody>
</table>
Since the last session has your child…
…had any new medical problems? □ Yes □ No. If Yes, explain: ______________________________________

These SIDE EFFECTS are sometimes experienced by a patient on medication. Has your child experienced any of these since being on MEDICATION?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Severe Problem</th>
<th>Moderate Problem</th>
<th>Minor Problem</th>
<th>Medication</th>
<th>Approximate Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty Falling asleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty waking up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interrupted sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extreme tiredness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trouble concentrating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of memory</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shaking/ Tics/twitches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Odd muscle movements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurred vision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach distress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty urinating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry mouth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to sit still</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Racing mind</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

…visited a health care provider? □ Yes □ No. If Yes, explain: ______________________________________

…started, stopped, or changed the dosage of any medication, herb, supplement, caffeine, or nicotine? □ Yes □ No. If Yes, explain: ______________________________________

…experienced stressful events at home, school, or work? □ Yes □ No
If Yes, explain: ______________________________________

Does your child need a refill on any of his/her medications? □ Yes □ No. If Yes, please list with current dosage: ______________________________________
Everything You Need to Know
Now That Your Coursework is Complete
EVERYTHING YOU NEED TO KNOW
NOW THAT YOUR RXP COURSEWORK IS COMPLETE

Regarding the 80-hour Practicum

- You must complete an 80-hour practicum with a licensed physician.

- This Supervisor must sign an evaluation form. The evaluation form is on the www.nmsu.edu/academic-programs/clinical-psychopharmacology website in the handbook.

- You can have more than one supervisor; there has to be a primary supervisor who is an MD (not a nurse) who signs off on the form.

- Send a copy of the evaluation form to the Training Director. Keep the original of that evaluation form for yourself; you will have to submit it to the board to get your license.

- Must be completed in time frame from two weeks to thirty weeks.

You also need to complete a 100 patient/400 hour practicum in which you evaluate and treat patients for psychotropic intervention.

- You need to submit a practicum plan with your signature and the supervisor’s signature to NMSU. I will sign it and return the original to you, and keep a copy in your student file.

- You must have one hour of supervision for each eight hours of clinical experience. If you are doing joint work with your supervisor, that qualifies as supervision time, as well as does the time talking about cases in between patient sessions.

- Writing case notes does not count. It has to be direct clinical time.

- You can have more than one Supervisor. The primary supervisor is responsible for getting feedback from the secondary supervisor at the midpoint and end of your program.

- You need to have an evaluation form completed after the first 50 patients and at end when you have seen 100 patients for 400 hours. That evaluation form is also in the practicum manual on the NMSU website.

- Send copies of those evaluation forms to the Training Director. Keep the original of it for yourself; you will need to send it to the Board in order to get your license.

- According to the law, there are records of the Practicum that you must keep:
  - A list of the dates and times you are with your supervisor.
  - A list of patients (using a code for their names to protect their identity) which describes the basic facts of each case.
  - Forms to use for those lists can be found on the website.
You must also keep a copy of your case notes.

- You do not need to send those case notes to the Training Director to get your degree, but, you must send a copy of your case notes to the Training Director before applying for your conditional license.
- The law requires that your Training Director look at your case notes.

- Must be completed in time frame of six months to three years

To remain eligible and apply for the Master’s degree:

- You must register for two sections of the practicum with CEP 811 and 812 the semester after completing the coursework. If you are not finished with your practicum at that time, these will carry forward as an “I” until you are done.
- The semester you plan to graduate, you need to register for one credit of CEP 698.
- The semester you intend to graduate, please notify the Training Director as early as possible.
- When you register for the final semester:
  - Make sure that your program of study that has been filed
  - You must complete a form online stating your intention to graduate
    Go to your MYNMSU and find the link for application to graduate
    Follow the instructions for the interdisciplinary Masters (IMAS)
- There is a “Capstone Experience” that needs to be completed for any Master's degree. The Capstone Experience is to be taken the semester you plan to graduate. The Capstone is a short essay exam for you to complete which asks you to evaluate one of the cases of your practicum. The test has been written in a way that will, hopefully, give you the opportunity to think through some interesting matters.
- When you are ready to take the exam, contact the Training Director. It will be emailed to you. However, it is important that you ask for the exam at the beginning of the semester you plan to graduate, which will give you time to do it. The Capstone must be completed about six weeks before the semester ends.

Taking the PEP

- You are eligible to take the PEP as soon as you complete the coursework, even before you complete the Practicum.
- To get the official PEP application you need to email Jan Ciuccio (jciuccio@apa.org) at the American Psychological Association.
• You need to submit an official transcript from NMSU and a certificate of coursework completion with the application. You can obtain an official copy of your transcript from your MYNMSU link on your account.

