Abhishek Rai, MD, Inc. Psychiatry
2600 East Bidwell Street. Suite 220 Folsom, CA 95630
747-200-0022 (Office) 747-261-1663 (Fax)

PATIENT INTAKE FORMS, INTRODUCTION

Dear Valued Community Member,

We are delighted that you have chosen to embark on your journey towards recovery. It is our privilege to extend our support and services to assist you throughout this process.

Our clinic specializes in integrative psychiatry and psychiatric services, ensuring a comprehensive and personalized approach to your care. We take pride in dedicating our undivided attention to you and your loved ones, and we appreciate your patience as we initiate the initial intake process.

The initial intake packet encompasses essential information that enables us to provide tailored care. Should you have any queries during this process, please do not hesitate to reach out to our friendly staff members. Your comprehensive health history and thoughtful responses allow us to optimize our services and treatments for you and your loved ones, fostering a collaborative journey towards healing.

Integrative Psychiatry integrates both conventional and complementary medicine approaches in treating psychiatric disorders. While conventional remedies, such as medication, are common, complementary remedies emphasize holistic well-being and empowerment. Our clinic focuses on partnering with individuals to influence and heal mental health disorders through techniques like sleep hygiene, dietary considerations, mindfulness practices, and grounding exercises.

Our treatment program encompasses medication, psychotherapy, dietary guidance, exercise recommendations, and sleep management, all aimed at holistic wellness.

Please note that our practice operates on a cash-pay basis and does not process insurance claims. Furthermore, we are unable to accept patients eligible for Medicare due to specific program requirements.

Thank you for choosing us as your healthcare partner. We look forward to accompanying you on your path to wellness.

Welcome!

Abhishek Rai, MD

OFFICE USE ONLY

NAME OF FORM	YES	NO
Face Sheet and Demographics		
HIPAA		
Consent for Assessment, Treatment, and Arbitration		
Release of Information		
Fee Schedule Agreement for All Patients		
Credit Card Authorization Agreement		
Controlled Medication Refill Policy		
Electronic / Text Communication		

Signature of Receptionist Verifying Packet:

____ Date: ___________________

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PATIENT INFORMATION		
First Name:	Last Name:	DOB:
Street Address:		Apartment Number:
City:	State:	Zip Code:
Daytime Phone #: ______________________________ Is it ok to leave a voicemail at this #? **Choose one:** *Yes* *No*	Evening Phone #: ______________________________ Is it ok to leave a voicemail at this #? **Choose one:** *Yes* *No*	Cell Phone #: ______________________________ Is it ok to leave a voicemail at this #? **Choose one:** *Yes* *No*
Which phone number do you prefer we contact? :	Referred by:	

EMERGENCY CONTACT INFORMATION		
Emergency Contact Name:	Relationship:	
Cell Phone #:	Alternative Phone #:	Which phone number do we contact first? **Circle one:** *Cell phone* *Alternative #*

I certify that the above information is correct and that I give Abhishek Rai, MD Inc. permission to render services to me and to release information about me to insurance carrier(s) for medication approvals.

Patient Signature: ____ **Date:** _______________

Guardian Signature:____ **Date:** _______________
(if patient is a minor)

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HIPAA – a.k.a. "SUMMARY OF PRIVACY PRACTICES"

A federal regulation called Health Insurance Portability and Accountability Act (HIPAA) requires that you be given information about how your personal health information is handled. This Act requires so much information, in fact, that it is difficult to condense all the information into a concise form for you to sign. For the detailed version of HIPAA, please visit www.hhs.gov/ocr/privacy/index.html.

In this document, we have attempted to explain what you *really need to know*. After reading this, please sign at the bottom.

YOUR RECORD AND CONFIDENTIALITY
Abhishek Rai, MD Inc. will not send your medical information out, or provide information about you to someone else, without your written permission (which you can later revoke at any time). DR. ABHISHEK RAI INC. *is* allowed to *receive* information about you from others, though we are *not* allowed to confirm that you are a patient of ours. DR. ABHISHEK RAI INC. must take care to not reveal information about you in the process of listening to others. Examples of DR. ABHISHEK RAI INC. receiving information about you include receiving a voicemail about you from a family member.

