New Beginnings Behavioral Health
Shelley L. Geil, DNP, ARNP-BC
Patient Intake Form

Please complete all information on this form and bring it to the first visit.

Today's Date: _____

Patient's Full Name: _____

Date of Birth (DOB): _____ **Sex:** _____ **Marital Status:** _____

Address: _____

Mailing Address (if different): _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Message:** _____ **Alternate Phone** _____ **Message:** _____

Length at Present Address: _____ **Social Security #:** _____

E-Mail: _____
***This will be used for automated appointment reminders only and cannot be used to communicate with providers or staff**

Employer: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Responsible Party: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security #: _____ **Employer:** _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Spouse of Responsible Party: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security #: _____ **Employer:** _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact: _____

Home Phone: _____ **Alternate Phone:** _____

Insurance Information

Primary Insurance Name	Secondary Insurance Name:
Address:	Address:
City, State, Zip Code:	City, State, Zip Code
Group Number:	Group Number:
ID Number:	ID Number
Insured Name:	Insured Name:

****

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Shelley L. Geil, DNP, ARNP-BC. to:

- Furnish my insurance company with any/all information requested concerning my present claim(s).
- Bill my insurance company and accept payment from that company on my behalf for all services from time to time relating to my case.

I acknowledge that I am responsible for all charges not covered by my insurance. I agree that if costs or fees are incurred in connection with the collection of this account, I will pay all such costs and fees, including, but not limited to, collection costs, attorney's fees and all court costs. I understand that failure to resolve any outstanding balance may result in my account being referred to a collection agency if it remains delinquent without a response from me.

NOTICE OF INFORMATION PRACTICES

Notice: We keep a record of the health-care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it from our office staff. The fees for copying records, searching for records or editing records are as follows:

Copying	$1.00 per page for the first 30 pages $1.50 for each additional page
Searching	$30.00 per search
Editing by the physician personally when required by statute	Basic office visit charge

All copies will be released only upon receipt of payment.

Patient's signature (if 18 or older)	Date	Responsible party signature (if for a minor)

New Beginnings Behavioral Health
Shelley L. Geil, DNP, ARNP-BC

Office Policies

This statement contains information regarding my office policies. Please read them and, if you have any questions, please discuss them with me. Your signature at the bottom of this sheet signifies you have read, understood, and agree to abide by these policies, and that you have received a copy of the policies for yourself.

APPOINTMENTS:

Appointment times vary in length depending on the service and complexity. Initial evaluations are 60 minutes; psychotherapy sessions are generally 30-60 minutes; medication management visits are 10-40 minutes.

Your appointment time is held exclusively for you and cannot usually be filled on short notice. **Unless cancelled with 48-hour advance notice, you will be charged a $150 missed appointment fee. Messages can be left on my voice mail 24 hours a day 360 571- 2134. If you no show for 2 appointments within a 365 day period, the termination process may begin.**

Emergency cancellations that occur less then 48 hours advance notice will be handled on an individual basis. Please note that insurance companies will not cover this charge and you will be responsible for covering this fee in full.

For **severe weather** events, please follow the Vancouver Public School System alerts. If the Vancouver school district is closed due to weather, my office will be closed, and we will work to re-schedule you.

INSURANCE:

We will bill your insurance for our services however, this can only occur if you provide us with current insurance information. It is your responsibility to provide us with updated insurance in the event of a change of coverage. Co-payments are to be paid at the time of the service. We will assist you, but you are responsible to check with your insurance company regarding your coverage. We do not guarantee payment from your insurance company. You are responsible for bills whether insurance pays or not. If your insurance company has not paid your account in full within 90 day, the balance will be automatically due and payable by you.