• The pass rate for the exam is set somewhere around 71-72% of the items. It is hard to know exactly what the rate is until you have taken the test.

Applying for you conditional license to prescribe

• The information for applying for your conditional license is on the Board of Psychologist Examiners webpage. That information, as well as the forms for the application, can be downloaded from there.

• You will be asked to fill out an application form and send to the Board copies of your evaluation of each practicum. They may also ask for the documentation of the number of hours of supervision and basic data about your patients. You will also need to provide evidence that you passed the PEP.

• They will ask me to fill out a form about you. In order for me to do that, I must have the following:
  o Copies of your evaluation forms.
  o Copies of your case notes of your 100-hour practicum without the names (using a code to protect their identity) OR completion of the form titled Verification of Specifics of 100 Patients/400 hour Practicum (that form is attached.)
  o Two short forms which indicate your hours of supervision and basic data about the patients.

Moving from a conditional to an unconditional license to prescribe:

• During the two years of a conditional license, you must see 50 patients and you must be supervised for four hours a month.

• There is no formal interaction with the NMSU program necessary at this point. NMSU does not keep records of your work as a conditional prescribing psychologist.

• You can obtain the application forms on the Board of Psychologist Examiners website.

• After you apply, you will be contacted by the Board about how they will review your cases.
Getting an ABMP designation

• The American Board of Medical Psychology offers a Diplomate that allows you to put the initials ABMP after your name.

• You can then call yourself a “medical psychologist.”

• They had an earlier grandfathering period which is now over. You now must complete an exam as well as document experience.

• Their requirements are online (www.abmp.org)

Remember, it is your responsibility that you progress smoothly through these steps.

• Please read New Mexico State University regulations regarding graduate school and a Master’s degree.

• Please be familiar with the law for prescriptive authority.

• Please carefully read the regulations for prescriptive authority.

• I have tried to make these notes as inclusive as possible, but there are so many steps and so many specific items, it really is important for you to become familiar with the regulations for yourself.
Final Form to be Submitted to the Training Director

Form 400-12
POST-DOCTORAL MASTER’S OF ARTS DEGREE
NEW MEXICO STATE UNIVERSITY

Verification of Specifics of 100 Patients/400 Hour Practicum

1. Attached to this form, have you included a coded log, which includes patient ID, age, gender, diagnosis, and time spent in treatment?
   ____YES  ____NO

2. Have you also included with the form a log of the dates and times of Supervision?
   ____YES  ____NO

3. Have you included a copy of the form you used to indicate to patients that you were under supervision?
   ____YES  ____NO

4. Have you submitted to the Training Director two formal written evaluations completed by the primary supervisor?
   ____YES  ____NO

5. Please describe the population parameters with whom you hope to practice with your conditional prescribing license (for example, only adults, only children, severely mentally ill, etc).

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

6. Please describe the range of disorders treated during your practicum experience.

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
7. How many of these were seen for acute conditions and chronic conditions.
   Acute ________  Chronic ________

8. In general terms, please provide evidence that you have seen a diverse set of patients throughout the lifecycle of various ethnicity and social/cultural backgrounds.

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

9. Do you attest that the primary or secondary supervisor was on site?
   ____YES   ____NO

10. Did your primary or secondary supervisor review charts and records?
    ____YES   ____NO

11. Will you attest that there was at least one hour of supervision for every eight hours or direct service?
    ____YES   ____NO

12. What was the date you began your practicum and completed your practicum?
    Begin_____________  Ended____________

13. In evaluating your application, the Board of Psychologist Examiners reserves the right to request clinical records from the applicant or the Training Director. Do you certify, that if requested by the Board of Psychologist Examiners, you can and will make available to the Training Director of NMSU or the Board of Psychologist Examiners clinical records that support all of the experiences described above?
    ____YES   ____NO
I, _________________________, swear or affirm under penalty of perjury under the laws of the State of New Mexico, that all forms requested are attached and that everything written above is complete and true.

Sworn this ___________ day of __________________________, 20___, at ____________________________________________.
City and State

______________________________________________
Signature

STATE OF ________   )
  )
COUNTY OF _______________  )

SUBSCRIBED AND SWORN TO BEFORE ME THIS
    ____________ DAY OF ____________, 20____
SEAL

Signature of Notary Public: __________________________________
My Commission expires on: ____________________________________
Last But Not Least!