There are three main exceptions to the complete confidentiality of your records:
EXCEPTIONS TO CONFIDENTIALITY

1) **LEGAL**: A court may subpoena your records, which means they are forcing DR. ABHISHEK RAI INC. to give information about you, including talking to some opposing attorney on the telephone or in court. You get to object first, in court if necessary. The HIPAA rule also says "law enforcement" may request information for public safety purposes. will handle these requests with great restraint and skepticism.
2) **DANGER:** If you or someone else is in danger, a health provider is *legally required* to reveal information about you, if it is thought necessary to protect you or another person. Examples of this include you informing a clinician that you intend to harm yourself or someone else.
3) **ABUSE:** When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is *legally required* to take steps to protect the child, and to inform the proper authorities.

I have received Abhishek Rai, MD Inc. Summary of Privacy Practices

Patient Signature: ____ **Date:** _______________

Guardian Signature:____ **Date:** _______________
(if patient is a minor)

CONSENT FOR ASSESSMENT & TREATMENT

This is a legal form authorizing us to evaluate you and treat you.

CONSENT FOR ASSESSMENT & TREATMENT
I understand that as a patient at Abhishek Rai MD Inc., Psychiatry Clinic, I may receive a range of mental health and wellness services. The type and extent of services that I receive will be determined following an initial assessment and will be discussed with you by your physician. The goal of the assessment process is to determine the best course of treatment for me.

I consent to participate in the evaluation and treatment offered to me by the clinic. I understand that either the clinic or I may discontinue treatment at any time.

Though my provider will do his/her best to fully advise me on the pros and cons of treatment options, I understand that it is also my responsibility to speak up and ask questions if I am confused about any of the recommended therapies. I acknowledge that there is no guarantee that I will be cured, or that a given treatment will be effective for me personally. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

Patient Signature: ____ **Date:** _______________

Guardian Signature:____ **Date:** _______________
(if patient is a minor)

ARBITRATION AGREEMENT

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

The patient signing below represents that he/she is giving his/her consent knowingly and voluntarily without any element of force, deceit duress or other form of constraint or coercion, with a general knowledge of the medical and psychiatric procedures outlined above, is aware of the circumstances and is physically and mentally competent to give consent.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE THE FIRST PARAGRAPH OF THIS ARBITRATION AGREEMENT.

IN WITNESS, the parties have signed this agreement.

Patient Signature: _______________________________________ **Date:** _______________

Guardian Signature:_______________________________________ **Date:** _______________
(if patient is a minor)

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CONSENT TO RELEASE/RECEIVE INFORMATION

(This is the form that you need to complete if you would like to grant permission for us to obtain and/or share your information with anyone in your life. Even if you refuse permission, you must sign this form.)

I hereby grant my provider at Abhishek Rai, MD, Inc. to release and/or receive information from the following person(s):

SUGGESTED	NAME	CITY	PHONE	FAX OR EMAIL
Primary Care Physician				
Other Mental Health Specialist				
Other Medical Specialist				
Spouse / Support Person				
Other family member (specify relationship)				

OR ☐ I do not give permission to anyone, except as described in the paragraph below.

Description of information that may be disclosed:
____

Purpose of the disclosures:
____

Expiration date of consent to release information: ______________________________

Patient Signature: ____ **Date:** _______________

Guardian Signature:____ **Date:** _______________
(if patient is a minor)

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FINANCIAL AGREEMENT

(This document describes our fees for the services we provide, including a clear explanation of fees we charge for communications outside of appointment time, late cancellations or no-shows, and paperwork.)

	Private Pay, Seeing Dr. Rai
INITIAL EVALUATION (60-90 Minutes)	$350*
PSYCHIATRIC FOLLOW-UP APPOINTMENT (60 minutes)	$300*
PSYCHIATRIC FOLLOW-UP APPOINTMENT (45 minutes)	$275*
MEDICATION CONSULTATION FOLLOW UP (20-30 minutes)	*$250**
****CORESPONDENCE OUTSIDE OF THE APPOINTMENT (Phone / Email / Text / etc.**	*$25**

Fees are subject to change and established patients will be provided a 30-day notice.
*****Assessment of charges will be determined on a case-by-case basis.***
Provider does not typically respond during non-business hours – For emergencies call 9-1-1.

