Lake Area Psychiatry, LLC
333 Dr. Michael DeBakey Drive, Suite 220, Lake Charles, LA 70601
☎337-478-9331 🖷337-478-9828 http://LakeAreaPsychiatry.org

Patient Registration Information

Please fill out this form completely. For children, include parent's name(s). Also list all phone numbers where you can be reached.
We must have an emergency number for all patients.

Patient Name: First Middle Last			**Today's Date:**
Social Security # of patient	Date of Birth:	Age:	Sex: Male Female
The following questions are optional and are used for Statistical and research purposes. If you choose not to answer, please check "Declined"	Race: Declined:	Ethnicity: Declined:	Preferred language: Declined:
Mailing Address:			
City	State / ZIP	e-mail address:	
Home Phone:	Cell Phone:	Alt No#	
May we leave a message? Yes/ No	Yes/ No	Yes /No	
Patient's Employer:		Occupation:	
Circle One: Married Divorced Widowed Single	Spouse, Parent or Guardian's Name:		
Spouse, Parent or Guardian's Employer:		Spouse, Parent or Guardian's SS#	
Primary Physician:	Phone #	Known allergies:	
Responsible Party/Guarantor (if other than patient):			
Guarantor's Address:			
City	State / ZIP		
Guarantor's Phone:	Relationship to Patient:		
Primary Insurance Company:	Policy Holder:	DOB:	
Group #	Member #	Phone #	
Secondary Insurance Company:	Policy Holder:	DOB:	
Group #	Member #	Phone #	

Please present insurance card, so we may photocopy for our records.

I, the undersigned, do hereby irrevocably assign and transfer to _____ all rights and benefits whether statutory, common law, contractual or implied, including, but not limited, to right to sue or recover penalties LSR 22:657. A photo static copy of this assignment of healthcare benefits shall be as valid and effective as if it were the original.

_____ _____ _____ _____

Signature of PATIENT or Authorized Person Date **Signature of Insured** or Authorized Person Date

Persons to contact in case of emergency: Name	Relationship:	Phone #
Name:	Relationship:	Phone #

Please list the names of people that you authorize our staff to communicate with regarding your appointments and medication:

_____ _____

_____ _____

I certify that I am giving my permission to communicate with the names listed above

_____ _____

Signature Date Signed

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you including demographic information that may identify you and that relates to your past, present, or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services your receive, manage our healthcare operations and for other purposes that are permitted or required by law. If you have any questions about this notice, please contact our Privacy Manager at **337-478-9331.**

Individuals are sometimes hesitant to seek mental health treatment because of privacy concerns. While we are committed to protecting your confidentiality to the fullest extent possible, we ask that you also protect the privacy of other patients. Please do not reveal the identity of other patients you may see in our office by sharing such information verbally, photographically, or by any other type of social media or other communication. This insures privacy for all patients and their family members.

YOUR RIGHTS UNDER THE PRIVACY RULE

The following is a statement of your rights, under the Privacy Rule, in reference to your PHI:

- You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time.
- You have the right to authorize other use and disclosure. This means you have the right to authorize any use or disclosure that is not specified within this notice. For example, we would need your authorization to use or disclose your PHI for marketing purposes or for any use or disclosure of psychotherapy notes. You may revoke an authorization, at any time, in writing, except to the extent that your Healthcare Provider or our office has taken an action in reliance on the use or disclosure indicated in the authorization.
- You have the right to request an alternative means of confidential communication. This means you have the right to ask us to contact you about medical matters using a method (i.e., e-mail, telephone, etc.), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. We will follow all reasonable requests. You must inform us in writing how you wish to be contacted (using a form provided by our practice).
- You have the right to inspect and copy our PHI. This means you may inspect and obtain a copy of PHI about you that is contained in your patient record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We ha eth right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines. ***However, under Federal Law, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.***
- You have the right to request a restriction of your protected health information. This means you may ask us in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. If we agree to the requested restriction, we ill abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you or someone on your behalf has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.
- You may have the right to request an amendment to your protected health information. This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.
- You have the right to request a disclosure accountability. This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Following are examples of uses and disclosures of your PHI that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