CHECKLIST OF MATERIAL TO BE SENT TO TRAINING DIRECTOR BEFORE APPLYING FOR YOUR CONDITIONAL PRESCRIBING LICENSE

_____ Copy of 80-Hour Practicum in a healthcare setting dated and signed by your supervising physician

_____ Copy of 100 patients/400 hours Practicum Plan

_____ Copy of form given to patients that they sign that explains you are a student in training

_____ Copy of your log for each of 100 patients seen in you 400-hour practicum

_____ Copy of your log which lists dates and times of supervision

_____ Copy of evaluations completed by your primary supervisor at the midpoint and end of practicum

_____ Copy of evaluation form completed by your secondary supervisor(s) of your practicum

_____ Copy of all your case notes with the identity and date blacked out or a notarized copy of the verification form that follows.

_____ It is also important for you to assure that your insurance carrier will cover you as a prescribing psychologist. The APA Insurance Trust has given their commitment to do so. If you have insurance coverage with a different carrier, it is strongly recommended that you write to them early on in your practicum to determine if they will cover you or if you need to seek another company.
TRAINING PROGRAM VERIFICATION OF EXPERIENCE

Board of Psychologist Examiners
P. O. Box 25101 • Santa Fe, New Mexico • 87505
(505) 476-4960

To the Training Director of a program of psychopharmacology

A. REQUEST FOR INFORMATION

The Board of Psychologist Examiners has received an application for a conditional certificate as a prescribing psychologist from the applicant named below. (To be filled out by Applicant and forwarded on to the Director of the training program)

Applicant:
Address:
City & State:
Telephone No.

Your name has been submitted by the applicant as a Director of the Training of that program. The Board has not received applicants from your program before. Therefore, we will need to complete an extensive review of the program to determine if it fulfills requirements of the New Mexico Prescribing Psychologist Act.

We would appreciate you providing the Board with the information requested and return this form and requested information directly to the Board office at the above address.

B. INFORMATION ABOUT THE TRAINING DIRECTOR

Training Director’s Name: ________________________________
Title and position of employment: ________________________________
Institution of employment: ________________________________
Address: ________________________________________________
City & State: ______________________________________________
Telephone No.: ______________________________________________

Please describe your training in psychopharmacology:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Do you hold a license as a psychologist?  
Yes  No

State: ___________  Year license awarded: ___________

Do you hold a license to prescribe psychotropics?  
Yes  No

State: ___________  Year license awarded: ___________

Do you hold any other professional licenses in this or other jurisdictions?  Yes  No

Please list below:

<table>
<thead>
<tr>
<th>State</th>
<th>License Type</th>
<th>When awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

C. INFORMATION ABOUT THE PROGRAM

Does the applicant’s psychopharmacology training meet the following criteria?

1. The program was an integrated program of study.  
Yes  No

2. The program had an identifiable body of students at different levels of matriculation.  
Yes  No

3. The program was clearly identified and labeled as a psychopharmacology Program and specified its intent to educate and train psychologists to Prescribe psychotropic medications.  
Yes  No

4. The program had a formally designated program director who was a Psychiatrist or a doctoral psychologist trained in the area of Psychopharmacology and licensed to practice in the jurisdiction in Which the program resides.  
Yes  No

5. The training director was primarily responsible for directing the training program and had administrative authority commensurate with those responsibilities.  
Yes  No

6. The training director’s credentials and expertise were consistent with the program’s mission and goals to train psychologists to prescribe psychotropic medications  
Yes  No

7. The program provided information regarding the minimum level of achievement required for postdoctoral trainees to satisfactorily progress
through and complete the training program, as well as evidence that it adhered to the minimum.  

8. The program had formally designated instructors and supervisors in sufficient number to accomplish the program’s education and training.  

9. Supervisors held an active, unrestricted license in their field of practice in the jurisdiction in which the program resides or where the supervisor was being provided.

10. The program’s supervisors and instructors had sufficient expertise, competence, and credentials in the areas in which they taught or supervised.

11. The program’s instructors and supervisors participated actively in the program planning, implementation, and evaluation.

12. The program, with appropriate involvement from its training supervisors, instructors, and trainees, engaged in a self-study process that addressed:

   A. Expectations for the quality and quantity of the trainees’ preparation and performance in the program
   B. Training goals and objectives for the trainees and the trainees’ views regarding the quality of the training experience and the program
   C. Procedures to maintain current achievements or to make changes as necessary
   D. Goals, objectives, and outcomes in relation to local, regional, and national changes in the knowledge base of psychopharmacology training

13. The program followed the guidelines for psychopharmacology training of postdoctoral psychologists established by the American Psychological Association.

