

Neuro-Therapy Clinic, Inc.

Changing the Face of Mental Health

Dear Future Patient,

We appreciate the confidence you have placed in us by requesting an appointment. We realize you have options in choosing a clinic and want you to know we are dedicated to providing the highest quality care and we look forward to serving your psychiatric needs.

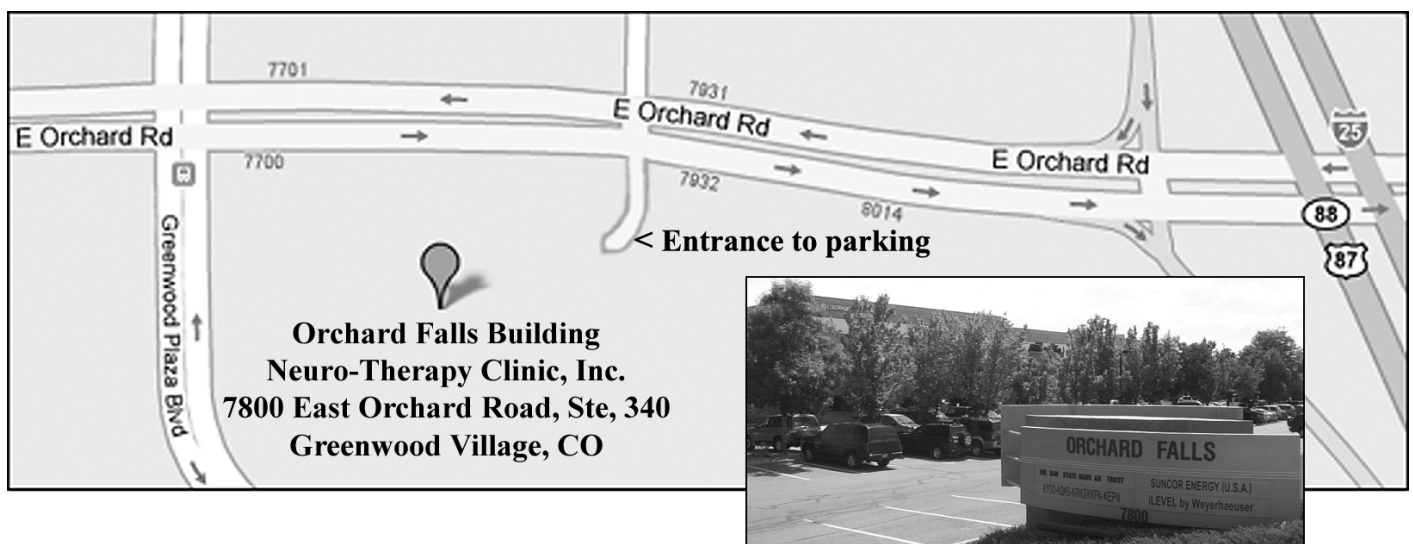
You are currently scheduled on _____ at _____ for an evaluation appointment.

Please remember the following when preparing for your appointment:

- Bring the attached paperwork to your appointment completed, including the enclosed medication list, with all past psychiatric meds you have been on, with dosages and any reactions you may have had. Please note that incomplete paperwork may prevent us from completing the initial evaluation in one session and may require you return again to complete the evaluation.
- Bring bottles of all psychiatric medications you are currently taking.
- Please arrive 15 minutes early for your first appointment. Late arrivals are subject to rescheduling and fees.
- Bring your insurance card and photo ID for identity verification.
- Please call your insurance company to verify coverage and to get pre-authorization if they require it.

Thank you in advance for your attention to the enclosed information. We look forward to meeting you. Should you have any questions or concerns please feel free to contact the office at (303) 741-4800.

~The Staff at Neuro-Therapy Clinic, Inc.



Directions from I-25: Take I-25 to the Orchard Exit Exit 198). Go west on Orchard, getting in the far left lane. Take a left at the first place you can go left. The building is on the right (the Orchard Falls Building) with parking all around.

REQUIRED PATIENT INFORMATION

Please print legibly (circle answers or fill in blanks).

Patient: _____
 First Middle Initial Last

Address: _____

City, State, Zip: _____

Home: (____) _____ Work: (____) _____

Cell Phone: (____) _____

Best # to leave a confidential voicemail: Home Work Cell

Email Address _____

Patient Occupation: _____

Name of Employer: _____

Date of Birth: _____ Age: _____

Sex: M F Social Security #: _____

Marital Status:
Single Married Separated Widowed Divorced x ____

Education Level: _____ # of years _____

Dominant Hand: Right / Left / Ambidextrous

Reason for Appointment: _____

Today's Date: _____

Emergency Contact: _____
 First Last

Relation: Parent Guardian Spouse Other: _____

Home: (____) _____ Cell: (____) _____

Emergency Contact #2: _____

(In case of minor, both parents must be listed.)

Relation: Parent Guardian Spouse Other: _____

Home: (____) _____ Cell: (____) _____

For Minors: Name(s) of Custodial Parent(s)/Guardian(s):

Address to send Statements: _____

Pharmacy (required): _____

Address: _____

City, State, Zip: _____

Phone: (____) _____ Fax: (____) _____

Referred By: _____

Optional Appointment Reminder Program

Email: _____

Text Message to: (____) _____

By signing this section I understand that this not a guaranteed service and is a courtesy to our patients. **OUR MISSED APPOINTMENT POLICY REMAINS IN EFFECT.** Do not reply to notifications via e-mail or text message. To change or cancel an appointment, please call the clinic. I understand that NTC cannot guarantee the confidentiality of email or text messages. NTC will not be liable for improper disclosure of confidential information.

Signature: _____

Date: _____

1) **PCP Name:** _____

Clinic Name: _____

Street: _____

City, State, Zip: _____

Office: (____) _____ Fax: (____) _____

2) _____

Clinic Name: _____

Street: _____

City, State, Zip: _____

Office: (____) _____ Fax: (____) _____

3) **Therapist Name** (if applicable) _____

Clinic Name: _____

Street: _____

City, State, Zip: _____

Office: (____) _____ Fax: (____) _____

4) **Attorney** (if applicable) _____

Firm Name: _____

Street: _____

City, State, Zip: _____

Office: (____) _____ Fax: (____) _____

REQUIRED INSURANCE INFORMATION

Please call your insurance company!