FEES:

60 minute initial evaluation 90791 or 90792	$350.00
30 minute psychotherapy with patient/family member with E&M service 90833	$150.00
45 minute psychotherapy with patient/family member with E & M service 90836	$200.00
60 minute psychotherapy with patient/family member with E &M service 90838	$250.00
Office visit, evaluation & management (E&M) 10 minutes established patient 99212	$100.00
Office visit, E & M, 15 minutes established patient 99213	$200.00
Office visit E & M 25 minutes established patient 99214	$250.00
Office visit E & M 40 minutes established patient 99215	$300.00
Office visit E & M new patient 60 minutes 99204/ 99205	$350.00/$400.00
Interactive complexity code in addition to psychotherapy, E&M visit 90785	$20.00
Additional services (your request or benefit)	$400/hour

PAYMENTS & INSURANCE:

1. Insurance co-payment and deductible are due at time of service.
2. It is your responsibility to provide us with current or updated insurance information.
3. You are responsibility for the bills whether insurance pays or not. If your insurance company has not paid your account in full within 90 days, the balance will be automatically due and payable by you.
4. You will be billed monthly for any outstanding balance. Payment is due by the 15th of the month.
5. There is a $35 returned check fee and payment must be made immediately
6. Seriously past due accounts may be sent to collections or legal action may be taken.
7. You agree to be responsible for any collection or court costs or attorney fees.

Emergency Calls:

We are not equipped to handle acute emergencies. If you have a non-emergent problem and wish to speak with me leave a message at the office and I will attempt to contact, you as soon as I am able. You can also page me at (360) 690-3014. If you need immediate support for an emergency, you may contact the Crisis Line at (360) 696-9560 or visit the nearest ER. When I am unavailable, another clinician will be available again for non-emergent issues. Please plan ahead, refills of medications are **not** emergencies.

Confidentiality and the Release of Information:

By law all information you share during the evaluation, psychotherapy and medication management visits remains confidential. Such information can only be released with the written consent of the patient, or in the case of a minor, the parent or guardian.

Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. The only exceptions are: a) cases of suspected abuse or neglect of a child or elder, b) cases where I believe the client presents a clear and imminent danger to him/herself or to another person, c) cases where a court subpoenas me to testify or subpoenas my records or d) cases where an insurance company is helping to pay your fee and requires information about diagnosis and/or reports about treatment.

HIPAA Notice of Policies and Practices:
We are committed to preserving the privacy of your personal health information. Additionally, we are required by the Federal law (Health Insurance Portability and Accountability Act, known as HIPAA), and by State law to protect the privacy of your personal information and to offer you a Notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information. Please ask for a copy of the *HIPAA Notice of Policies and Practices* should you wish to have a complete copy for your records.

Your signature below indicates that you have read this agreement and agree to its terms. Your signature also serves as an acknowledgment that you have received the *HIPAA Notice of Policies and Practices* described above.

I HAVE READ THE ABOVE POLICIES AND AGREE WITH THE TERMS

Please print patient name:_____

Signature:_____ Date _____

Witness_____ Date _____

New Beginnings Behavioral Health
Shelley L. Geil, DNP, ARNP-BC

Patient Name:_____DOB: _____

I understand that Shelley L. Geil, DNP, ARNP-BC is not a contracted provider for Medicare, Medicaid, Oregon Medical Assistance Program (OMAP), Oregon Health Plan (OHP), Crime Victims or Labor and Industry. Dr. Geil will not bill any of these agencies

These services may be available through a contracted provider. If you choose a contracted provider, these services will be paid for up to the allowable amount.

Patient's Request and Consent for Non-Medicare Services:

I provide this Request and Consent to protect my future access to private medical care based on payments using Medical Savings Accounts or other private payment methods. I request and consent that the medical office of Dr. Geil ("this private provider") provide medical services to me outside of the Medicare and other government programs in emergency and non-emergency circumstances. I acknowledge and consent that no documentation will be provided for such services to enable reimbursement from Medicare or other governmental programs.

Neither I nor my heirs, executors, administrators, successors, beneficiaries, or assigns will submit a claim (or request that a claim be submitted) for services provided by this private physician. I acknowledge that such services may fall within the scope of Medicare or other governmental programs, and that I have the right to seek such services from other providers if I wish to obtain reimbursement by the government. I consent that the fees charged by this private physician for such services may be greater or less than limiting charges established by Medicare or other programs.