14. Does the program include didactic instruction of no fewer than 450 classroom hours in at least the following core areas:
   * Neuroscience,
   * Pharmacology,
   * Psychopharmacology,
   * Physiology,
   * Pathophysiology
   * Appropriate and relevant physical assessment Clinical pharmacotherapeutics

15. The training program assures that every student completes necessary training in the basic sciences (physiology, chemistry, biochemistry, the biological bases of behavior, and psychopharmacology)

16. When students are not in residence, the program provides on-line access to a library of sufficient diversity and level to support the
advanced study of the psychopharmacological treatment of mental
disorders from wherever the student resides. Access remains
available throughout all didactic and clinical phases of the training program. Yes No

17. Frequent face-to-face evaluation and discussion are included in
the didactic training. Yes No

18. The program provided formal, written, measurement of the mastery
of the course content. Yes No

19. The program demonstrated in its written materials or course syllabi
that integrates into the training the following areas: socio-cultural
issues in psychopharmacological treatment, ethno-pharmacology,
use of translators, the cultural context of compliance and non-compliance
with prescribed medications, creating a culturally appropriate environment
to meet patient care treatment and language needs, and working
collaboratively with traditional healers. Yes No

D. SUBSTANTIATION

1. Please provide documentation that your program addresses the above requirements by providing as
much of the following material as possible and checking below documentation forwarded to the Board.

___________ Program curriculum

___________ University Catalog Description

___________ Relevant Policy Manual

___________ Relevant Student Handbook

___________ Resume of Director

___________ Resumes of Faculty

___________ Evaluation of program by external experts or associations

2. Does the program maintain a website? Yes No
If so, please give url: ________________________________________________

E. EVALUATION OF THE APPLICANT

1. Do you, as training director, certify that the applicant successfully
completed didactic training as outlined above? Yes No
2. Eighty-Hour Practicum

SUPERVISOR

Name:

Address:

City & State:

Telephone No.

Describe the supervisor’s area of practice in which he or she is formally trained and/or certified/licensed?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

License #___________ State:__________ Date of Initial License____________

Was the 80-hour practicum part of the psychopharmacology Training program from which the applicant obtained His/her certification or degree?       Yes No

Did your program receive an evaluation form about this applicant from this supervisor, which discusses the student’s adequate development of skills in:

Assessing a diverse and significantly medically ill population       Yes  No

Observing the progression of illness and continuity of care of individual patients       Yes  No

Adequately assessing vital signs       Yes  No

Demonstrating competent laboratory assessment       Yes  No

Was the 80-hour practicum completed from full-time to over thirty weeks?       Yes  No
3. 400 Hour Practicum in Psychopharmacology

PRIMARY SUPERVISOR
Name:
Address:
City & State:
Telephone No.

Describe the supervisor’s area of practice in which he or she is formally trained and/or certified/licensed.
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
License #___________ State:__________ Date of Initial License____________

SECONDARY SUPERVISOR 1
Name:
Address:
City & State:
Telephone No.

Describe the supervisor’s area of practice in which he or she is formally trained and/or certified/licensed.
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
License #___________ State:__________ Date of Initial License____________

SECONDARY SUPERVISOR 2
Name:
Address:
City & State:
Telephone No.

Describe the supervisor’s area of practice in which he or she is formally trained and/or certified/licensed.
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
License #___________ State:__________ Date of Initial License____________

SECONDARY SUPERVISOR 3

Name:
Address:
City & State:
Telephone No.

Describe the supervisor’s area of practice in which he or she is formally trained and/or certified/licensed.
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
License #___________ State:__________ Date of Initial License____________
Was the 400-hour practicum part of the psychopharmacology training program from which the applicant obtained his/her certification or degree? Yes No

- Did the applicant submit a 400-hour practicum plan to the Practicum Director? Yes No

- Did the practicum meet the following requirements?

  A. A minimum of 100 separate patients? Yes No

  B. A range of disorders listed in the most recent DSM? Yes No

  C. Both acute and chronic conditions? Yes No

  D. 400 hours included time spent with patients to provide evaluation and pharmacotherapy, and time spent in collaboration with treating healthcare practitioners? Yes No

  E. Was there diversity, including gender, ages throughout the life cycle, various ethnicities, socio-cultural background, various economic backgrounds as much as possible within the psychologist’s area of practice? Yes No

  F. Was the primary or secondary supervisor on-site? Yes No

  G. Did the primary/secondary supervisor(s) review charts and records? Yes No

  H. Was there at least one hour of supervision for every eight hours of direct service? Yes No

  I. Did the applicant keep a log of dates & times of supervision? Yes No

  I. Was the practicum completed in no less than 6 months and no more than three years? Yes No

  K. Was the practicum completed within the 5 years preceding this application? Yes No

  L. Is there evidence that during the initial contact with patients or guardians, the status of applicant as a licensed psychologist receiving specialized training in psychopharmacology and who is under supervision was Fully explained? Yes No