I understand that I am responsible for paying all fees incurred at the time services are rendered via check, credit card, or cash. We submit no claims to insurance plans.

FEES FOR NO-SHOW OR LATE CANCELLATION (< 24 BUSINESS HOURS)

- First Missed Appointment- $50
- Second Missed Appointment- Full Appointment Fee ("Medication Review, Typical", see above)

Please be aware that we will bill these charges directly to you.

I understand that I will need to pay my missed appointment fee before I can make another appointment.

***Payment is due at time of services.**

Patient Signature: ____ **Date:** _______________

Guardian Signature:____ **Date:** _______________
(if patient is a minor)

(Financial Agreement is continued on next page.)

FEES FOR PAPERWORK (e.g. school or work letters, disability applications, etc.)

I understand that if I want my provider to complete paperwork, I will need to schedule an appointment for this. (EXCEPTION**-** Simple forms which can be completed by office staff will be provided free of charge.)

Patient Signature: ____ **Date:** _______________

Guardian Signature:____ **Date:** _______________
(if patient is a minor)

Bank fees: Your account will be charged $35 for any insufficient funds checks, closed account checks or any other fee, we might incur as a result of a check written by you. You will also be responsible to reconcile the initial payment in addition to the $35 charged fee.

Billing: Questions regarding your billing may be directed to our office.

Patient Signature: ____ **Date:** _______________

Guardian Signature:____ **Date:** _______________
(if patient is a minor)

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Controlled Medication Agreement & Refill Policy

(This document delineates our practice policy as it pertains to controlled medications -- such as stimulants used to treat ADHD, or benzodiazepines such as Valium & Xanax).

Controlled Medications are governed by multiple federal and state laws and monitored through multiple agencies. Monitoring agencies include the Drug Enforcement Agency (DEA), California's Department of Health, California Board of Medicine, and the California Board of Pharmacy. Physicians and pharmacists themselves can monitor any stimulant prescription ever filled by a given patient or client (irrespective of payment type, including cash), by logging on to the California CURES system.

An unfortunate risk with controlled medications is the development of dependency or engaging in medication diversion. For all of these reasons, we see our patients frequently and consider the ongoing risk-benefit ratio of the medications that we prescribe. This is the standard of care that you deserve.

SEVERAL GENERAL GUIDELINES:

The longest interval between visits for patients on stimulant medications (i.e. for ADD/ADHD) is three months.

No prescriptions for controlled substances will be written for you unless you accept the following agreement.

1. I agree to follow the dosing schedule prescribed to me by my doctor.

2. I will never share, sell or exchange my medications with anyone for any reason. This is a felony and very dangerous.

3. I understand that I am solely responsible for the safekeeping of my medications. I will treat my medication as I would any valuable possession. I know that my doctor at Abhishek Rai, MD, Inc. may not replace lost or stolen prescriptions of controlled medications in the absence of a filed police report.

4. The maximum quantity of stimulant medication that may be dispensed is a ninety-day supply. Even if you are stable on the medication, an evaluation of your progress on these medications needs to take place at least every three months. It is unlawful to phone or fax these medications or medication refills into a pharmacy.

5. Stimulant medications prescriptions expire sixty days from the date on the prescription. (In contrast, prescriptions for non-controlled substances are good for 12 months.)

6. I understand that medication refills for stimulant medication require a scheduled appointment with my primary doctor in the office. For this type of medication, refills cannot be called into a pharmacy and dosages will not be adjusted by phone.

7. I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments. I understand that if I am more than 15 minutes late to my scheduled appointment time, I will have to reschedule for another time.

