Megan Dye LLC
(360) 977-8935

MDyeNP@gmail.com
www.megandyenp.com

Consent for Mental Health Evaluation and/or Treatment

Name:

Date of Birth:

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health evaluation and/or treatment by staff from Megan Dye LLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services, including "off-label" use of medications
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable)
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a Psychiatric Nurse Practitioner.Treatment will be conducted within the boundaries of Washington Law. It is my responsibility to update my provider regarding insurance or medical/medication changes, including the use of over the counter medications and supplements.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles, and know I am ultimately responsible for the balance of my account for any professional services rendered. I have been provided a fee schedule with the Policies & Procedures.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Megan Dye LLC, and I consent to disclosure for use by Megan Dye LLC's staff for the purpose of continuity of my care. Per Washington mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; 3) if a court order is issued to obtain records; or 4) pertinent information is needed to make an emergent decision.

5. **Appointment Cancellations:** I understand I am responsible for charges accrued for missed appointments and appointment cancellations without 48-hour advanced notice, unless it is a verifiable emergency. I understand my insurance company will not reimburse for missed sessions.

6. **Termination of Treatment:** Termination of treatment is usually a mutually agreed upon ending of the therapeutic relationship, but some circumstances may result in premature termination or closing of my case. Circumstances include (2) or more unexcused missed appointments within one rotating calendar year, no office appointments scheduled within (30) days of a missed appointment, undisclosed substance use, physical threat to providers or staff, non- compliance with treatment guidelines, or no payment received on my balance over (60) days.

7. **Prescription Refills:** I agree to contact my provider for refill requests 7-10 days before the refill is needed.

8. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

9. **Expiration of Consent:** This consent to treat will expire with termination of services.

By initialing here, I acknowledge that I have received a copy of Megan Dye LLC's Policies and Procedures:

_____
Initials

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____ _____
Signature of client ages 18 years or older **Date**

HIPAA CONSENT

Our notice of privacy practices (on the back) provides information
about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

-Protected health information may be disclosed or used for treatment, payment, or healthcare operation

-The practice reserves the right to change the privacy policy as allowed by law

-The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions

-The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease

-The practice may condition receipt of treatment upon execution of this consent

The following are rare exceptions where pertinent health information may be shared without written consent:

-A patient is an imminent danger to themselves or others.

-A court has subpoenaed me to testify or has subpoenaed my records.

-An insurance company is helping to pay the fee and requires information about diagnosis and/or reports about treatment

-An emergent decision needs to be made in the absence of consent but where clinical information is needed to make that decision.

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature:_____ Date:_____

Witness:_____ Date:_____

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HIPAA CONSENT

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMRATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

**Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
**Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
**Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we already have taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Offer.

**The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any person identifiable by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

**The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alterative locations.
**The right to inspect and copy your protected health information.
**The right to amend your protected health information.
**The right to receive an accounting of disclosures of protected health information.
**The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of January 1, 2017 and we are required to abide by the terms of this Notice of Privacy Practice currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint:

The US Dept of Health and Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington, DC 20201 202-619-0257 or 1-800-696-6775

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Megan Dye LLC

Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Megan Dye LLC to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychiatric health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; expressed intent to imminently harm myself; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Megan Dye LLC utilizes secure,encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my provider believes I would be better served by another form of intervention (e.g., face-to-face services), I will be offered referrals, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to care through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my provider, I may be directed to “face-to-face” care.
6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
8. I understand that my express consent is required to forward my personally identifiable information to a third party.
9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based mental health services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

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Megan Dye LLC

11. I understand that different states have different regulations for the use of telehealth and that such services offered by Megan Dye LLC may be temporary based on urgent and unprescedented global circumstances.

Payment for Telehealth Services
Megan Dye LLC will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, payment at the time of service is required.

Patient Consent to the Use of Telehealth
I have read and understand the information provided above regarding telehealth, have discussed it with my provider, and all of my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____
Print Name

_____ _____
Patient's Signature Date

_____ _____
Parent or Guardian Signature for minor under 18 Date

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Megan Dye ARNP, PMHNP, BC

Policies & Procedures

PRACTICE DETAILS:

Appointment times vary in length depending on the service. An initial (new client) visit is 90 minutes in length. Follow up visits are 15-45 minutes depending on psychotherapy involved.

Your appointment time is held exclusively for you. All non-emergency cancellations with less than 48 hours notice will be charged a late cancellation fee of $100. You are responsible for payment of that charge as your insurance company will not pay for a missed session. To make or reschedule an appointment, please call my confidential business number at 360-977-8935. Please arrive on time for your appointment; you use your own time when you are late. Patients are subject to termination of treatment if they miss 2 sessions within a 365-day period.

On call/coverage: I share call rotation with a group of Psychiatric Nurse Practitioners. You will be notified by calling my voicemail if another Nurse Practitioner is covering for urgent needs. Medication refills are not considered an urgent need and should be planned for many days in advance. In emergent situations, patients should call 911 or go to the nearest emergency room.

By consenting to treatment, you agree to provide 7-10 days' notice prior to a needed refill. Please leave a voicemail or request your pharmacy fax a refill request to 360-597-3822. Medication changes will not be made outside of appointments (urgent situations are exempt). Clients on controlled medications, like benzodiazepines or stimulants, are required to be seen every 3 months or sooner (typically monthly) based on this provider's discretion. There will be no controlled substance refills in between appointments.