- Did the applicant and the training program keep records of time spent during the practicum? Yes No
- Does the program have a coded log, without patient ID, submitted by the applicant, which includes for each of the 100 patients: age, gender, diagnosis, and time spent in treatment  Yes  No

- Does the program have at least two formal written evaluations of the applicant, completed by the primary supervisor, for the practicum experience assessing progress, competence, and deficiencies?  Yes  No

- Did the supervisor(s) certify in writing that the applicant’s performance was satisfactory for the practicum?  Yes  No

- Do you, as training director, certify that the applicant has adequately completed a 400-hour/100-patient practicum  Yes  No

4. Overall evaluation

1. I would rate this student’s performance under my training:
   (Please circle one)

   Excellent         Acceptable         Not Acceptable         Unable to Evaluate

2. REMARKS: The Board would appreciate any information regarding your evaluation in Item 1 above. Please include any information you consider to be relevant regarding the applicant.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
As Director of Training, I certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

____________________________________
Signature of Training Director/Supervisor

____________________________________
Date

Please mail directly to the Board Office upon completion:

New Mexico Board of Psychologist Examiners
P. O. Box 25101
Santa Fe, New Mexico 87505
Please note: to be completed by the supervisor

Supervisor 80-hour practicum

The Board of Psychologist Examiners has received an application for a conditional certificate as a prescribing psychologist from the applicant named below. (To be filled out by Applicant and forwarded on to the Director of the training program)

Applicant:
Address:
City & State:
Telephone No.

We would appreciate you providing the Board with the information requested and return this form directly to the Board office at the above address.

Supervisor

Name:
Address:
City & State:
Telephone No.

Describe the supervisor’s area of practice in which he or she is formally trained and/or certified/licensed?

New Mexico licensure

Is your medical license current and unrestricted? Yes □ No □
Date New Mexico medical license was issued:
License Number and Type of License:
Do you hold any other professional licenses in this or any other jurisdiction? Please list below:

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<th>License No.</th>
<th>Type</th>
<th>State</th>
<th>Status (Active/Inactive)</th>
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Name and Address of Applicant’s Training Director:________________________________________

Date Practicum Began:_________________ Date Practicum Ended:_________________

1. Have you sent an evaluation form about this applicant to the Director of Training discussing the student’s adequate development of skills in:
   a. Assessing a diverse and significantly ill medical population?    Yes □  No □
   b. Observing the progression of illness and continuity of care of individual patients? Yes □  No
   c. Adequately assessing vital signs?    Yes □  No □
   d. Demonstrating competent laboratory assessment? Yes □  No □
   e. Demonstrating competence in physical and health assessment techniques? Yes □  No □

2. Has the student successfully completed the eighty-hours of supervised experience with you as specified in the Prescribing Psychologist Act?    Yes □  No □

The Board would appreciate any comments you might have regarding this applicant’s practicum. Please include any information you consider relevant regarding this applicant.

________________________________________

As the Clinical Supervisor of the 80-Hour Practicum, I certify that all of the statements made in this document are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

________________________________________
Signature of Clinical Supervisor

____________________
Date

Please mail directly to the Board Office upon completion.
New Mexico Board of Psychologist Examiners
P. O. Box 25101
Santa Fe, New Mexico 87505
CONDITIONAL PRESCRIBING PSYCHOLOGIST PROPOSED SUPERVISORY PLAN

Please note: To be completed by supervisor(s)

Name of applicant: ________________________________

To be completed by: Primary supervisor

Primary supervisor name: ________________________________
Address: ____________________________________________
City & state: ____________________________
Telephone no.: ________________________________

Please describe the area of practice in which you are formally trained and/or certified/licensed. If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications.

License no. ____________ State: _______ Date of initial license: _______

Is your license current and unrestricted? Yes No

Do you have any other license in this or any other jurisdiction? Yes No
If yes, explain below.

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State Board of Psychologist Examiners
CONDITIONAL PRESCRIBING PSYCHOLOGIST CERTIFICATE APPLICATION

To be completed by: Secondary Supervisor
Secondary Supervisor Name: ____________________________________________
Address: ____________________________________________________________
City & State: _________________________________________________________
Telephone No.: _______________________________________________________

Please describe the area of practice in which you are formally trained and/or certified/licensed. If you are not a psychiatrist, please indicate your experience and training in prescribing psychotropic medications.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

License No.___________   State:_______   Date of Initial License:_______

Is your license current and unrestricted?  
Yes  No

Do you have any other license in this or any other jurisdiction?
If yes, explain below.
Yes  No

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To be completed by: Primary Supervisor

List beginning and end date(s) of the two-year supervised practice covered by the plan.
Approximate beginning date:__________________ Ending date:__________________

List the setting(s) in which the conditional prescribing psychologist will practice and the hours per week worked at each setting.
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

List duties and clinical responsibilities of the conditional prescribing psychologist.
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
List location(s) where the supervision will occur and with whom.