I hereby acknowledge and consent that this private physician is justified in relying upon this Request and Consent in providing all future services to me, whether during an emergency or not. In the event that I take any action contrary to this Request and Consent which causes administrative or legal expense to this private physician, I will provide reasonable reimbursement.

THIS IS NOT A PRIVATE CONTRACT FOR ANY ITEM OR SERVICE. THE UNDERSIGNED IS NOT OBLIGATED IN ANY MANNER TO OBTAIN ANY MEDICAL SERVICES FROM THIS PRIVATE PROVIDER AND REMAINS FREE TO SEEK MEDICAL CARE FROM ANY OTHER PROVIDER AT ANY TIME. THIS FORM IS CONFIDENTIAL, AND MAY NOT BE CONSTRUED TO ALLOW DISCLOSURE OF ANY INFORMATION CONCERNING PATIENT.

I have disclosed all of my insurance information, including any coverage through any of the agencies listed above.

Patient's Name _____

Patient's Signature (or responsible party)_____

Date _____

New Beginnings Behavioral Health
Shelley L. Geil, DNP, ARNP-BC

Acknowledgment of Confidential Information to Primary Care Physician

Patient Name: _____

Date of Birth: _____

I acknowledge that information about my mental health outpatient treatment may be shared with my primary care physician and behavioral healthcare professional to coordinate care if necessary and appropriate.

Patient Signature:_____

Date:_____

Primary Care Physician: _____

City:_____Phone: (____)_____Fax: (____)_____

****

The above-named patient is being seen by me, Shelley L. Geil, DNP, ARNP-BC, on an outpatient basis.

My initial diagnosis is:_____

Treatment consists of:_____

_____

If you are prescribing medications or have other information that might relate to this treatment, please feel free to mail or fax a summary to **(360) 253-3196.** If you need additional treatment information, or wish to coordinate this patient's treatment with me, please feel free to call me at **(360) 253-6425.**

Date form sent to PCP:_____Sent by:_____

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. 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
( ) Increased sleep
( ) Loss of interest in usual activities
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Overwhelmed
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Hopeless
( ) Helpless
( ) 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, non-psychiatric hospitalization, or surgeries: _____

_____

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

Have you ever had a sleep study ( ) Yes ( ) No, If yes, when _____
Was the sleep study ( ) normal ( ) abnormal or ( ) unknown

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? _____

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: _____

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? _____

Personal and Family Medical History:

	You	**Family**	**Which Family Member?**
Anemia	( )	( )	_____
Asthma/Respiratory Problems	( )	( )	_____
Cancer (type)	( )	( )	_____
Chronic Fatigue	( )	( )	_____
Chronic Pain	( )	( )	_____
Diabetes	( )	( )	_____
Epilepsy or Seizures	( )	( )	_____
Fibromyalgia	( )	( )	_____
Heart Disease	( )	( )	_____
High Blood Pressure	( )	( )	_____
High Cholesterol	( )	( )	_____
Kidney Disease	( )	( )	_____

Personal and Family Medical History Continued:

	You	Family	Which Family Member?
Liver Disease	( )	( )	_____
Stomach or Intestinal Problems	( )	( )	_____
Other	( )	( )	_____
Other	( )	( )	_____
Other	( )	( )	_____

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

_____

_____

Prenatal History:

Did your mother receive regular prenatal care? ( ) Yes ( ) No Comments: _____

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

_____

Developmental History:

Did you meet developmental milestones? ( ) Yes ( ) No Comments:_____

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).