FEES:

Initial evaluation - 99204, 99205	$400.00/$450.00
Psychotherapy – 90833	$150.00
Psychotherapy – 90836	$200.00
Psychotherapy – 90838	$250.00
Established pt., E & M, complexity – 99213	$150.00
Established pt., E & M, complexity – 99214	$200.00
Established pt., E & M, complexity – 99215	$300.00
Interactive complexity code with E & M and psychotherapy – 90785	$20.00
Letters and other paperwork services	$35.00 and up

PAYMENTS:

1. Insurance co-payment and deductible are due at time of service. Please bring a form of payment at each visit. I accept cash, checks, and cards. Payment for returned checks must be made immediately. There is a $25 processing fee for each returned check.
2. Past due accounts may be sent to collections or legal action may be taken. You agree to be responsible for any collection or court costs or attorney fees.
3. Please call your insurance to verify your benefits prior to your appointment. Mental Health benefits may be through another insurance carrier than your medical plan. Throughout the treatment process, patients are responsible for tracking any changes to their coverage and updating this provider accordingly.

CRISIS:

The crisis line can be reached at 360-696-9560. For medical or mental health emergencies, please call 911 or proceed to the nearest Emergency Department.

Authorization for Release of Information:

Name: _____ Date: _____ DOB:_____

I authorize the following individual or agency:

_____ _____

Name of facility or provider disclosing information Address

_____ _____

Phone Fax Number

I authorize the release of my health care information to:

Megan Dye, MN, ARNP, BC 7600 NE 41st Street, Suite 310, Vancouver, WA 98662

By marking the space below, I specifically authorize the release of the following medical record/s, if such records exist:

_____ Psychiatric Treatment

_____ Mental Health Services

_____ Alcohol/ Drug Treatment or Referral

_____ Medical Treatments

_____ Labs (last 6 months)

_____ HIV/ AIDS status

_____ Other / Description _____

I agree that the agencies and individuals listed above may share and exchange information about my family and my circumstances _____ YES _____ NO

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me, my family, or for other purposes as specified: COORDINATION OF CARE

Signature: _____ Date: _____

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Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date_____

Date of Birth _____ Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor_____ Therapist's Phone_____

What are the problem(s) for which you are seeking help?
1._____
2._____
3._____

What are your treatment goals?
_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

Suicide Risk Assessment
Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

Past Medical History:

Allergies_____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____
_____
_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements: _____
_____

Current medical problems: _____
_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____
_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ .
Was the EKG ( ) normal ( ) abnormal or ( ) unknown**?**

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam: _____

Personal and Family Medical History:

	You	**Family**	**Which Family Member?**
Thyroid Disease ----------	( )	( )	_____
Anemia----------	( )	( )	_____
Liver Disease ----------	( )	( )	_____
Chronic Fatigue ----------	( )	( )	_____
Kidney Disease ----------	( )	( )	_____
Diabetes ----------	( )	( )	_____
Asthma/respiratory problems ------	( )	( )	_____
Stomach or intestinal problems ---	( )	( )	_____
Cancer (type) ----------	( )	( )	_____
Fibromyalgia ----------	( )	( )	_____
Heart Disease ----------	( )	( )	_____
Epilepsy or seizures ----------	( )	( )	_____
Chronic Pain ----------	( )	( )	_____
High Cholesterol ----------	( )	( )	_____
High blood pressure----------	( )	( )	_____
Head trauma ----------	( )	( )	_____
Liver problems ----------	( )	( )	_____
Other ----------	( )	( )	_____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

_____

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Dates Dosage Response/Side-Effects

Antidepressants

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Cymbalta (duloxetine) _____

Wellbutrin (bupropion) _____

Remeron (mirtazapine) _____

Serzone (nefazodone) _____

Anafranil (clomipramine) _____

Pamelor (nortrptyline) _____

Tofranil (imipramine) _____

Elavil (amitriptyline) _____

Other _____

Mood Stabilizers

Tegretol (carbamazepine)_____

Lithium_____

Depakote (valproate) _____ _____

Lamictal (lamotrigine) _____

Tegretol (carbamazepine) _____

Topamax (topiramate) _____

Other _____

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other			

Sedative/Hypnotics

Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon)_____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other _____

ADHD medications

Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Other _____

Antianxiety medications

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____
Other _____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____
_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment? _____
_____

Substance Use:
Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____
_____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? _____
_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Other			_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:
How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? **( )** Yes **( )** No How many packs per day on average? _____ How many years? _____
In the past? **( )** Yes **( )** No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? **( )** Yes **( )** No In the past? **( )** Yes **( )** No
What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when? _____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom: _____
_____

Educational History:
Highest Grade Completed? _____ Where? _____
Did you attend college? _____ Where? _____Major? _____
What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No Other type discharge _____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed
How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer
What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other:
_____
Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____
How long? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____
_____
Describe your relationship with your children: _____
List everyone who currently lives with you: _____
_____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

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Signature_____Date_____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____Date _____

Reviewed by _____Date _____

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
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GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Adult Version

These questions refer to the past 12 months.	**Circle Your Response**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Have you abused prescription drugs?	Yes	No
3. Do you abuse more than one drug at a time?	Yes	No
4. Can you get through the week without using drugs?	Yes	No
5. Are you always able to stop using drugs when you want to?	Yes	No
6. Have you had "blackouts" or "flashbacks" as a result or drug use?	Yes	No
7. Do you every feel bad or guilty about your drug use?	Yes	No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10. Have you lost friends because of your use of drugs?	Yes	No
11. Have you neglected your family because of your use of drugs?	Yes	No
12. Have you been in trouble at work (or school) because of drug abuse?	Yes	No
13. Have you lost your job because of drug abuse?	Yes	No
14. Have you gotten into fights when under the influence of drugs?	Yes	No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16. Have you been arrested for possession of illegal drugs?	Yes	No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19. Have you gone to anyone for help for drug problem?	Yes	No
20. Have you been involved in a treatment program specifically related to drug use?	Yes	No

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

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Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B