8. Abhishek Rai, MD, Inc. medication refill triage hours are 9:00 am to 5:00 pm, Monday through Friday for Non-Emergency refill requests. I understand that it may take up to 48 hours before I receive a response to my request for a prescription refill. Therefore, since my prescription can be expected to run out every month, I should make an appointment in advance. I understand that poor planning on my part does NOT constitute an emergency on the part of CLINIC.

9. I understand Abhishek Rai, MD, Psychiatry reserves the right to perform a urine or blood drug screen at any time while I am being treated with a controlled substance. If I do not comply with a drug screen within twenty-four hours I will be dismissed from the practice.

10. I understand that dealing with a forged, falsified, or altered prescription will result in a report to the police.

Patient Name: ____

Patient Signature: ________________________________ **Date:** ____________

Guardian Signature: ________________________________ **Date:** ____________
(if patient is a minor)

ELECTRONIC COMMUNICATIONS RELEASE

(You may want to send or receive e-mails and/or text messages from us or engage in video-conferencing. This document describes how our practice handles these electronic communications.)

E-MAIL

E-mail can offer an easy and convenient way for patients and doctors to communicate. If you decide to e-mail us, here are some things for you to know:

- E-mail is *not* confidential. E-mail is like sending a postcard through the mail. My staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a *legal right* to read your e-mail if he or she chooses.
- E-mail communications become part of your medical record and will likely be placed in your chart.
- E-mails may be forwarded to my staff for handling, if appropriate.
- E-mail should be limited to a brief question, requiring a one sentence response.
- If you have a question about changing your medication regimen (stopping, starting, changing dose), you will need to schedule an appointment, since e-mail communication will not be adequate to fully inform you of the risks and benefits.
- E-mail is never, ever, appropriate for urgent or emergency problems! In an emergency, please dial "911", or go the nearest Emergency Room.
- If you agree to the option of communication via e-mail:
  - We will not spam you.
  - You can have automatically-generated appointment reminders e-mailed to you (which you may opt out of).
  - You can receive your bloodwork via e-mail, at your request.

PLEASE CHECK ONE:

I DO want to communicate with my clinician (dba Abhishek Rai, MD, Psychiatry) electronically. I have read the above information and understand the limitations of security on information transmitted.

- **E-Mail Address: ___________________________**

I do NOT want to communicate with my clinician electronically. However, if I do e-mail my clinician (or CLINIC), I am automatically authorizing CLINIC to e-mail me in return.

Patient Signature: _______________________________________ **Date:** _______________

Guardian Signature: _______________________________________ **Date:** _______________
(if patient is a minor)

TEXT MESSAGING

You may choose to receive reminders (e.g. for appointments) as a text message to your mobile phone. This option is for your convenience. Be advised that text messages—like e-mails—are not encrypted to HIPAA-compliant standards.

PLEASE CHECK ONE:

□ I DO want to receive appointment reminders and other correspondence via text messaging. (Note: You will NOT receive spam or marketing.)

- **Patient Mobile Phone Number**: ________________________________
- **Mobile Phone Carrier (e.g. Verizon, etc.)**: ________________________

□ I do NOT want to receive appointment reminders via text messaging. However, if I do text CLINIC, I am automatically authorizing CLINIC to text me in return.

►Patient (or Parent/Guardian, if patient is a minor) Signature:

_________________________ **Date:** ____________

VIDEO-CONFERENCING PLATFORM

For your convenience but at the sole discretion of your clinician, this office may sometimes offer you the option to complete your appointment via videoconferencing. This can be a good option for patients who unexpectedly fall ill, are homebound (e.g. from surgery), away on vacation, out of state for college, or live more than one hour away. Please note:

- The videoconferencing services are not encoded to HIPAA-compliant standards.
- Your fee for your scheduled video appointment (e.g. co-pay) will be charged to your credit card *in advance* of your appointment, usually the night before or the morning of.

PLEASE CHECK ONE:

I DO want the convenient option of videoconferencing with my clinician (dba Abhishek Rai, MD Inc,. I have read the above information and understand the limitations of security with video conferencing.

I do **NOT** want to communicate with my clinician via videoconferencing. However, I understand that if I change my mind and schedule a video appointment, I am automatically authorizing CLINIC to use video-conferencing service.

Patient Signature: ____ **Date:** _______________

Guardian Signature:____ **Date:** _______________
(if patient is a minor)

PHQ-9

GAD – 7

THANK YOU!

Please give completed paperwork to receptionist and keep the remainder of the packet for your personal reference.

Page 17 - ** are yours to keep.**

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Practice Policies

By Dr. Abhishek Rai, MD

Dear Patient:

Thank you for allowing us to serve you on your journey towards wellness.

We describe our policies below. We hope you find this useful.

FREQUENCY AND NATURE OF VISITS

- Your first visit with us called the initial psychiatric evaluation is 90 minutes. We might be educating you on quite a bit so feel free to take notes!
- Your follow-up appointment on progress and treatment review is 30 – 60 minutes.
- Your medication review will be 20 – 30 minutes. At the beginning of treatment with us, your medication reviews may be every 1 – 6 weeks, but as you get better the interim between appointments will gradually lengthen to as infrequent as 3 months.
- To remain an active patient here, you must be seen at this clinic at least every 3 months. After 3 months, we assume you have moved on to a new provider. If you did choose to return after 3 months, your next appointment with us will need to be 60 – 90 minutes.
- Please be on time for your appointment. **If you arrive ≥ 15 minutes late for your follow-up appointment, you will need to reschedule.**
- At the end of each session, you will receive your treatment plan as a printed handout. Follow the instructions on this treatment plan closely.

GENERAL MEDICATION TCLINIC

When to Start A New Medication?

- It is best to start a new medication on a day off from work/school (or the night before a day off from work/school, if it is an evening medication).

Side Effects

- If you experience unpleasant side effects, stop the medication immediately. Any medication you have been on for less than one month is safe to stop abruptly.
- **NOTE: Please do NOT tough out unpleasant side effects.** If in doubt, STOP your medication.

Allergic Reaction

- The following could be signs you are having an allergic reaction:
  - Rash
  - Hives
  - Itching
- If you develop an allergy, STOP the medication and seek MEDICAL ATTENTION
- If the allergy medication fails to help your symptoms, or if you develop any of the following:
  - **Fever**
  - **Swelling of the face or throat**

  then call 911 or proceed to your nearest Emergency Department.

QUESTIONS BETWEEN APPOINTMENTS

- **DURING OFFICE HOURS: Leave your question <u>with the receptionist</u>**. The receptionist will communicate with your provider and then get back to you, usually within 24 hours.

- **OUTSIDE OFFICE HOURS: We do not have an after-hours answering service.** In an emergency (e.g. allergy to medication, thoughts of wanting to harm yourself or others), call 911 or proceed to your nearest Emergency Department.

- **MEDICATION CHANGES:** This will need an appointment (*see footnote end of packet*).
    - Already have an appointment but it's too far out? You may call to request an earlier "crisis appointment" which may be available.

- **MEDICATION REFILLS**
    - You will be provided sufficient refills to last until your next appointment.
    - **Refill requests outside of appointments will be honored at providers' discretion.**
        - Provider may refuse your request if you failed to follow-up within the timeframe specified on your typed treatment plan, if you cancelled or no-showed your last appointment, or if you carry an overdue balance > $100.
    - **We require 72 hours' notice for all medication refills. Please plan ahead.**

- **LABWORK RESULTS:** These will be reviewed at your next appointment.

- **PAPERWORK COMPLETION (WORK, SCHOOL, LEGAL)**
    - Paperwork completed by receptionists is free.
    - **Paperwork completed by your provider requires an appointment.**

DIFFICULTY GETTING TO OUR OFFICE

- **VIDEOCONFERENCING**: Though we generally prefer to see you in person, we may in certain instances agree to see you via videoconferencing.

PSYCHIATRIC CARE – DIFFERENT LEVELS

- If your symptoms are sufficiently severe or acute that you need to see your provider more frequently than once per week, you probably require a higher level of care. In this case we will provide you a referral. You may return to us once your condition is more stable.