Patient Name: _____
Patient's SS#: _____
Patient's DOB: _____

Name of Insured Person _____
Insured's SS#: _____
Insured's DOB: _____

The following information can be found on your insurance card:

Insurance company: _____
Subscriber #: _____
(May be listed as Insured's SS#, Policy #, Member #, or ID #)

Employer: _____
Group #: _____
(May be listed as account #)

Member Services Phone #: (_____) _____

Mental Health Phone #: (_____) _____

Name of Mental Health Division: _____

Please call the Mental Health phone number on your insurance card (or Member Services number, if no Mental Health number is listed). Let the insurance representative know you need to know your MENTAL HEALTH BENEFITS.

Name of Person Contacted at Insurance Co. : _____ Date: _____

1. Are these providers in network?

Neuro-Therapy Clinic: Yes No
Daniel A. Hoffman, MD: Yes No
Debora Arrera, CNS, RXN: Yes No
Nicole Shadid, MD: Yes No

2. Is preauthorization needed for these CPT codes?

90801: Yes No 90805: Yes No
90862: Yes No 90807: Yes No

3. If "YES", ask for an authorization to be created:

What is the authorization #: _____
How many sessions is it for: _____
Start date: _____ End date: _____
What CPT codes are authorized: _____

4. Are these providers in network?

Jennifer Buchanan, LPC: Yes No
Jason Howard, LPC: Yes No
Mary Valuck, LCSW: Yes No

5. Is preauthorization needed for these CPT codes?

90801: Yes No
90806: Yes No

6. If "YES", ask for an authorization to be created:

What is the authorization #: _____
How many sessions is it for: _____
Start date: _____ End date: _____
What CPT codes are authorized: _____

7. Effective date of coverage: _____ **Benefits renew:** Calendar Year or Plan Year _____
Date

8. Individual Mental Health Deductible: \$ _____ **Amount of deductible met to date:** \$ _____
(Note: Our office will collect for your appointment in full according to the contracted rate with your insurance company if your deductible is not met.)

9. Co-Insurance: Patient _____% / Insurance _____% **OR** **Mental Health Copay:** \$ _____
Copay for Parity Diagnosis: \$ _____

10. Is there any of the following on this plan (circle)? Health Savings Account or Health Reimbursement Account or Flex Savings Account or Other _____ **How does it work?**

- Insurance company will send claim to HSA/HRA/FSA for processing and payment to NTC
- Patient has HSA/HRA/FSA credit card to use for payment
- Other (please explain): _____

10. Number of Mental Health visits allowed per year: _____ or Unlimited **# remaining this year:** _____

11. Billing address for Mental Health Claims: _____
(Usually different than address on insurance card) _____

NTC Staff Only:
Entered by _____
Date _____

POLICIES & PATIENT AGREEMENT (Please initial each section.)

Appointments: Due to the sensitive nature of matters discussed and in order for us to give our full attention to the person being evaluated, children may not come to the appointment, unless he/she is the one being evaluated. For patients under the age of 18, all persons with legal, medical decision-making authority should be present for the initial and any follow-up visits. In order to give you and our other patients the highest level care possible, if you are more than 15 minutes late and/or you haven't completed your paperwork it may be necessary to reschedule your appointment and you may incur a reschedule fee. We will make every effort to provide you with a "reminder" call for your first visit. Please note that reminder calls on subsequent appointments are done as a courtesy to our patients and are NOT guaranteed. We do have a program that can send you an appointment reminder automatically by email and/or text messages. You are welcome to sign-up for this service at your first visit.

Specialty: Dr. Hoffman is a Neuropsychiatrist, not a neurologist or a child and adolescent psychiatrist. We point this out as many insurance companies have Dr. Hoffman listed incorrectly since they don't have his specialty as an option in their systems. Debora Arrera, CNS, RXN, is a Clinical Nurse Specialist with an advanced degree in psychiatry. She has the ability to prescribe psychiatric medication.

General information on prescription refills: Typically, your provider writes prescriptions for the amount of medication needed until your next scheduled appointment, a 30-day supply at a time. Every time you have a medication management visit, he/she will send your prescriptions directly to your pharmacy electronically. Each time a prescription is sent to your pharmacy, it is assigned a new prescription number, making any old refill or prescription numbers obsolete. When refilling your medications, be sure to speak with a live pharmacist instead of using their automated system, to have them check for any refills or new prescriptions.

Medication Extensions: If you are an existing patient and will be out of a medication we've previously prescribed before you can get in for an appointment, we can extend that prescription for you, as long as you have the next appointment scheduled. We will only give you enough pills to get to that appointment. Medications refill requests called in to the clinic may take up to 72 business hours to fulfill.

Out-of-State Prescriptions: Due to state laws, we will not send your prescription to an out-of-state pharmacy.

90-day Supplies: Our clinic gets many requests from our patients for a 90-day supply of their medications or to have their prescriptions sent to a mail order pharmacy. In most cases, these mail order groups will only fill a prescription for 90 days at a time. Unfortunately, we cannot and will not approve 90-day supplies of any medication. As a rule, psychiatric and malpractice guidelines discourage the prescribing of 90 days worth of medication in one prescription. While for many of you this rule may increase your drug costs, it is created for the safety of patients to help in the prevention of drug overdoses, for which the psychiatric population is at higher risk. Even the FDA has warned "prescriptions for [medications] should be written for the smallest quantity of pills consistent with good patient management, in order to reduce the risk of overdose."

Conditions not suitable for our clinic: Adult patients with the following conditions/situations may not be able to be treated by our clinic and thus may be referred elsewhere for proper care: Significant acting out behavior including violence, anger or aggression, to include illegal or criminal behaviors; Psychiatric evaluations as required by probation, courts or work-related assessments; Patients needing monitoring of injectible medications; Substance abuse treatment as the chief complaint. For patients seeking care of general psychiatric conditions who also have substance abuse problems, we will require verification of treatment in a reputable substance abuse therapy. Please feel free to call us to provide more patient history so we can better advise you about the appropriateness of coming here for an appointment.

Cell Phones & Messages: It is important to note that cell phones may not be secure. If you are using a cell phone while communicating with our office, you must be aware that we cannot ensure the confidentiality of the call. It may be necessary at times for our office to leave you a message at the phone numbers you provide us. By supplying us with specific phone numbers, you authorize us to leave messages for you at those numbers.

Emergency Access: We try to service our clients whenever possible; however we are not a 24-hour facility. In case of an emergency, if you are unable to talk with your provider or have not received a call back within a couple of hours, call 911 or go to the nearest emergency room.

Missed, late, cancelled and “no show” appointments: As scheduled appointment times are reserved especially for you, all appointments are subject to charge, whether missed, unattended or canceled, unless there has been 2 business days notice given. In order to avoid being charged the full amount of the appointment you must call by 5 pm at least 2 business days prior to the appointment day. Please use the chart below for guidance. It is our policy that the time lost, not the reason, is what determines a charge. You may request a review of any missed, late cancellations or late appointment charges through a written letter to our Appeals Committee. Insurance companies do not pay for cancellation fees and, therefore, these charges will be your responsibility. Repeated “no show” appointments could result in treatment termination for non-compliance or in referral back to your insurance company for reassignment to another provider. We are open Monday through Friday from 8 am to 5 pm.

<u>If appt. is:</u>	<u>Cancel By:</u>
Monday	Preceding Thursday by 5 pm
Tuesday	Preceding Friday by 5 pm
Wednesday	Preceding Monday by 5 pm
Thursday	Preceding Tuesday by 5 pm
Friday	Preceding Wednesday by 5 pm

Insurance Verification: The information you receive when you call your insurance company is not a guarantee of payment and your insurance company may or may not pay for services. Once charges are submitted, the insurance company may determine benefits differently than they initially indicated. At any time during treatment should you become ineligible for insurance coverage or should your insurance coverage change please notify Neuro-Therapy Clinic (NTC) prior to your next appointment. You are responsible for obtaining prior authorization for treatment and for verifying the services you are coming here for are covered services by your insurance carrier or you will be responsible for payment in full at the time of service.

Limits of Confidentiality Statement: All information between practitioner and patient is held strictly confidential. There are legal exceptions to this: (1) The patient authorizes a release of information with a signature. (2) The patient’s mental condition becomes an issue in a lawsuit. (3) The patient presents as a physical danger to self or others. (4) Child or Elder abuse and/or neglect is suspected. (5) Any official review of the services provided (if you have signed a release authorizing a review, such as insurance forms). In the case of (3) or (4) above, our clinic is required by law to inform potential victims and legal authorities so that protective measures can be taken.

Consent for Treatment: I authorize and request my practitioner to carry out psychological exams, treatment and/or diagnostic procedures, which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

Photo Authorization: I give authorization to NTC and their affiliates to obtain a photograph of me for my permanent medical record. I understand that the photograph is to help my providers assure proper patient identification and will not be copied or released. For patients under 18, a parent will be asked to be in the photograph as well.

HIPAA Privacy Practice Notice: I understand NTC follows HIPAA privacy guidelines which are outlined in their Notice of Privacy Practices, which is available at their office.

Release of Confidential Information to Primary Care Physicians and/or Referring Practitioners: It is a requirement of many insurance companies, as well as an acceptable protocol under HIPAA guidelines, that we communicate and coordinate with other healthcare professionals involved in your care. By signing below, I authorize the release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. I authorize the release of necessary information to a collection agency should that become necessary. I authorize payment of medical benefits to NTC and its staff.

Payment Responsibility: Because we strive to provide a high level of care and a more thorough evaluation you may see two licensed professionals at your initial appointment, an Intake Specialist and a prescribing practitioner. Your insurance company requires that we bill them for both providers, which means that you are responsible for two copays, one per provider. Please note that if you have a deductible to meet, it is our office policy to collect in full for your appointments until your deductible is met. Any portion of your responsibility of payment (copays/coinsurance/deductible) is collected at the time services are rendered. Charges for services which are not benefits of the insurance plan are the patient's responsibility. These may include, but not be limited to: Some diagnostic testing; neurofeedback treatment; some telephone calls to a patient for consultation or medical management; intervention for medical management purposes on a patient's behalf with agencies, employers or insurance companies, including preauthorization for non-formulary medications; psychiatric evaluation of records, reports and other data for medical persons; preparation of reports for other physicians, agencies, insurance carriers, or attorneys; missed appointment fees.

I understand that I am responsible for payment of all fees charged. I agree to pay for all services rendered, unless my insurance carrier (if I have one) pays for some or all charges. If I have insurance, I agree to make the co-payment for services rendered at the time of each visit. I understand that NTC will submit any insurance claims for me, including those with or without a co-payment arrangement. I understand that if my insurance company denies payment or does not reimburse NTC within 60 days for services rendered, or reimburses NTC differently than they initially indicated, I will be personally responsible for payment, subject to interest of 1.5% per month on any unpaid balance. Services may be discontinued and your bill may be turned over to a collection agency if your account becomes delinquent and you will be responsible for payment of all legal and all other collection costs. There will be a \$35.00 service charge applied to your account for all returned checks. I understand that NTC will bill me directly for any balances due.

By signing below, I certify that I have read and understand these policies and agreements and have full knowledge of its meaning and effect.

Patient or Parent/Guardian Signature

Date

Patient Printed Name

ADULT AD/HD INTAKE EVALUATION (Attach additional sheets if needed)

Name: _____ Age: _____ Date: _____

Name would you like to go by: _____

Others present: _____

Marital Status: Married Divorced Separated Widowed Single In a Relationship

How long have you been with your partner/married? _____ Do you have any children? Yes No

If yes, how many & what are their ages? _____

Current living situation (relationship of person(s) with whom patient resides)? _____

Are you interested in natural approaches to your treatment? Yes No

Allergies to medication:

_____ Allergy Adverse Reaction Please Describe: _____

_____ Allergy Adverse Reaction Please Describe: _____

_____ Allergy Adverse Reaction Please Describe: _____

Reason for this appointment:

What are the reasons you scheduled an appointment with our office? _____

How long have you had these symptoms? _____

Are these symptoms related to a life situation? Yes No If yes, please explain: _____

Do these symptoms seem to come and go regularly, as in a cycle? Yes No If yes, please describe: _____

Who has been prescribing your meds? _____

Name: _____

Date: _____

Medical History:

Do you have any of the following medical conditions? (check all that apply, use the space provided next to each condition to elaborate if needed)