List areas in which the primary and secondary supervisor(s), if any, have specialized skills to render competent supervision.

List the number and name of the psychologists with conditional prescription certificates that you will be supervising during this time period:

Describe the manner in which the conditional prescribing psychologist will be represented to the public, including all written communications and public announcements. (Please enclose copies of any printed materials.)

Is there any direct or indirect financial agreement between or among the conditional prescribing psychologist and the primary and secondary supervisor(s)?

If yes, please describe the agreement on a separate page.

Describe and other information necessary to clarify the nature and scope of the supervision.

Provide a statement specifying the manner in which supervision and clinical and professional responsibility will be provided during the supervisor’s absence (during vacations or unexpected events that require that supervisor to be absent for any period of time).

As the primary supervisor, will you provide supervision on a one-to-one basis for at least 4 hours per month and a total of at least 46 hours of one-to-one supervision per year?

As the supervising physician, will you have access to and review records relating to the treatment of patients under his/her supervision?
As the primary supervisor will you contact any secondary supervisor(s) at least every six months to obtain written or verbal progress reports concerning how the prescribing psychologist is performing?

| Yes | No |

Will the supervision be provided either face-to-face, telephonically, or by tele-video live communication?

| Yes | No |

Will you, as primary supervisor, inform any secondary supervisor(s) of any concerns about the conditional prescribing psychologist’s performing?

| Yes | No |

Will you maintain a supervision log containing dates, duration, and place/method of supervision, the same identification code for patients as used by the psychologist with a conditional prescribing certificate, and a brief description of the content of supervision?

| Yes | No |

Will you, as primary supervisor, maintain a log of contacts with the secondary supervisor(s)?

| Yes | No |

Will you review the results of laboratory tests as appropriate?

| Yes | No |

**PRIMARY SUPERVISOR AGREEMENT**

I, as a licensed physician, knowledgeable of the administration of psychotropic medications, agree to supervise Dr. _______________________. He/She holds a conditional certificate as a prescribing psychologist.

I have read the above document and agree to comply with the terms and conditions as described above. I understand that the supervisory plan may be modified if I deem appropriate by submitting to the application committee for its approval, a modified plan agreed to be me, any secondary supervisors, and the conditional prescribing psychologist. The intent of my modified plan would be to best reflect the psychologist’s needs for supervision.

____________________________________  ________________________  
Signature of Supervisor     Date

____________________________________  ________________________  
Signature of Psychologist Supervisee    Date
SECONDARY SUPERVISOR AGREEMENT

Please complete this form for each Secondary Supervisor. Make copies as needed.

Secondary Supervisor

Will you, as secondary supervisor, inform the primary supervisor of any concerns about the conditional prescribing psychologist you are supervising? [ ] Yes [ ] No

Will you maintain a supervision log containing dates, duration, place/method of supervision, the same identification code for patients as used by the conditional prescribing psychologist and a brief description of the content of supervision? [ ] Yes [ ] No

Will you review the results of laboratory tests as appropriate? [ ] Yes [ ] No

I, _____________________________, a licensed physician and secondary supervisor, agree to supervise Dr. ______________________________, who holds a conditional certificate as a prescribing psychologist. I have read the above document and agree to comply with the terms and conditions described above.

_____________________________________  ________________________
Signature        Date

_____________________________________  ________________________
Signature of Psychologist Supervisee    Date

Mail to:
New Mexico State Board of Psychologist Examiners
P.O. Box 25101
Santa Fe, NM 87505
Section 3. Section 61-9-1 NMSA 1978 (being Laws 1963, Chapter 92, Section 1) is amended to read:

"61-9-1. SHORT TITLE.–[This act] Chapter 61, Article 9 NMSA 1978 may be cited as the “Professional Psychologist Act”.