- Treatment- We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your protected health information as necessary to a pharmacy that would fill your prescriptions. For example, we would disclose your PHI to other healthcare providers who may be involved in your care.
- Special Services- We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results for exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right opt out of such special notices by notifying our office in writing.
- Payment- Your PHI will be sued, as needed, to obtain payment for your healthcare services. This may include certain activities that our health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits
- Healthcare operations- We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to, business planning and development, quality assessment and improvement, medical review, legal services, and audition functions.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES

We may also use and disclose your PHI in the instances outlined below:

- **To Others Involved in Your Healthcare** – Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that **you identify**, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present to able to agree or object to the use or disclosure of the PHI, then your Healthcare Provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your healthcare will be disclosed.
- **As Required by Law** - We may use or disclose your PHI to the extent that is required by Law.
- **For Public Health** – We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- **For Communicable Diseases** - We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **For Health Oversight** – We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- **In Cases of Abuse or Neglect** - We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.
- **To The Food and Drug Administration** – We may disclose your PHI to a person required by the Food and Drug Administration to report adverse events, to monitor product defects or problems, to report biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance as required.
- **For Legal Proceedings** – We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful process.
- **To Law Enforcement** – We may also disclose PHI, as long as applicable legal requirements are met, for law enforcement purposes.
- **To Coroners, Funeral Directors, and Organ Donation** – we may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
- **For Research-** We may disclose your PHI to researchers when an institutional review board has reviewed and approved the research proposal and establish the protocols to ensure the privacy of your PHI.
- **In Cases of Criminal Activity** – Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lesson a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI, if it is necessary for law enforcement authorities, to identify or apprehend an individual.
- **For Military Activity and National Security** - When the appropriate conditions apply, we may use or disclose PHI to individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military service.
- **For Workers' Compensation** – Your PHI may be disclosed as authorized to comply with workers' compensation laws and other similar legally-established programs.
- **When an Inmate** – We may use or disclose your PHI if you are an inmate of a correctional facility and your Healthcare Provider created or received your protected health information in the course of providing care to you.
- **Required Uses and Disclosures** – Under the law, we must make disclosures about when required by the Secretary of the Department of Health and Human Services to Investigate or determine our compliance with the requirements of the Privacy Rule.

PRIVACY COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager at 337-478-9331.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____ _____ _____

Print Name Signature Date

Financial Policy Acknowledgement

All payments are due at the time of service. If we are providers for your insurance, we will bill your insurance and collect the patient responsibility amount due. IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE. Many insurance plans have "timely filing deadlines". If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered.

Lake Area Psychiatry has preferred provider contracts with several major insurance companies. Please contact your insurance company to determine if our practice has a contract with *your* insurance company. Any financial portion that is the "member's responsibility" such as deductible or a non-covered percentage will be collected ***at the time of service.*****_____(initial)** If, for any reason, it is not collected at the time of service, a billing fee will be added to your outstanding balance for each statement that is mailed.**_____(Initial)** Remember, your insurance coverage is a contract between you and your insurance company. Lake Area Psychiatry is not responsible for services denied by your insurance company.**____(initial)**

PPO INSURANCE PLANS: We have agreed to accept discounted rates from plans we participate in, however all co-insurance and/or deductibles are your responsibility. We will estimate co-payments to the best of our ability. Since co-pays are estimates only, we will bill you or credit you for your balance.

NON-CONTRACTED INSURANCE PLANS: We have not agreed to accept discounted rates from plans that are not contracted with Lake Area Psychiatry, therefore, all co-insurance and deductibles are your responsibility.

INDEMNITY INSURANCE PLANS: We will estimate co-pays to the best of our ability. Since co-pays are estimates only, we will bill you are credit you for the balance.

DIVORCE DECREE: We are not a party to your divorce decree. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult.

PAYMENTS: We accept cash, debit cards, Visa, MasterCard, Discover Card, and personal checks (with photo id only). Any outstanding balances are due within 30 days of statement. The second and each subsequent statement will be assessed a $5 rebilling fee. All balances older than 90 days may be sent to a collection agency.
Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the delinquent balance.