- | | |
|--|---|
| <input type="checkbox"/> High/Low blood pressure _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> High cholesterol _____ | <input type="checkbox"/> Gastrointestinal problems _____ |
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Blood disorder _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Thyroid disorder _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other glandular disorder _____ |
| <input type="checkbox"/> Liver problems _____ | <input type="checkbox"/> Sleep disorder _____ |
| <input type="checkbox"/> Kidney problems _____ | <input type="checkbox"/> Headaches/Migraines _____ |
| <input type="checkbox"/> Respiratory problems _____ | <input type="checkbox"/> Pain disorder _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Plastic Surgery _____ |
| <input type="checkbox"/> Nervous system disorder _____ | <input type="checkbox"/> Other (please be specific) _____ |

When was your most recent physical? _____

Did you or your doctor have any concerns about your health? Yes No If yes, please describe: _____

Did you have any blood work done (i.e., thyroid testing)? Yes No
If yes, was anything abnormal? _____

Check any significant family medical illness or history:

- | | | |
|--|--|---|
| <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other glandular disorder |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Nervous system disorder | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Pain disorder |
| <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Glucose intolerance and/or diabetes | <input type="checkbox"/> Thyroid disorder | _____ |

Do you currently, or have you in the past, experienced:

- Depression? Yes No
 Anxiety? Yes No
 Panic attacks? Yes No

If yes, please describe when you experienced any of these: _____

If you have depression and anxiety, which affects you more? _____

Have you had one or more severely stressful events that have affected your well-being? Yes No
If yes, please describe, including how long you have felt stressed: _____

- Has your ability to handle stress and pressure decreased? Yes No
 Do you experience constant stress in your life or work? Yes No
 Are any of your relationships at work and/or home unhappy? Yes No
 Do you feel overwhelmed and have little control over your life? Yes No

Name: _____

Date: _____

Do most events feel like a chore? Yes No

If you answered yes to any of the questions above, please describe: _____

Have you experienced any traumas or Post-Traumatic Stress Disorder (PTSD)? Yes No

If yes, please describe: _____

Do you have feelings of hopelessness or despair? Yes No

If yes, please help us understand why: _____

Are you irritable, agitated or angry or do you have less tolerance or a short fuse? Yes No

If yes, have you reacted in a way that has caused problems? Please describe. _____

Please answer the following questions, 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 in trouble? Yes No

...you were so irritable that you shouted at people or started fights or arguments? Yes No

...you were much more self-confident than usual? Yes No

...you got much less sleep than usual and found you didn't really miss it? Yes No

...you were much more talkative or spoke faster than usual? Yes No

...thoughts raced through your head or you couldn't slow your mind down? Yes No

...you were so easily distracted by things around you that you had trouble concentrating or staying on track? Yes No

...you had much more energy than usual? Yes No

...you were much more active or did many more things than usual? Yes No

...you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night? Yes No

...you were much more interested in sex than usual? Yes No

...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? Yes No

...spending money got you or your family into trouble? Yes No

Total number of questions answered "Yes": _____

If you checked "Yes" to more than one of the questions above:

Have several of these ever happened during the same period of time? Yes No

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

No Problem Moderate Problem Minor Problem Serious Problem

Have any blood relatives had manic-depression or bipolar disorder? Yes No

Has a health professional ever told you that you have manic-depression or bipolar disorder? Yes No

Do you suffer from anorexia, bulimia or any other eating disorder? Yes No

If yes, please describe: _____

How is your appetite? _____

Name: _____

Date: _____

Have you had any recent changes in weight? Yes No If yes, please describe: _____

How are you functioning sexually? Are any of your medications causing sexual side effects? _____

Are there other medical symptoms we should know about (e.g. forgetfulness, weight changes, dry, coarse skin/hair, change in bowel habits etc)? _____

Support System:

Do you feel that you have a support system? Family Friends Coworkers Other: _____

Sleep Habits:

Do you have any trouble falling asleep? Yes No If yes, what prevents you from falling asleep? _____

How is the quality of your sleep (e.g., light, deep, etc.)? _____

Do you snore? Yes No Don't know

Have you been told that you stop breathing or gasp for breath when asleep? Yes No Don't know

Do you wake up in the middle of the night? Yes No
If so, how often and are you able to fall back to sleep? _____

Do you feel rested in the morning? Yes No Sometimes

How long have you suffered with sleep problems? _____

Have you ever had a sleep study? Yes No
If yes, when and what were the results? _____

If you have a problem with sleepiness or fatigue, please rate the following questions based on how likely you are to doze off or fall asleep in the following situations, in contrast to just feeling tired. Even if you haven't done some activities recently, think about how they would have affected you. Use this scale to choose the most appropriate number for each situation: 0= would never doze, 1= slight chance of dozing, 2= moderate chance of dozing, 3= high chance of dozing

Situation:	Chance of Dozing:			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (i.e., a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
Add all of your circled numbers together to get a total score:				

Name: _____

Date: _____

Substance Use:

Do you use alcohol? Yes No

If so, how many drinks do you have a night, and how many nights per week do you drink? _____

When you drink do you drink to get buzzed, drunk, or black-out? _____

Do you use nicotine? Yes No

If so, how much/often? _____

Do you use any recreational drugs? Yes No

If so, which ones and how often? _____

Do you have a history of drug use? Yes No

Does your use of any of these substances play a part in the reason for your appointment today? Yes No

If yes, please explain: _____

Do family or friends disagree with this? Yes No

Have you ever been treated for substance abuse in the past? Yes No

If so, when and what type of treatment did you receive? _____

Do any genetic relatives have a history of problems with alcohol or substance abuse? Yes No

If yes, which relative(s)? _____

Psychiatric History:

Have you had any past psychiatric treatment or psychotherapy? Yes No

If yes, please list the names of the psychiatrists or therapists you've seen, why you were you seen, when and for how long you were treated. _____

Have you had any hospitalizations for a psychiatric condition? Yes No

If yes, please explain: _____

Where and when were you hospitalized? _____

Name: _____

Date: _____

Are you currently in psychotherapy/counseling? Yes No

If yes, who is your therapist and how long have you seen him/her? _____

If no, do you think psychotherapy would be of benefit? Yes No

Do you feel that your current or past psychiatric care/psychotherapy has been helpful to you? Yes No N/A