Section 4. Section 61-9-3 NMSA 1978 (being Laws 1963, Chapter 92, Section 3, as amended) is amended to read:

"61-9-3. DEFINITIONS.–As used in the Professional Psychologist Act:

A. "board" means the New Mexico state board of psychologist examiners;

B. “conditional prescription certificate” means a document issued by the board to a licensed psychologist that permits the holder to prescribe psychotropic medication under the supervision of a licensed physician pursuant to the Professional Psychologist Act;

[B.] C. "person" includes an individual, firm, partnership, association or corporation;

D. “prescribing psychologist” means a licensed psychologist who holds a valid prescription certificate;

E. "prescription certificate" means a document issued by the board to a licensed psychologist that permits the holder to prescribe psychotropic medication pursuant to the Professional Psychologist Act;

F. "psychotropic medication" means a controlled substance or dangerous drug that may not be dispensed or administered without a prescription and whose primary indication for use has been approved by the federal food and drug administration for the treatment of mental disorders and is listed as a psychotherapeutic agent in drug facts and comparisons or in the American hospital formulary service;

C.] G. “psychologist” means any a person who engages in the practice of psychology or holds himself out to the public by any title or description of services representing himself as a psychologist, which incorporates the words "psychological", "psychologist", "psychology", or when a person describes himself as above and, under such title or description, offers to render or renders services involving the application of principles, methods and procedures of the science and profession of psychology to persons for compensation or other personal gain;
[D.] H. “practice of psychology” means the observation, description, evaluation, interpretation and modification of human behavior by the application of psychological principles, methods and procedures for the purpose of preventing or eliminating symptomatic, maladaptive or undesired behavior and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health and mental health, and further means the rendering of such psychological services to individuals, families or groups regardless of whether payment is received for services rendered. The practice of psychology includes psychological testing or neuropsychological testing and the evaluation or assessment of personal characteristics such as intelligence, personality, abilities, interests, aptitudes and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, behavior analysis and therapy; diagnosis and treatment of any mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct and the psychological aspects of physical illness, accident, injury and disability; and psychoeducational evaluation, therapy, remediation and consultation; and

[E.] I. “school” or “college” means [any] a university or other institution of higher education that is regionally accredited and that offers a full–time graduate course of study in psychology as defined by rule of the board or that is approved by the American psychological association."

Section 5. Section 61–9–17 NMSA 1978 (being Laws 1963, Chapter 92, Section 16, as amended) is amended to read:

“61–9–17. DRUGS–MEDICINES.–[Nothing in the Professional Psychologist Act shall be construed as permitting psychologists or psychologist associates licensed under the Professional Psychologist Act to]

A. Except as provided in Subsections B and C of this section, psychologists or psychologist associates shall not administer or prescribe drugs or medicine or in any manner engage in the practice of medicine as defined by the laws of this state.

B. A licensed psychologist holding a conditional prescription certificate may prescribe psychotropic medication under the supervision of a licensed physician pursuant to the Professional Psychologist Act.

C. A prescribing psychologist may prescribe psychotropic medication pursuant to the Professional Psychologist Act.”
Section 6. A new section of the Professional Psychologist Act is enacted to read:

“[NEW MATERIAL] CONDITIONAL PRESCRIPTION CERTIFICATE—PRESCRIPTION CERTIFICATE—APPLICATION—REQUIREMENTS—RULEMAKING BY BOARD—ISSUANCE, DENIAL, RENEWAL AND REVOCATION OF CERTIFICATION.—

A. A psychologist may apply to the board for a conditional prescription certificate. The application shall be made on a form approved by the board and be accompanied by evidence satisfactory to the board that the applicant:

(1) has completed a doctoral program in psychology from an accredited institution of higher education or professional school, or, if the program was not accredited at the time of the applicant’s graduation, that the program meets professional standards determined acceptable by the board;

(2) holds a current license to practice psychology in New Mexico;

(3) has successfully completed pharmacological training from an institution of higher education approved by the board or from a provider of continuing education approved by the board;

(4) has passed a national certification examination approved by the board that tests the applicant’s knowledge of pharmacology in the diagnosis, care and treatment of mental disorders;

(5) within the five years immediately preceding the date of application, has successfully completed an organized program of education consisting of intensive didactic instruction of no fewer than four hundred fifty classroom hours in at least the following core areas of instruction:

a) neuroscience;

(b) pharmacology;

(c) psychopharmacology;

(d) physiology;

(e) pathophysiology;

(f) appropriate and relevant physical and laboratory assessment; and

(g) clinical pharmacotherapeutics;
(6) within the five years immediately preceding the date of application, has been certified by the applicant’s supervising psychiatrist or physician as having successfully completed a supervised and relevant clinical experience of no less than an eighty-hour practicum in clinical assessment and pathophysiology and an additional supervised practicum of at least four hundred hours treating no fewer than one hundred patients with mental disorders, the practica to have been supervised by a psychiatrist or other appropriately trained physician and determined by the board to be sufficient to competently train the applicant in the treatment of a diverse patient population;

(7) has malpractice insurance in place that will cover the applicant during the period the conditional prescription certificate is in effect; and

(8) meets all other requirements, as determined by rule of the board, for obtaining a conditional prescription certificate.

B. The board shall issue a conditional prescription certificate if it finds that the applicant has met the requirements of Subsection A of this section. The certificate shall be valid for a period of two years, at the end of which the holder may again apply pursuant to the provisions of Subsection A of this section. A psychologist with a conditional prescription certificate may prescribe psychotropic medication under the supervision of a licensed physician subject to the following conditions:

(1) the psychologist shall continue to hold a current license to practice psychology in New Mexico and continue to maintain malpractice insurance;

(2) the psychologist shall inform the board of the name of the physician under whose supervision the psychologist will prescribe psychotropic medication and promptly inform the board of any change of the supervising physician; and

(3) a physician supervising a psychologist prescribing psychotropic medication pursuant to a conditional prescription certificate shall be individually responsible for the acts and omissions of the psychologist while under his supervision. This provision does not relieve the psychologist from liability for his acts and omissions.

C. A psychologist may apply to the board for a prescription certificate. The application shall be made on a form approved by the board and be accompanied by evidence satisfactory to the board that the applicant:

(1) has been issued a conditional prescription certificate and has successfully completed two years of prescribing psychotropic medication as certified by the supervising licensed physician;
(2) holds a current license to practice psychology in New Mexico;

(3) has malpractice insurance in place that will cover the applicant as a prescribing psychologist; and

(4) meets all other requirements, as determined by rule of the board, for obtaining a prescription certificate.

D. The board shall issue a prescription certificate if it finds that the applicant has met the requirements of Subsection C of this section. A psychologist with a prescription certificate may prescribe psychotropic medication pursuant to the provisions of the Professional Psychologist Act if the psychologist:

(1) continues to hold a current license to practice psychology in New Mexico and continues to maintain malpractice insurance; and

(2) annually satisfies the continuing education requirements for prescribing psychologists, as set by the board, which shall be no fewer than twenty hours each year.

E. The board shall promulgate rules providing for the procedures to be followed in obtaining a conditional prescription certificate, a prescription certificate and renewals of a prescription certificate. The board may set reasonable application and renewal fees.

F. The board shall promulgate rules establishing the grounds for denial, suspension or revocation of conditional prescription certificates and prescription certificates authorized to be issued pursuant to this section, including a provision for suspension or revocation of a license to practice psychology upon suspension or revocation of a certificate. Actions of denial, suspension or revocation of a certificate shall be in accordance with the Uniform Licensing Act.”

Section 7. A new section of the Professional Psychologist Act is enacted to read:

“[NEW MATERIAL] PRESCRIBING PRACTICES.–

A. A prescribing psychologist or a psychologist with a conditional prescription certificate may administer and prescribe psychotropic medication within the recognized scope of the profession, including the ordering and review of laboratory tests in conjunction with the prescription, for the treatment of mental disorders.

B. When prescribing psychotropic medication for a patient, the prescribing psychologist or the psychologist with a conditional prescription certificate shall maintain an ongoing collaborative relationship with the health care practitioner who oversees the patient’s general medical care to ensure that necessary medical
examinations are conducted, the psychotropic medication is appropriate for the patient’s medical condition and significant changes in the patient’s medical or psychological condition are discussed.

C. A prescription written by a prescribing psychologist or a psychologist with a conditional prescription certificate shall:

(1) comply with applicable state and federal laws;

(2) be identified as issued by the psychologist as "psychologist certified to prescribe"; and

(3) include the psychologist's board-assigned identification number.

D. A prescribing psychologist or a psychologist with a conditional prescription certificate shall not delegate prescriptive authority to any other person. Records of all prescriptions shall be maintained in patient records.

E. When authorized to prescribe controlled substances, a prescribing psychologist or a psychologist with a conditional prescription certificate shall file with the board in a timely manner all individual federal drug enforcement agency registrations and numbers. The board shall maintain current records on every psychologist, including federal registrations and numbers.

F. The board shall provide to the board of pharmacy an annual list of prescribing psychologists and psychologists with conditional prescription certificates that contains the information agreed upon between the board and the board of pharmacy. The board shall promptly notify the board of pharmacy of psychologists who are added or deleted from the list.

G. For the purpose of this section:

(1) “collaborative relationship” means a cooperative working relationship between a prescribing psychologist or a psychologist with a conditional prescription certificate and a health care practitioner in the provision of patient care, including diagnosis and cooperation in the management and delivery of physical and mental health care; and

(2) “health care practitioner” means a physician, osteopathic physician or nurse practitioner.”

Section 8. EFFECTIVE DATE.—The effective date of the provisions of this act is July 1, 2002.