RETURNED CHECKS: Checks returned to us by the bank will be assessed a $35 returned check fee, in addition to the original amount of the check. You will have 10 days to clear up the outstanding check. If you do not pay the check plus the return fee in the specified time, the check will be sent to a collection agency. In addition, we will only accept cash or credit card for any future visits.

MISSED APPOINTMENTS: (Please refer to the attached Cancelled/Missed Appointments Agreement attached)

I authorize treatment and accept the financial responsibility for myself or my minor child that I am accompanying. I am responsible for all fees and will assure the charges are paid in a reasonable time.

I authorize the release of any medical or other information necessary to process any claims.

I have read and fully understand the financial policies of Lake Area Psychiatry, and agree to the terms. I also understand that the terms of theses financial policies may be amended by the Practice at any time without prior notification

_____ _____

Patient/Parent/Guardian/Personal Representative Date

Appointment Cancellation & No Show Policy For Patients

We are happy to reserve a time in your provider's schedule just for your. However, in consideration of others, we do request at least a **24-HOUR NOTICE** during normal business hours prior to cancellation of any appointment. **Monday appointments must be cancelled before Friday at 12:00pm noon.** We do understand that there are circumstances that may prevent you from keeping your appointment. If you provide us with as much notice as possible, we may be able to contact another patient who needs an appointment. Appointments fill quickly, and cancelling with less than a 24-hour notice does not allow us enough time to schedule another patient in need of treatment. Therefore, a cancellation or no-show fee will apply if our office is not notified on a timely basis that you will be unable to keep your appointment.

LATE CANCELLATION AND NO SHOW FEES

PSYCHIATRISTS	NURSE PRACTITIONERS	SOCIAL WORKER	COUNSELORS
○ DAVID BUTTROSS III, MD ○ JAYENDRA PATEL, MD ○	○ MICHELLE DYER, APRN ○ ERICA HESSIFER, APRN ○ TODD GATTE, APRN	○ ROBBI DOWDEN, LCSW ○ ALAN WALKER, LCSW ○ ANN KERN, LCSW	○ CINDY NASSAR, LPC

NEW PATIENT NO-SHOW/LATE CANCELLATION for MD's and APRN's	$100.00
ESTABLISHED PATIENT NO-SHOW/LATE CANCELLATION FOR MD's and APRN's	$75.00
NEW PATIENT NO-SHOW/LATE CANCELLATION FOR LCSW'S & LPC'S	$75.00
ESTABLISHED PATIENT NO-SHOW/LATE CANCELLATION FOR LCSW'S and LPC'S	$75.00

* A deposit equal to the above rates will be conducted at the time of scheduling appointment. If you do not show or cancel within 24-hours of your scheduled appointment, this deposit will be applied as a "No Show Fee". Otherwise, the deposit collected at the time of scheduling will be applied toward your scheduled office visit. If nothing is owed at the time of your scheduled office visit, the deposit will be returned to you upon check-in. A charge for a missed appointment is not a charge for service, therefore will not be billed to your insurance company. This deposit implies a contracted mutual agreement.

Patients who are running late for their scheduled appointment are asked to contact our office as soon as possible to determine whether-or-not it will be necessary to reschedule your appointment.

Patients who arrive at our office 15-minutes or later for their scheduled appointment may need to be rescheduled to another date and time. Upon arrival, please consult with the front desk to confirm whether-or-not it will be necessary to reschedule your appointment.

All Providers have the right to terminate treatment to a patient for non-compliance if the patient fails more than one appointment. For patients of prescribers, medications may not be refilled without seeing their prescriber.

We greatly appreciate your understanding and cooperation of our office policies, and assisting us with accommodating our patients scheduling needs.

ALL MONDAY APPOINTMENTS NEED TO BE CANCELLED OR RESCHEDULED BY 12:00PM ON THE FRIDAY BEFORE.

TO RESCHEDULE OR CANCEL AN APPOINTMENT AT LEAST 24 HOURS IN ADVANCE, PLEASE CALL 337-478-9331

Please sign below that you have read and acknowledge the above information provided to you.