Why or why not? _____

Is there any family genetic psychiatric history? Yes No

If yes, please be specific (who has what problem? on mother's or father's side?). If no formal diagnoses were made, what is your "gut" feeling about your family genetic psychiatric history? _____

Are any relatives on medications? _____

Which medications? _____

Were they helpful? _____

Do you have any current thoughts of harming yourself or anyone else (thoughts, plans, attempts, cutting, passive thoughts of wishing you weren't here, etc.)? Yes No

If yes, please describe: _____

Do you have a suicide or homicide plan? Yes No

If yes, please describe: _____

Has there been any past history of suicidal attempts, cutting, or self-mutilation? Yes No

If yes, please explain: _____

Head Injuries:

Have you ever had any head injury, sports injury to the head, falls, concussions or car accidents? Yes No

(If no, skip to next section)

If yes, describe where on the head the injury occurred and at what age: _____

Was there any loss of consciousness or amnesia? Yes No Don't know

Has there been any change in mood or memory since the head trauma occurred? Yes No

If yes, please describe: _____

Name: _____

Date: _____

Were you hospitalized for the head injury? Yes No

If yes, please describe: _____

Was any type of scan performed (CAT scan, MRI, EEG, etc.)? Yes No Don't know

If yes, what did it show? _____

Pain:

Do you have any problems with pain? Yes No (If no, skip to next section)

If yes, describe your pain: _____

What is your average daily pain level, using the pain scale from 1 to 10, 10 being excruciating pain: _____

How long have you been suffering with this level of pain? _____

Are you being treated for this problem? Yes No

If yes, by whom? _____

Female Patients:

Do you have regular periods? Yes No N/A

If no, please describe: _____

Are you taking contraceptives? Yes No N/A

If so, did you notice a change in your mood when you started or stopped birth control? Yes No

If yes, please describe: _____

Have you noticed any perimenopausal/ menopausal symptoms (i.e., hair falling out, dry eyes, irregular periods, irritability, vaginal dryness, etc.)? Yes No N/A

If yes, have you consulted a doctor about this? Yes No

Did the doctor do any additional tests other than blood work, or how did the doctor treat your condition? _____

Do you have any PMS symptoms? Yes No

If yes, please describe, including how many days of your cycle the symptoms last: _____

Childhood/Cultural History:

Describe your childhood, including whether or not your parents divorced and if so, how old you were, any siblings and their ages, any trauma, physical, emotional or sexual abuse, and birth history. _____

Name: _____

Date: _____

Are there any cultural or spiritual factors that you would like to tell us about? _____

Legal History:

Have you ever had any legal problems including jail, prison, lawsuits, bankruptcy, etc.? Yes No

If yes, please explain: _____

Are you presently on diversion or probation? Yes No

If yes, what are the requirements of your diversion or probation? _____

Have you ever served in the military? Yes No

If yes, what branch of the military? _____

What type of discharge did you receive? _____

ADD/ADHD Symptom Information:

Have you previously been evaluated for ADD/ADHD? Yes No

If yes, please tell us who evaluated you, with what tests, and what the results were: _____

What are your primary symptoms related to your ADD/ADHD:

- Attention Distractibility Focus
- Impulsivity Restless/always active Procrastination

Please describe these symptoms in more detail and how they are affecting your life in the following areas:

Home: _____

School or work: _____

Relationships: _____

What would others who are close to you say about your symptoms? _____

Name: _____

Date: _____

How long have these symptoms been a problem for you? _____

Are these symptoms: Always present Intermittent

Please describe: _____

School performance: (Please answer the questions below as they pertained to you when you were in school.)

How did you do in school? (In grade school, high school, college; what did teachers say; did you live up to your academic potential; absences, tardiness, alertness in class, etc.). _____

Were any grades repeated? Yes No If so, which ones? _____

On average, what grades did you receive? _____

Did school performance get worse as you got older? _____

In what grade did you notice a decline in grades? _____

Was homework an issue in receiving poor grades? Yes No

Did you complete homework? Yes No

Did you forget to turn in homework? Yes No

Was there a variation in grades from year to year or subject to subject? Yes No

If so, please explain: _____

What subjects were the biggest struggles? _____

Were these struggles related to the subject matter or the teacher? _____

If problems were in math, did you struggle with retention of math facts or comprehension of how to solve the problem?

What were the best subject(s) for you? _____

What was unique or different about your favorite teacher? _____

Did you receive any special education assistance or tutoring? If so, what kind? _____

Did you have an IEP (Individualized Education Program) or 504? Yes No

Do you understand why you had an IEP or 504? If so, please describe your understanding of it. _____

Do you feel that the school followed through with the suggested accommodations described in the IEP or 504?

Name: _____

Date: _____

ADD/ADHD/Learning Disorder Background Information:

Are there any ADD/ADHD/Learning Disorders or Behavioral Problems in the family genetics? Yes No
If so, in whom (also state whether it was on mother's or father's side)? If no formal diagnosis was ever made, what is your "gut" feeling about this question? _____

Were there any problems in pregnancy or birth (i.e. cord wrapped around neck or ankle, oxygen required at birth, etc.)?
 Yes No Don't know
If yes, please describe: _____

Were there many ear infections as a child? Yes No Don't know
If yes, how many would you estimate: <5 5-10 >10
Were tubes ever surgically inserted? Yes No
Were any antibiotics taken? Yes No If yes, which ones? _____

As a child, how did you get along with friends and peers (e.g., isolated, age appropriate, attention seeking, respect for other's personal space and possessions, oppositional, aggressive, etc.)? _____