Antidepressants	Dates	Dosage	Response/Side-Effects
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)			
Trintellix (vortioxetine)			
Pristiq (desventafaxin)			
Desyrel (trazodone)			

Past Psychiatric Medications Continued:

	Dates	Dosage	Response/Side-Effects
Vibryd (vilazodone)			
Adamin (doxepin)			
Asendin (amocapine)			
Ludiomil (maprotiline)			
Norpramin (desipramine)			
Surmontil (trimipramine)			
Vivctil (protriptyline)			
Other			
Mood Stabilizers	Dates	Dosage	Response/Side--Effects
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Topamax (topiramate)			
Vraylar (Cariprazine)			
Other			
Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Rexulti (brexpiprazole)			
Latuda (lurasidone)			
Other			
Sedative/Hypnotics	Dates	Dosage	Response/Side-Effects
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			
ADHD medications	Dates	Dosage	Response/Side-Effects
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Vyvanse (lisdexamfetimine)			
Other			
Antianxiety medications	Dates	Dosage	Response/Side-Effects
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Other			

Family Psychiatric History:

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

ADHD/ADD	( ) Yes	( ) No	If yes, who? _____
Bipolar disorder	( ) Yes	( ) No	If yes, who? _____
Schizophrenia	( ) Yes	( ) No	If yes, who? _____
Depression	( ) Yes	( ) No	If yes, who? _____
Post-Traumatic Stress	( ) Yes	( ) No	If yes, who? _____
Alcohol Abuse	( ) Yes	( ) No	If yes, who? _____
Other substance abuse	( ) Yes	( ) No	If yes, who? _____
Anxiety	( ) Yes	( ) No	If yes, who? _____
Other	( ) Yes	( ) No	If yes, who/what? _____
Other	( ) Yes	( ) No	If yes, who/what? _____

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 which were NOT prescribed for you?:

	Yes	No	If yes, how long and when did you last use
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Other	( )	( )	_____

How many caffeinated beverages do you drink a day? Coffee_____Sodas_____Tea_____
Energy Drinks: _____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No Do you currently smoke cigarettes? **( )** Yes **( )** No
How many packs per day on average?_____How many years? _____
How many years did you smoke?_____When did you quit? _____
Have you ever used electronic cigarettes? ( ) Yes ( ) No Do you currently use e-cigarettes? ( ) Yes ( ) No
How many electronic cigarettes per day on average?_____How many years? _____
How many years did you use e-cigarettes? _____When did you quit? _____
Pipe, cigars, or chewing tobacco: Do you currently use tobacco products? **( )** Yes **( )** No
Have you used tobacco products 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 were you born? _____
Where did you grow up?_____
How would you describe your childhood?_____
_____
_____
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: _____
_____
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: _____
_____
Have your witnesses traumatic events during your life? (car accident, war, shooting)
Please describe: _____
_____

Educational History:

Highest grade completed?_____Where?_____

Relationship History and Current Family:
Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) unsure/questioning ( ) asexual ( ) other
( ) prefer not to answer
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?

_____
_____
_____
_____
_____
_____
_____
_____

Signature_____Date_____

Guardian Signature (if underage 18)_____Date_____

Emergency Contact_____Telephone # _____

For Office Use Only:

Reviewed by_____Date_____

Reviewed by_____Date _____

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...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 you didn't really miss it?	○	○
...you were much 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 much 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 into 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? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

The Bipolar Spectrum Diagnostic Scale (BSDS)

Instructions:

Please read through the entire passage below before filling in any blanks.

Some individuals notice that their mood and/or energy levels shift drastically from time to time_____.

These individuals notice that, at times, their mood and/or energy level is very low, and at other times, very high_____.

During their "low" phases, these individuals often feel a lack of energy; a need to stay in bed or get extra sleep; and little or no motivation to do things they need to do_____.

They often put on weight during these periods_____.

During their low phases, these individuals often feel "blue", sad all the time, or depressed_____.

Sometimes, during these low phases, they feel hopeless or even suicidal_____.

Their ability to function at work or socially is impaired_____.

Typically, these low phases last for a few weeks, but sometimes they last only a few days_____.

Individuals with this type of pattern may experience a period of "normal" mood in between mood swings, during which their mood and energy level feels "right" and their ability to function is not disturbed_____.