PATIENT/GUARDIAN NAME PRINTED	PATIENT/GUARDIAN NAME SIGNATURE	DATE
PATIENT/GUARDIAN NAME PRINTED	PATIENT/GUARDIAN NAME SIGNATURE	DATE

REVISED 5/1/2019

Lake Area Psychiatry, LLC

333 Dr. Michael DeBakey Dr. #220
Lake Charles, LA 70601
Phone: 337.478.9331
Fax: 337.478.9828

Consent for Treatment

By my signature below, I consent to receive treatment from _____, for
Provider Name

mental health service for myself or my minor child.

I understand that treatment means the provision, coordination, or management of health care and related services, consultation between providers and staff of Lake Area Psychiatry relating to an individual, or referral of an individual to another provider for health care.

I understand that I may revoke this consent at any time by notifying _____
Provider Name

or staff at Lake Area Psychiatry in writing.

This consent will expire on the following date:_____, or on the date that the following event occurs:

__Completion of treatment as agreed upon by you and _____or You revoke this Consent for Treatment in writing.

By initialing below, I understand that audio and video recording on any and all devices is prohibited inside the offices of Lake Area Psychiatry without the expressed written consent of the physician, nurse practitioner or therapist that is providing psychiatric services for me. ___Initial

_____ _____
Name of Patient (Please Print) Patient's Date of Birth

_____ _____
Patient Signature Date

_____ _____
Name of Parent/Legal Guardian Parent/Legal Guardian Name (Print)

_____ _____
Witness of Signatures (Please Print) Date Witnessed

_____
Signature of Witness

David Buttross III, M Jayendra Patel, MD

Michelle Dyer, APRN Erica Hessifer, APRN Todd Gatte, APRN

Cynthia Nassar, LPC, LMFT Robbi Dowden, LCSW Alan Walker, LCSW Ann Kern, LCSW

LAKE AREA PSYCHIATRY, LLC

333 Dr Michael Debakey Drive, Suite 220

Lake Charles, LA 70601
337-478-9331 fax 337-478-9828

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary.

I, the undersigned understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

Patient Authorization:

____ I agree to release any applicable mental health/ substance abuse information to my PCP

My Primary Care Physician is _____

Address _____

Telephone Number _____

____ I agree to release ONLY medication information to my PCP

____ I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services.

____ I do not wish to confer with a PCP. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

_____

(Patient Name) (Date of Birth) (Patient/Guardian Signature) (Date)

Patient Rights:

- You can end this authorization anytime.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep for your records.
- You do not have to agree to this request for use of disclosed information.

Information to be completed by Behavioral Health Provider

saw _____ on _____ for _____

(Patient Name) (Date) (Reason/Diagnosis)

ummary:

_____

_____

_____

_____

_____

_____

(Provider Signature)

Intake Questionnaire for New Patients

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Name: _____ Date of Birth: _____

How did you hear about us? _____
Who, if anyone, will be accompanying you in your appointment? _____

Have you ever used tobacco? _____ If yes, what type? _____
What year did you start? _____ Are you currently using tobacco? _____
If yes, how much and how often? _____ If no, what year did you quit? _____

In your own words, describe the current problems as you see them:

_____

_____

_____

_____

How long has this been going on? _____
What made you come in at this time? _____
_____

What do you hope to gain from this evaluation and/or counseling? _____
_____

If you had difficulties in the past, what have you done to cope? _____
_____

Was it helpful? _____

Symptoms:
Please check any symptoms or experiences that you have had **in the last month**:

- o Difficulty getting out of bed
- o Not feeling rested in the morning
- o Average hours of sleep per night: _____
- o Persistent loss of interest in previously enjoyed activities
- o Withdrawing from other people
- o Frequent feelings of guilt
- o Depressed mood
- o Crying spells
- o Feelings of Helplessness

- o Feelings of Hopelessness
- o Feelings of Worthlessness
- o Thoughts about harming or killing yourself. If yes, have you developed a plan?_____
- o Thoughts about harming or killing someone else
- o Increased energy
- o Decreased energy
- o Rapid mood changes
- o Difficulty falling asleep
- o Difficulty staying asleep
- o Irritability
- o Anxiety
- o Panic attacks
- o Avoiding people, places, activities, or specific things
- o Difficulty leaving your home
- o Fear of certain objects or situations (i.e., flying, heights, bugs) Describe:

  _____

- o Excessive worry or difficulty controlling worry
- o Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- o Outburst of anger
- o Changes in eating/appetite
- o Weight gain: _____lbs.
- o Weight loss: _____lbs.
- o Increase muscle tension
- o Racing thoughts
- o Difficulty concentrating or thinking
- o Flashbacks and/or nightmares
- o Persistent, repetitive, intrusive thoughts, impulses, or images
- o Unusual visual experiences such as flashes of light, shadows
- o Hear voices when no one else is present
- o Inappropriate expression of anger (i.e. outburst or violent episodes)
- o
- o Self-Mutilation/cutting
- o Decreased ability to handle stress

Please describe any other symptoms or experiences you have recently have problems with:

_____

_____

What currently causes you to feel stressed? _____

_____

_____

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before? (Circle one) Yes or No

If yes, who: _____ Dates of treatment: _____

Reason for seeking help: _____

Have you been hospitalized for psychiatric reasons? (Circle one) Yes or No
If YES, describe:

Hospital	Dates	Reason

Have you ever attempted suicide? (Circle one) Yes or No
If Yes, describe: _____

_____

_____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? (Circle one) Yes or No
If YES, list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Have you been on **PSYCHIATRIC** medication(s) in the past? (Circle one) Yes or No
If YES, list:

Medication	Dosage	First/Last time you took it?	Effect of medication?

SUBSTANCE ABUSE:

ALCOHOL:

Do you drink alcohol? _____ If yes, age of first use? _____

How much do you drink? _____

How often do you drink?

Have you ever passed out from drinking? _____ How often? _____

Have you ever blacked out from drinking? _____ How often? _____

Have you ever felt you should cut down on your drinking/drug use? _____

Have people annoyed you by criticizing your drinking/drug use? _____

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

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? _____

OTHER SUBSTANCES:

Please indicate for each listed below

Substances	Ever used?	Age at 1st use?	Time since last use?	Approx. use in last 30 days?
Caffeine				
Marijuana				
Cocaine				
Heroin				
Methamphetamine				
PCP				
Prescription drugs				

FAMILY HISTORY:

Please place a check mark in the appropriate box if these are or have been present in your relatives:

	Children	Brothers	Sisters	Mother	Father	Aunt/Uncle	Grandparents
Depression							
Anxiety Disorder							
Biploar Disorder							
Schizophrenia							
Death by suicide							
Alcoholism							
Drug Abuse							

Medical History:

Are you **CURRENTLY** under treatment for any medical condition (Circle one) Yes or No
If Yes, what? _____

_____

_____

List all **PRIOR** surgeries and/or accidents: _____

_____

_____

List any allergies: _____

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? (Circle one) Yes or No
If Yes, list:

Medication	Dosage	How long have you been taking it?

SOCIAL HISTORY:

Marital Status: Single Married Separated Divorced
Remarried Engaged Widowed Cohabiting

If applicable, please complete the following:
Partner's Name: _____ Partner's Age: _____

Past Martital History:
Have you previously been married? _____ If Yes, how many times? _____
When? _____ How long? _____

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

How many of your children live in the area? _____

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults/children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

Father:
Age: _____ Living Deceased

Cause of Death: _____

If deceased, HIS age at the time of death: _____

YOUR age at the time of his death: _____

Mother:
Age: _____ Living Deceased

Cause of Death: _____

If deceased, HER age at the time of death: _____

YOUR age at the time of her death: _____

Education:
Highest grade level completed: _____ Degree obtained, if applicable: _____

Have you served in the military? (Circle one) Yes or No
If yes, please describe briefly: _____
What type of discharge (separation) did you get? _____

Employment
Are you currently employed? _____

If yes, employer's name _____
What type of work? _____

Have you ever been arrested? _____ If yes, why? _____

Do you have a religious affiliation? _____ If yes, what? _____

What are your hobbies? _____

Who do you turn to for support and/or help with your problems? _____

Have you ever been abused? (circle all that apply)

Verbally Emotionally Physcially Sexually Neglected

Please describe: _____

Is there anything else you would like us to know about you? _____
_____
_____

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?	○	○

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