What are your strengths and talents? _____

Any other miscellaneous information we should know? _____

Developmental Milestones	Behavior/Characteristics
<p>As an infant, the patient usually:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Was restless, squirmy, into everything <input type="checkbox"/> Had difficulty in how they handled change in routine <input type="checkbox"/> Protested when first introduced to new foods, places, or people <input type="checkbox"/> Was intense and/or loud <input type="checkbox"/> Was unpredictable in feeding and sleeping <input type="checkbox"/> Was sensitive to noise, texture, clothing <input type="checkbox"/> Was fussy and unhappy <input type="checkbox"/> Did not enjoy cuddling <input type="checkbox"/> Was not calmed by holding or stroking <input type="checkbox"/> Had colic <input type="checkbox"/> Had sleep problems <input type="checkbox"/> Was hard to arouse while asleep <input type="checkbox"/> Had bedwetting or problems with soiling (until what age _____) <input type="checkbox"/> Don't know 	<p>Check any symptoms that apply (off medication) either now or in the past:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fails to pay attention to details or is careless <input type="checkbox"/> Has difficulty organizing tasks and activities <input type="checkbox"/> Is forgetful in daily activities <input type="checkbox"/> Doesn't seem to listen to what is being said <input type="checkbox"/> Avoids, dislikes or is reluctant to engage in tasks requiring sustained mental effort <input type="checkbox"/> Is easily distracted by external stimuli <input type="checkbox"/> Neither follows through on instructions nor completes chores, schoolwork or jobs (not because of oppositional behavior or failure to understand) <input type="checkbox"/> Loses things <input type="checkbox"/> Has trouble keeping attention on tasks <input type="checkbox"/> Shifts from one uncompleted activity to another <input type="checkbox"/> Has difficulty remaining seated <input type="checkbox"/> Has difficulty awaiting turns <input type="checkbox"/> Blurts out answers to questions before they have been completed <input type="checkbox"/> Has difficulty engaging in leisure activity <input type="checkbox"/> Talks excessively <input type="checkbox"/> Interrupts or intrudes on others <input type="checkbox"/> Squirms in seat or fidgets <input type="checkbox"/> Has a feeling of restlessness <input type="checkbox"/> Appears driven or "on the go"

MEDICATION HISTORY

Name:

Date:

Instructions: Check the box next to the names of any medications that you have EVER taken, and complete the remaining boxes as completely as possible.

Medications		Dosage Information			Response	Side Effects	Reason Stopped	
Brand Name	Generic Name	Max Total Daily Dose	Start Date Mo / Yr	Stop Date Mo / Yr			List any that occurred while taking that medication	1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)
Selective Serotonin Reuptake Inhibitors (SSRIs)					Circle Answer		Circle Answer	(if 2 or 3, describe)
<input type="checkbox"/> Celexa	citalopram		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Lexapro	escitalopram		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Luvox	fluvoxamine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Paxil	paroxetine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Prozac	fluoxetine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Zoloft	sertraline		/	/	-1 0 1 2 3 9		1 2 3	
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)								
<input type="checkbox"/> Cymbalta	duloxetine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Effexor	venlafaxine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Pristiq	desvenlafaxine		/	/	-1 0 1 2 3 9		1 2 3	
Other Antidepressants								
<input type="checkbox"/> Desyrel	trazodone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> ECT			/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Remeron	mirtazapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Serzone	nefazodone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Wellbutrin	bupropion		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Aplenzin	bupropion hydrobromine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Venlafaxine ER	Venlafaxine hydrochloride		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Viibryd			/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name:

Date:

Medications		Dosage Information			Response	Side Effects	Reason Stopped	
Brand Name	Generic Name	Total Daily Dose	Start Date Mo / Yr	Stop Date Mo / Yr	-1 Worse, 0 No change, 1 Marginally improved 2 Markedly improved 3 Resolved 9 No information	List any that occurred while taking that medication	1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)	
<i>Tricyclic Antidepressants</i>					Circle Answer		Circle Answer	(if 2 or 3, describe)
<input type="checkbox"/> Adapin	doxepin		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Anafranil	clomipramine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Asendin	amoxapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Endep/Elavil	amitriptyline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Ludiomil	maprotiline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Norpramin	desipramine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Pamelor/Aventyl	nortriptyline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Sinequan	doxepin		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Surmontil	trimipramine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Tofranil	imipramine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Vivactil	protriptyline		/	/	-1 0 1 2 3 9		1 2 3	
<i>Monoamine Oxidase Inhibitors (MAOIs)</i>								
<input type="checkbox"/> Eldepryl/EMSAM	selegiline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Manerix	moclobemide		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Marplan	isocarboxazid		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Nardil	phenelzine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Parnate	tranylcypromine		/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name:

Date:

Medications		Dosage Information			Response	Side Effects	Reason Stopped	
Brand Name	Generic Name	Max Total Daily Dose	Start Date Mo / Yr	Stop Date Mo / Yr	-1 Worse, 0 No change, 1 Marginally improved 2 Markedly improved 3 Resolved 9 No information	List any that occurred while taking that medication	1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)	
Stimulants					Circle Answer		Circle Answer	(if 2 or 3, describe)
<input type="checkbox"/> Adderall	dexlevoamphetamine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Concerta	methylphenidate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Cylert	pemoline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Daytrana			/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Dexadrine	dextroamphetamine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Eldepryl	selegiline		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Focalin	dexmethylphenidate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Intuniv			/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Nuvigil	armodafinil		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Provigil	modafinil		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Ritalin	methylphenidate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Strattera	atomoxetine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Vyvanse			/	/	-1 0 1 2 3 9		1 2 3	
Anti-Convulsants/Mood Stabilizers								
<input type="checkbox"/> Depakote, Depakene	valproic acid		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Eskalith, Lithobid	lithium carbonate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Keppra	levetiracetam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Lamictal	lamotrigine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Lyrica	pregabalin		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Neurontin	gabapentin		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Tegretol, Eptol, Carbatrol	carbamazepine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Topamax	topiramate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Trileptal	oxcarbazepine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Zonegran	zonisamide		/	/	-1 0 1 2 3 9		1 2 3	
Beta Blockers								
<input type="checkbox"/> Inderal	propranolol		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Pindolol			/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Tenormin	atenolol		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Toprol	metoprolol		/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name:

Date:

Medications		Dosage Information			Response	Side Effects	Reason Stopped	
Brand Name	Generic Name	Max Total Daily Dose	Start Date Mo / Yr	Stop Date Mo / Yr	-1 Worse, 0 No change, 1 Marginally improved 2 Markedly improved 3 Resolved 9 No information	List any that occurred while taking that medication	1. Lack of therapeutic Effect 2. Side Effects (describe below) 3. Other (describe below)	
<i>Minor Tranquilizer / Hypnotics</i>								
<input type="checkbox"/> Ambien	zolpidem		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Atarax	hydroxyzine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Ativan	lorazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Benedryl	diphenhydramine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Buspar	buspirone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Dalmane	flurazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Doral	quazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Halcion	triazolam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Klonopin	clonazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Librium	hlordiazepoxide		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Lunesta	eszopiclone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Prosom	estazolam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Restoril	temazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Rozerem	ramalteon		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Serax	oxazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Sonata	zaleplon		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Tranxene	clorazepate		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Unisom	doxylamine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Valium	diazepam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Xanax	alprazolam		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/>	chloral hydrate		/	/	-1 0 1 2 3 9		1 2 3	

MEDICATION HISTORY

Name:

Date:

Medications		Dosage Information			Response -1 Worse, 0 No change, 1 Marginally improved 2 Markedly improved 3 Resolved 9 No information	Side Effects List any that occurred while taking that medication	Reason Stopped	
Brand Name	Generic Name	Max Total Daily Dose	Start Date Mo / Yr	Stop Date Mo / Yr			1. Lack of therapeutic Effect	2. Side Effects (describe below)
Major Tranquilizers/Atypicals					Circle Answer		Circle Answer	(if 2 or 3, describe)
<input type="checkbox"/> Abilify	aripiprazole		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Clozaril	clozapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Geodon	zipazodone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Haldol	haloperidol		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Invega	paliperidone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Loxitane	loxapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Mellaril	thioridazine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Moban	molindone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Navane	thiothixene		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Prolixin	fluphenazine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Risperdal	risperdone		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Saphris	asenapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Seroquel	quetiapine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Sonazine, Thorazine	chlorpromazine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Stelazine	trifluoperazine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Symbyax	olanzapine/fluoxetine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Trilafon	perphenazine		/	/	-1 0 1 2 3 9		1 2 3	
<input type="checkbox"/> Zyprexa	olanzapine		/	/	-1 0 1 2 3 9		1 2 3	
Others								
	verapamil		/	/	-1 0 1 2 3 9		1 2 3	
	Cerepholin NAC		/	/	-1 0 1 2 3 9		1 2 3	
	Deplin		/	/	-1 0 1 2 3 9		1 2 3	

INVENTORY OF DEPRESSIVE SYMPTOMOLOGY (Self-Report) (IDS-SR)

Name: _____

Date: _____

Instructions: Please circle the one response to each item that best describes you for the past seven days.

1. Falling Asleep:

- 0 I never take longer than 30 minutes to fall asleep.
- 1 I take at least 30 minutes to fall asleep, less than half the time.
- 2 I take at least 30 minutes to fall asleep, more than half the time.
- 3 I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep During the Night:

- 0 I do not wake up at night.
- 1 I have a restless, light sleep with a few brief awakenings each night.
- 2 I wake up at least once a night, but I go back to sleep easily.
- 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time

3. Waking up Too Early:

- 0 Most of the time, I awaken no more than 30 minutes before I need to get up.
- 1 More than half the time, I awaken more than 30 minutes before I need to get up.
- 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
- 3 I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping Too Much:

- 0 I sleep no longer than 7-8 hours/night, without napping during the day.
- 1 I sleep no longer than 10 hours in a 24-hour period including naps.
- 2 I sleep no longer than 12 hours in a 24-hour period including naps.
- 3 I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling Sad:

- 0 I do not feel sad.
- 1 I feel sad less than half the time.
- 2 I feel sad more than half the time.
- 3 I feel sad nearly all of the time.

6. Feeling Irritable:

- 0 I do not feel irritable.
- 1 I feel irritable less than half the time.
- 2 I feel irritable more than half the time.
- 3 I feel extremely irritable nearly all of the time.

7. Feeling Anxious or Tense:

- 0 I do not feel anxious or tense.
- 1 I feel anxious (tense) less than half the time.
- 2 I feel anxious (tense) more than half the time.
- 3 I feel extremely anxious (tense) nearly all of the time.

8. Response of Your Mood to Good or Desired Events:

- 0 My mood brightens to a normal level which lasts for several hours when good events occur.
- 1 My mood brightens but I do not feel like my normal self when good events occur.
- 2 My mood brightens only somewhat to a rather limited range of desired events.
- 3 My mood does not brighten at all, even when very good or desired events occur in my life.

Name: _____

Date: _____

9. Mood in Relation to the Time of Day:

- 0 There is no regular relationship between my mood and the time of day.
 - 1 My mood often relates to the time of day because of environmental events (e.g., being alone, working).
 - 2 In general, my mood is more related to the time of day than to environmental events.
 - 3 My mood is clearly and predictably better or worse at a particular time each day.
- 9A. Is your mood typically worse in the: Morning, Afternoon, or Night?
- 9B. Is your mood variation attributed to the environment? Yes No

10. The Quality of Your Mood:

- 0 The mood (internal feelings) that I experience is very much a normal mood.
- 1 My mood is sad, but this sadness is pretty much like the sad mood I would feel if someone close to me died or left.
- 2 My mood is sad, but this sadness has a rather different quality to it than the sadness I would feel if someone close to me died or left.
- 3 My mood is sad, but this sadness is different from the type of sadness associated with grief or loss.

PLEASE COMPLETE EITHER 11 OR 12 (NOT BOTH).

11. Decreased Appetite:

- 0 There is no change in my usual appetite.
- 1 I eat somewhat less often or lesser amounts of food than usual.
- 2 I eat much less than usual and only with personal effort.
- 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

12. Increased Appetite:

- 0 There is no change from my usual appetite.
- 1 I feel a need to eat more frequently than usual.
- 2 I regularly eat more often and/or greater amounts of food than usual.
- 3 I feel driven to overeat both at mealtime and between meals.

PLEASE COMPLETE EITHER 13 OR 14 (NOT BOTH)

13. Decreased Weight (Within the Last Two Weeks):

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight loss.
- 2 I have lost between 2-4 pounds.
- 3 I have lost 5 pounds or more.

14. Increased Weight (Within the Last Two Weeks):

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight gain.
- 2 I have gained 2-4 pounds.
- 3 I have gained 5 pounds or more.

15. Concentration/Decision Making:

- 0 There is no change in my usual capacity to concentrate or make decisions.
- 1 I occasionally feel indecisive or find that my attention wanders.
- 2 Most of the time, I struggle to focus my attention or to make decisions.
- 3 I cannot concentrate well enough to read or cannot make even minor decisions.

Name: _____

Date: _____

16. View of Myself:

- 0 I see myself as equally worthwhile and deserving as other people.
- 1 I am more self-blaming than usual.
- 2 I largely believe that I cause problems for others.
- 3 I think almost constantly about major and minor defects in myself.

17. View of My Future:

- 0 I have an optimistic view of my future.
- 1 I am occasionally pessimistic about my future, but for the most part I believe things will get better.
- 2 I'm pretty certain that my immediate future (1-2 months) does not hold much promise of good things for me.
- 3 I see no hope of anything good happening to me anytime in the future.

18. Thoughts of Death or Suicide:

- 0 I do not think of suicide or death.
- 1 I feel that life is empty or wonder if it's worth living.
- 2 I think of suicide or death several times a week for several minutes.
- 3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

19. General Interest:

- 0 There is no change from usual in how interested I am in other people or activities.
- 1 I notice that I am less interested in people or activities.
- 2 I find I have interest in only one or two of my formerly pursued activities.
- 3 I have virtually no interest in formerly pursued activities.

20. Energy Level:

- 0 There is no change in my usual level of energy.
- 1 I get tired more easily than usual.
- 2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking or going to work).
- 3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

21. Capacity for Pleasure or Enjoyment (excluding sex):

- 0 I enjoy pleasurable activities just as much as usual.
- 1 I do not feel my usual sense of enjoyment from pleasurable activities.
- 2 I rarely get a feeling of pleasure from any activity.
- 3 I am unable to get any pleasure or enjoyment from anything.

22. Interest in Sex (Please Rate Interest, not Activity):

- 0 I'm just as interested in sex as usual.
- 1 My interest in sex is somewhat less than usual or I do not get the same pleasure from sex as I used to.
- 2 I have little desire for or rarely derive pleasure from sex.
- 3 I have absolutely no interest in or derive no pleasure from sex.

23. Feeling Slowed Down:

- 0 I think, speak, and move at my usual rate of speed.
- 1 I find that my thinking is slowed down or my voice sounds dull or flat.
- 2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
- 3 I am often unable to respond to questions without extreme effort.

Name: _____

Date: _____

24. Feeling Restless:

- 0 I do not feel restless.
- 1 I'm often fidgety, wring my hands, or need to shift how I am sitting.
- 2 I have impulses to move about and am quite restless.
- 3 At times, I am unable to stay seated and need to pace around.

25. Aches and Pains:

- 0 I don't have any feeling of heaviness in my arms or legs and don't have any aches or pains.
- 1 Sometimes I get headaches or pains in my stomach, back or joints but these pains are only sometime present and they don't stop me from doing what I need to do.
- 2 I have these sorts of pains most of the time.
- 3 These pains are so bad they force me to stop what I am doing.

26. Other Bodily Symptoms:

- 0 I don't have any of these symptoms: heart pounding fast, blurred vision, sweating, hot and cold flashes, chest pain, heart turning over in my chest, ringing in my ears, or shaking.
- 1 I have some of these symptoms but they are mild and are present only sometimes.
- 2 I have several of these symptoms and they bother me quite a bit.
- 3 I have several of these symptoms and when they occur I have to stop doing whatever I am doing.

27. Panic/Phobic Symptoms:

- 0 I have no spells of panic or specific fears (phobia, such as animals or heights).
- 1 I have mild panic episodes or fears that do not usually change my behavior or stop me from functioning.
- 2 I have significant panic episodes or fears that force me to change my behavior but do not stop me from functioning.
- 3 I have panic episodes at least once a week or severe fears that stop me from carrying on my daily activities.

28. Constipation/Diarrhea:

- 0 There is no change in my usual bowel habits.
- 1 I have intermittent constipation or diarrhea which is mild.
- 2 I have diarrhea or constipation most of the time but it does not interfere with my day-to-day activities.
- 3 I have constipation or diarrhea for which I take medicine or which interferes with my day-to-day activities.

29. Interpersonal Sensitivity:

- 0 I have not felt easily rejected, slighted, criticized or hurt by others at all.
- 1 I have occasionally felt rejected, slighted, criticized or hurt by others.
- 2 I have often felt rejected, slighted, criticized or hurt by others, but these feelings have had only slight effects on my relationships or work.
- 3 I have often felt rejected, slighted, criticized or hurt by others and these feelings have impaired my relationships and work.

30. Lethargy/Physical Energy:

- 0 I have not experience the physical sensation of feeling weighted down and without physical energy.
- 1 I have occasionally experienced periods of feeling physically weighted down and without physical energy, but without a negative effect on work, school, or activity level.
- 2 I feel physically weighted down (without physical energy) more than half the time.
- 3 I feel physically weighted down (without physical energy) most of the time, several hours per day, several days per week.

**PSYCHIATRIC SYMPTOMS
(For Adult Patients Only)**

Name:

Date:

Below is a list of common psychiatric symptoms. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly - but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score.

Write that score here _____

QUALITY OF LIFE ENJOYMENT AND SATISFACTION QUESTIONNAIRE - SHORT FORM (Q-LES-Q-SF)

Name:

Date:

Instructions: Please place a check mark in the box that best describes your satisfaction **during the past few weeks**. Answer questions 1 through 16, using the N/A for those which do not apply.

Taking everything into consideration, during the <u>past few weeks</u>,	OVERALL LEVEL OF SATISFACTION					N/A
	Very Poor	Poor	Fair	Good	Very Good	
How satisfied have you been with your...	1	2	3	4	5	
1) ...physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) ...mood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) ...work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) ...household activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) ...social relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) ...family relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) ...leisure time activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) ...ability to function in daily life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) ...sexual drive, interest and/or performance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) ...economic status?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11) ...living/housing situation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12) ...ability to get around physically without feeling dizzy or unsteady or falling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13) ...your vision in terms of ability to do work or hobbies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) ...overall sense of well being?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15) ...medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16) How would you rate your overall life satisfaction and contentment during the past few weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OFFICE USE ONLY						
Total Raw Score from Questions 1-14 (0-70):	+	+	+	+	=	
Total number of questions <u>Un</u>answered in Questions 1-14 above (valid test must be 0-4):						
					PERCENTAGE:	%