DISSATISFACTION

- If you are dissatisfied with your service here at any time, we encourage you to talk to us (e.g. to one of the receptionists, a provider, or Dr. Rai directly). You can also ask for the anonymous suggestion box. Your feedback is taken very seriously. It is our policy to actively engage in continued improvement in our practices and policies.

TERMINATION

- In certain instances, we may decide to terminate our professional relationship. Reasons for termination may include any of the following: failure to improve under our care after a reasonable amount of time, abuse of staff or providers, or consciously engaging in self-destructive behaviors such that to continue to see your professionally would constitute enabling.

***All medication changes, and complicated questions you have of your provider, require an appointment. What may seem to you like a "simple request" is actually more complicated than it may seem. To answer your question with the thoroughness that you deserve, your provider must review the following aspects of your chart: your psychiatric and medical diagnoses, your current list of medications and supplements (to avoid drug-drug interactions), your past psychiatric medications tried & failed (to avoid repeating past negative effects), your bloodwork (to ensure your kidney and liver are capable of metabolizing the medication correctly), and your personal preferences (e.g. "needs generics", "wants to avoid weight gain", or "sexual side effects are unacceptable", etc…)*

Abhishek Rai MD *Inc.*

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Ph: 747-200-0022 Fax: 747-261-1663
Email: doctorraimd@gmail.com

Mental Health Intake Form

Please complete and bring this form for your first visit. Most questions just need a check, so it's quick. You might ask your family about family history. Thank You!

Name: ____Date:___________________

Date of Birth: ___________________ Primary Care Physician (PCP): ___________________________________

Preferred Pronouns: _____________________________

PCP Phone Number: ___________________ Do you permit regular updates of your PCP? ( ) Yes ( ) No

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
( ) ________________
( ) ________________

NEXT SECTION – SUICIDE RISK ASSESSMENT

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Suicide Risk Assessment

1. Have you ever had feelings or thoughts that you didn't want to live?
   ( ) Yes ( ) No
   a. If YES, please answer the following. If NO, please skip to the next section.
2. Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
   a. If Yes - How often do you have these thoughts?
   ____
3. When was the last time you had thoughts of dying?
   ____ ( ) Not Applicable
4. Has anything happened recently to make you feel this way?
   ____ ( ) Not Applicable
5. On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?
   ____ ( ) Not Applicable
6. Would anything make it better?
   ____ ( ) Not Applicable
7. Have you ever thought about how you would kill yourself?
   ____ ( ) Not Applicable
8. Is the method you would use readily available?
   ____ ( ) Not Applicable
9. Have you planned a time for this?
   ____ ( ) Not Applicable
10. Is there anything that would stop you from killing yourself?
    ____ ( ) Not Applicable
11. Do you feel hopeless and/or worthless?
    ____ ( ) Not Applicable
12. Have you ever tried to kill or harm yourself before?
    ____ ( ) Not Applicable
13. Do you have access to guns? If yes, please explain:
    ____ ( ) Not Applicable

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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**?**

Menstrual History:

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? – If applicable please describe: ____________________________________

Have you ever been pregnant? ( ) Yes ( ) No
If Yes -How many times have you been pregnant?_________
How many live births? _________

Do you have any health concerns to discuss with us? ( ) Yes ( ) No

Date and place of last physical exam: ____

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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	Location/Facility

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

Reason	Date Hospitalized	Where

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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). Please check if Not Applicable ________

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 ____________________

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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			

Supplements

___

___

___

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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 check "Yes" above, 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 misuse? ( ) 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 ____ Soda ____ Tea ____ Not Applicable ___

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? _____________

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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

( ) Demisexual ( ) Asexual ( ) Pansexual

( ) Other ________________ ( ) Decline to answer

How would identify your gender identity?

( ) Cisgender ( ) Transgender ( ) Non-Binary

( ) Other ________________ ( ) Decline to answer

RELATIONSHIP HISTORY CONTINUED:

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? ( ) Yes ( ) No
If yes ____
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

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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 _____________________________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 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

FOR OFFICE CODING ___0___ + _______ + _______ + _______

=Total Score: _______

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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

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