They may then notice a marked shift or "switch" in the way they feel_____.

Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do_____.

Sometimes, during these "high" periods, these individuals feel as if they have too much energy or feel "hyper"_____.

Some individuals, during these high periods, may feel irritable, "on edge", or aggressive_____.

Some individuals, during these high periods, take on too many activities at once_____.

During these high periods, some individuals may spend money in ways that cause them trouble_____.

They may be more talkative, outgoing, or sexual during these periods_____.

Sometimes, their behavior during these high periods seems strange or annoying to others_____.

Sometimes, these individuals get into difficulty with co-workers or the police, during these high periods_____.

Sometimes, they increase their alcohol or non-prescription drug use during these high periods_____.

Now that you have read this passage, please check one of the following four boxes:

( ) This story fits me very well, or almost perfectly
( ) This story fits me fairly well
( ) This story fits me to some degree, but not in most respects
( ) This story does not really describe me at all

Now please go back and put a check after each sentence that definitely describes you.

Scoring: each sentence checked is worth one point. Add 6 points for "fits me very well," 4 points for "fits me fairly well," and 2 points for "fits me to some degree."

Total Score = _____

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Careqiver

Today's Date: _____

Child's Name: _____ *Date of birth:* _____

Your Name: _____ *Relationship to Child:* _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	*Happened to me*	*Witnessed it*	*Learned about it*	*Not Sure*	*Doesn't apply*
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 or 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 are 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 figety 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	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these 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 _____

A2663B 10-04-2005

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

OCI-R

The following statements refer to experiences that many people have in their everyday lives. Circle the number that best describes **HOW MUCH** that experience has **DISTRESSED or BOTHERED you during the PAST MONTH.** The numbers refer to the following verbal labels:

0 Not at all	1 A little	2 Moderately	3 A lot	4 Extremely

1.	I have saved up so many things that they get in the way.	0	1	2	3	4
2.	I check things more often than necessary.	0	1	2	3	4
3.	I get upset if objects are not arranged properly.	0	1	2	3	4
4.	I feel compelled to count while I am doing things.	0	1	2	3	4
5.	I find it difficult to touch an object when I know it has been touched by strangers or certain people.	0	1	2	3	4
6.	I find it difficult to control my own thoughts.	0	1	2	3	4
7.	I collect things I don't need.	0	1	2	3	4
8.	I repeatedly check doors, windows, drawers, etc.	0	1	2	3	4
9.	I get upset if others change the way I have arranged things.	0	1	2	3	4
10.	I feel I have to repeat certain numbers.	0	1	2	3	4
11.	I sometimes have to wash or clean myself simply because I feel contaminated.	0	1	2	3	4
12.	I am upset by unpleasant thoughts that come into my mind against my will.	0	1	2	3	4
13.	I avoid throwing things away because I am afraid I might need them later.	0	1	2	3	4
14.	I repeatedly check gas and water taps and light switches after turning them off.	0	1	2	3	4
15.	I need things to be arranged in a particular way.	0	1	2	3	4
16.	I feel that there are good and bad numbers.	0	1	2	3	4
17.	I wash my hands more often and longer than necessary.	0	1	2	3	4
18.	I frequently get nasty thoughts and have difficulty in getting rid of them.	0	1	2	3	4

Updated STOP-Bang Questionnaire

Yes ○ No ○ **S**noring?
Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

Yes ○ No ○ **T**ired?
Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?

Yes ○ No ○ **O**bserved?
Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?

Yes ○ No ○ **P**ressure?
Do you have or are being treated for **High Blood Pressure**?

Yes ○ No ○ **B**ody Mass Index more than 35 kg/m^2?

Yes ○ No ○ **A**ge older than 50 year old?

Yes ○ No ○ **N**eck size large? (Measured around Adams apple)
For male, is your shirt collar 17 inches/43 cm or larger?
For female, is your shirt collar 16 inches/41 cm or larger?

Yes ○ No ○ **G**ender = Male?

Scoring Criteria: