IN-TOUCH PSYCHIATRY, INC.

Child, Adolescent, Adult, and Geriatrics Psychiatry
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*****EVERY FIELD MUST BE COMPLETED*****

Patient Information:

First Name: _____ MI: _____ Last Name: _____

Address: _____

Date of Birth: _____ SSN: _____-_____-_____

Phone: _____-_____-_____ Cell: _____-_____-_____

Email: _____

(Emails are for appointment reminders only)

INSURANCE INFORMATION: PLEASE PROVIDE A COPY OF INSURANCE CARDS AT TIME OF SERVICE

Policy Holder: _____ SS#:_____ Date of Birth: _____

Insurance Company: _____ ID: _____

Group Number: _____ Phone: _____

Secondary Carrier: _____ ID: _____

In case of an emergency call:

Name: _____ Relation: _____

Phone: _____

Patient's mother's name: ***This is for patient identifying purposes only***

Maiden Last Name: _____

PLEASE READ AND SIGN:

All charges are due at the time of service. You are responsible for all fees. All costs not covered by your insurance company will be your responsibility. It is your responsibility to obtain referral/ authorizations from your insurance company prior to any services rendered.

I hereby authorize Excellent Care Psychiatry to furnish information to my insurance carriers concerning my illness and treatment for myself and/or my dependents.

_____ _____ _____

Date Signature Relationship to patient

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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

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

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

Patient Name		Today's Date	

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

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

Part A

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

Part B

The Mood Disorder Questionnaire (MDQ)

INSTRUCTIONS: Please answer each question as best you can.	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 that you didn't really miss it?	◯	◯
... you were more talkative or spoke much faster than usual?	◯	◯
... thoughts raced through your head or you couldn't slow your mind down?	◯	◯
... you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
... you had 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 in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	◯	◯
3. How much of a problem did any of these cause you - like being able to work; having family, money or legal troubles; getting into arguments or fights? ◯ 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?	◯	◯

PROMIS–29 Profile v2.0

Please respond to each question or statement by marking one box per row.

	Physical Function	**Without any difficulty**	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
1	Are you able to do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
2	Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
3	Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
4	Are you able to run errands and shop?	☐	☐	☐	☐	☐
	Anxiety **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
5	I felt fearful	☐	☐	☐	☐	☐
6	I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
7	My worries overwhelmed me	☐	☐	☐	☐	☐
8	I felt uneasy	☐	☐	☐	☐	☐
	Depression **In the past 7 days...**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
9	I felt worthless	☐	☐	☐	☐	☐
10	I felt helpless	☐	☐	☐	☐	☐
11	I felt depressed	☐	☐	☐	☐	☐
12	I felt hopeless	☐	☐	☐	☐	☐
	Fatigue **During the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
13	I feel fatigued	☐	☐	☐	☐	☐
14	I have trouble starting things because I am tired	☐	☐	☐	☐	☐

PROMIS–29 Profile v2.0

Fatigue

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
15	How run-down did you feel on average? ...	☐	☐	☐	☐	☐
16	How fatigued were you on average?	☐	☐	☐	☐	☐

Sleep Disturbance

	In the past 7 days…	Very poor	Poor	Fair	Good	Very good
17	My sleep quality was.....	☐	☐	☐	☐	☐

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
18	My sleep was refreshing.....	☐	☐	☐	☐	☐
19	I had a problem with my sleep	☐	☐	☐	☐	☐
20	I had difficulty falling asleep	☐	☐	☐	☐	☐

Ability to Participate in Social Roles and Activities

		Never	Rarely	Sometimes	Usually	Always
21	I have trouble doing all of my regular leisure activities with others.....	☐	☐	☐	☐	☐
22	I have trouble doing all of the family activities that I want to do	☐	☐	☐	☐	☐
23	I have trouble doing all of my usual work (include work at home)	☐	☐	☐	☐	☐
24	I have trouble doing all of the activities with friends that I want to do	☐	☐	☐	☐	☐

Pain Interference

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
25	How much did pain interfere with your day to day activities?.....	☐	☐	☐	☐	☐
26	How much did pain interfere with work around the home?	☐	☐	☐	☐	☐
27	How much did pain interfere with your ability to participate in social activities? .	☐	☐	☐	☐	☐
28	How much did pain interfere with your household chores?	☐	☐	☐	☐	☐

PROMIS–29 Profile v2.0

Pain Intensity

In the past 7 days…

29	How would you rate your pain on average?.....	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst imaginable pain**

PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability

A. During the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered (0)**	**Bothered a little (1)**	**Bothered a lot (2)**
1. Stomach pain	☐	☐	☐
2. Back pain	☐	☐	☐
3. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐
5. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐
6. Menstrual cramps or other problems with your periods	☐	☐	☐
7. Pain or problems during sexual intercourse	☐	☐	☐
8. Headaches	☐	☐	☐
9. Chest pain	☐	☐	☐
10. Dizziness	☐	☐	☐
11. Fainting spells	☐	☐	☐
12. Feeling your heart pound or race	☐	☐	☐
13. Shortness of breath	☐	☐	☐
14. Constipation, loose bowels, or diarrhea	☐	☐	☐
15. Nausea, gas, or indigestion	☐	☐	☐

PHQ-15 Score ☐ = _____ + _____

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

GAD-7 Score ☐ = _____ + _____ + _____

C. Questions about anxiety attacks.

	NO	YES
a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?……..	☐	☐
If you checked "NO", go to question E.		
b. Has this ever happened before?……	☐	☐
c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?……	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?……..….	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping?……..……	☐	☐

D. Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1.	Little interest or pleasure in doing things.....……	☐	☐	☐	☐
2.	Feeling down, depressed, or hopeless……..…	☐	☐	☐	☐
3.	Trouble falling or staying asleep, or sleeping too much…… ……	☐	☐	☐	☐
4.	Feeling tired or having little energy.....……...…..	☐	☐	☐	☐
5.	Poor appetite or overeating.....……..…	☐	☐	☐	☐
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down……..	☐	☐	☐	☐
7.	Trouble concentrating on things, such as reading the newspaper or watching television…….	☐	☐	☐	☐
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual……..	☐	☐	☐	☐
9.	Thoughts that you would be beter off dead of or hurting yourself in some way……..	☐	☐	☐	☐

PHQ-9 Score ☐ = _____ + _____ + _____

E. If you checked off any problems on this questionnaire, 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
☐	☐	☐	☐