Patient Information for Medical Records

Please fill out all applicable areas

Patient's Name: ______________________________ _Today's Date: ______________

DOB:____________________ SS#: ____________________ Age: ____________ Sex: ☐ M ☐ F

Address: ____ Marital Status: ☐Married

____ ☐Separated ☐Divorced

List only contact numbers where we will be able to leave a message: ☐Single ☐Widowed

Hm Phone: ____________________ Wk Phone: ____________________ Cell Phone: ____________________

INSURANCE INFORMATION

Primary Insurance: ______________________________ Effective Date of Primary: ____________________

Name of Subscriber: ______________________________ Subscriber Date of Birth: ____________________

Claims Address (usually on back of card): ____

The patient is the subscriber's (circle one): self spouse child/stepchild other

Patient's Primary Insurance ID: ______________________________ Group Number: ____________________

Secondary Insurance: ______________________________ Effective Date of Secondary: ____________________

Name of Subscriber: ______________________________ Subscriber Date of Birth: ____________________

Claims Address (usually on back of card): ____

The patient is the subscriber's (circle one): self spouse child/stepchild other

Patient's Secondary Insurance ID: ______________________________ Group Number: ____________________

Emergency Contact Name: ____

Phone #: ____________________ Relationship to Pt: ____________________

Primary Care Physician: ____________________ Phone ______________ Last Seen: ____________________

Referring Physician: ____________________ Phone: ______________ Last Seen: ____________________

Other Physician(s)/Therapist(s) Involved in Your Care:

1. ______________________________ Last Seen: ______________
2. ______________________________ Last Seen: ______________
3. ______________________________ Last Seen: ______________

Has the patient been evaluated by a Psychiatrist this year? ☐ Yes ☐ No If yes, when?______________

Employment: ______________________________ ☐Full-time ☐Part-time

Student: ______________________________ ☐Full-time ☐Part-time

Pharmacy:______________________________ Fax Number:______________

I,______________________, give permission for Psychiatry Associates of Tallahassee, Faisal A. Munasifi, MD, Lina M. Reyes, MD and Linda McKay, RN to provide me with services. I also assign directly to Psychiatry Associates of Tallahassee all medical benefits for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the physician to release all information necessary to secure payment for benefits. I also authorize a release of information between my referring/primary physicians regarding my treatment.

______________________________ ______________________________
Patient or legally authorized individual signature Printed name

____
Relationship (parent, legal, guardian, personal representative, etc.)

Please check with your physician regarding their refill policy, otherwise, please allow 72 hours for medications to be called in.

	Initial
All payments/co-payments are due at the time of services.	________
Failure to give 24-business hour notice will result in a "no show" fee.	________
Please do not leave children unattended in the building.	________
Prescription requests for controlled substance require 72-hour notice.	________
Prescriptions outside of regular appointments/lost prescriptions will result in a $25 replacement fee.	________
Patients on controlled substances must be seen (minimum – Dr.'s discretion) every three months.	________
There is a charge (depending on size and difficulty) for letters, paperwork etc.	________
Requests for a change of medication (type or dosage) or adding a medication require an appointment.	________

Acknowledgement of Receipt of Notice of Privacy Policies and Office Policies

I acknowledge that I have received a copy of the Providers Notice of Privacy Polices with the effective date of April 4, 2003 (attached).

______________________________ ______________________________
Signature of Parent/Patient representative Date

____
Relationship to patient

Mental Health Questionnaire

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

Name____Date__________________

Age______Date of Birth ________________ Primary Care Physician _________________________

Occupation_____________________________Marital Status____________________________

Current Therapist/Counselor ____________________Who referred you to us?____________________

What are the problem(s) for which you are seeking help?

1. ____
2. ____
3. ____

What are your treatment goals?

____

____

Current Symptoms Checklist: (please check all that apply)

( ) Depressed Mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Racing thoughts
( ) Impulsivity
( ) Increased risky behavior
( ) Increased libido
( ) Decreased need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive Worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) Decreased libido
( ) Nightmares

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No

If YES, please answer the following. If NO, please skip the next question.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No

Past Psychiatric History:

Outpatient Treatment? ( ) Yes ( ) No If yes, describe below:

Reason Dates Treated By Whom

____

____

____

____

Inpatient Treatment/Psychiatric Hospitalization? ( ) Yes ( ) No If yes, describe below:

Reason Dates Treated By Whom

____

____

____

History of significant psychological trauma? ( ) Yes ( ) No If yes, please briefly describe below:

____

____

____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants: Dates Dosage Response/Side-Effects

Prozac (fluoxetine) ____________________

Zoloft (sertraline) ____________________

Luvox (fluvoxamine) ____________________

Paxil (paroxetine) ____________________

Celexa (citalopram) ____________________

Lexapro (escitalopram) ____________________

Effexor (venlafaxine) ____________________

Cymbalta (duloxetine) ____________________

Wellbutrin (bupropion) ____________________

Remeron (mirtazapine) ____________________

Trintellix (voritioxetine) ____________________

Viibryd (vilazodone HCL) ____________________

Pamelor (nortriptyline) ____________________

Tofranil (imipramine) ____________________

Elavil (amitriptyline) ____________________

Fetzima (levomilnacipran)____________________

Mood Stabilizers:

Tegretol (carbamazepine) ____________________

Lithium ____________________

Depakote (valproate) ____________________

Lamictal (lamotrigine) ____________________

Topamax (topiramate) ____________________

Neurontin (gabapentin)____________________

Trileptal (oxcarbazepine)____________________

Antipsychotics/Mood Stabilizers:

Seroquel (quetiapine) ____________________

Zyprexa (olanzepine) ____________________

Geodon (ziprasidone) ____________________

Abilify (aripiprazole) ____________________

Clozaril (clozapine) ____________________

Haldol (haloperidol) ____________________

Prolixin (fluphenazine) ____________________

Risperdal (risperidone) ____________________

Latuda (lurasidone HCL)____________________

Vraylar (cariprazine)____________________

Rexulti (brexpiprazole)____________________

Fanapt (iloperidone)____________________

Saphris (asenapine)____________________

Sedative/Hypnotics:

Ambien (zolpidem) ____

Sonata (zaleplon) ____

Lunesta (eszopiclone) ____

Restoril (temazepam) ____

Desyrel (trazodone) ____

Silenor (doxepin)____

ADHD/Stimulant medications:

Adderall (amphetamine) ______________________________________

Concerta (methylphenidate) ___________________________________

Ritalin (methylphenidate) _____________________________________

Stratterra (atomoxetine) ______________________________________

Focalin (dexmethylphenidate)_____ ____

Vyvanse (lisdexamfetamine)____________________________________

Provigil (modafinil)____

Nuvigil (armodafinil)____

Intuniv (guanfacine)____

Anti-Anxiety medications:

Xanax (alprazolam) ____

Ativan (lorazepam) ____

Klonopin (clonazepam) _______________________________________

Valium (diazepam) ____

Tranxene (clorazepate) _______________________________________

Buspar (buspirone) ____

Family Psychiatric History:

Has anyone in your immediate family (parents,grandparents,siblings,children,aunts/uncles) been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-Traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol Abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	ADD/ADHD	( ) Yes ( ) No

Substance Use:

Have you ever been treated for alcohol or drug abuse? ( ) Yes ( ) No

If yes, which substances? ____________________________________

If yes, where were you treated and when? ______________________________

How many caffeinated beverages do you drink a day? _________________

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No Currently? ( ) Yes ( ) No How much and for how long? ________

Alcohol History:

Do you drink alcohol? ( ) Yes ( ) No How much and for how long?_________________________

When was your last drink?_____________________________

Have you ever tried the following? (check yes or no)

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	______
Cocaine	( )	( )	______
Stimulants (pills)	( )	( )	______
Heroin	( )	( )	______
LSD or Hallucinogens	( )	( )	______
Marijuana	( )	( )	______
Pain Killers (not as prescribed)	( )	( )	______
Methadone	( )	( )	______
Tranquilizer/Sleeping pills	( )	( )	______
Ecstasy	( )	( )	______

Medical History:

Allergies ____

Current Weight _____________ Height ______________

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No

Date and place of last physical exam: ____

List any major health problems for which you currently receive treatment:

____

____

____

____

List *ALL current prescription medications* and how often you take them (if none, write 'none'):

Medication Name Total Daily Dosage Estimated Start Date

____

____

____

____

Surgeries: ____

____

Women: Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _______________What is/was your occupation? _____________________________

Where do you work? ____

Have you ever served in the military? ( ) Yes ( ) No If so, what branch and when? ____________________________

Legal History:

Do you have any pending legal problems? ( ) Yes ( ) No If yes, please explain.

____

Relationship and Current Family History:

Are you currently: ( )Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed For how long? _______________

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, for how long? ________________________

What is your spouse/significant other's occupation? ____

Have you had any prior marriages? ( ) Yes ( ) No If yes, how many? _______________________

Do you have children? ( ) Yes ( ) No If yes, How many?_________________________

Interests:

Please list any hobbies, sports, community or special groups:

____

____

____

____

Is there anything else you would like us to know?

____

____

____

____

____

Signature ____ Date ________________

Guardian Signature _____________________________________ Date ________________

Emergency Contact ______________________________________ Phone ________________

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Full Name: ________________________________ Date of Birth: ___________________

Name When Treated (if different from above): ____

Treatment Dates: __________________________________

I. My Authorization

Please release the following information: (check all that apply)

- ☐ HIV/AIDS Testing and/or Treatment
- ☐ Alcohol and/or Drug Treatment
- ☐ Medical Evaluation
- ☐ Medical Progress Notes
- ☐ Laboratory Test Results
- ☐ Medication Information
- ☐ Psychiatric Evaluation
- ☐ Psychiatric Progress Notes
- ☐ Psychotherapy Notes
- ☐ Summary of Care
- ☐ Financial Information
- ☐ Re-disclosure of Information Received From Outside Sources

This information is to be disclosed from: ____
Provider Name and Phone # - or - Patient Name

This information is to be disclosed to: ____
Provider Name and Phone # - or - Providing info to parent, etc.

The reason for this authorization is: ____

This authorization ends when revoked by the patient or the patient's representative in writing.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. This authorization may be revoked by writing a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

____
Patient or Legally Authorized Individual Signature — Date

______________________________________ ______________________________________
Printed Name if Signed on Behalf of the Patient — Relationship to patient

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	________

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Hamilton Anxiety Scale (HAM-A)

Patient Name ______________________________ **Today's Date** ______________

The Hamilton Anxiety Scale (HAM-A) is a rating scale developed to quantify the severity of anxiety symptomatology, often used in psychotropic drug evaluation. It consists of 14 items, each defined by a series of symptoms. Each item is rated on a 5-point scale, ranging from 0 (not present) to 4 (severe).

0 = Not present to 4 = Severe

Score

☐ **1. ANXIOUS MOOD**
- Worries
- Anticipates worst

☐ **2. TENSION**
- Startles
- Cries easily
- Restless
- Trembling

☐ **3. FEARS**
- Fear of the dark
- Fear of strangers
- Fear of being alone
- Fear of animal

☐ **4. INSOMNIA**
- Difficulty falling asleep or staying asleep
- Difficulty with Nightmares

☐ **5. INTELLECTUAL**
- Poor concentration
- Memory Impairment

☐ **6. DEPRESSED MOOD**
- Decreased interest in activities
- Anhedoni
- Insomnia

☐ **7. SOMATIC COMPLAINTS: MUSCULAR**
- Muscle aches or pains
- Bruxism

☐ **8. SOMATIC COMPLAINTS: SENSORY**
- Tinnitus
- Blurred vision

☐ **9. CARDIOVASCULAR SYMPTOMS**
- Tachycardia
- Palpitations
- Chest Pain
- Sensation of feeling faint

☐ **10. RESPIRATORY SYMPTOMS**
- Chest pressure
- Choking sensation
- Shortness of Breath

☐ **11. GASTROINTESTINAL SYMPTOMS**
- Dysphagia
- Nausea or Vomiting
- Constipation
- Weight loss
- Abdominal fullness

☐ **12. GENITOURINARY SYMPTOMS**
- Urinary frequency or urgency
- Dysmenorrhea
- Impotence

☐ **13. AUTONOMIC SYMPTOMS**
- Dry Mouth
- Flushing
- Pallor
- Sweating

☐ **14. BEHAVIOR AT INTERVIEW**
- Fidgets
- Tremor
- Paces

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

	YES	NO
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?	❍	❍

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Dear Patients:

The following is to remind our current patients and inform out new patients of current office policies. Please note that all fees for prescriptions, telephone consultations, and letters/forms/medical records, etc. will be due in full at the time of the pick-up or service.

PRESCRIPTION POLICY

All prescription and refills are now sent to your pharmacy electronically. So please make sure we have your pharmacy on file. Additionally, when prescribing some controlled substances, there is a federal requirement that the clinician see the patient at least once every three months. If you have not been seen within that time frame, your refill request for a controlled substance may be denied.

APPOINTMENT CANCELLATION POLICY

We would like to remind all our patients that cancellations require a one-business day notice **(at least 24 hours**) to avoid the **$40 missed appointment charge**. We understand that occasionally an emergency may occur that may prevent proper notice. In those cases we will not charge subject to the approval of your provider.

LETTERS, FORMS AND PAPERWORK POLICY

There is a fee of **$50 per hour** for all forms completed in our office and most forms take anywhere from 30 minutes to 90 minutes to complete. We receive many daily requests to complete a variety of forms (disability, return to work, work excuses, school requests, etc.) We employ a registered nurse and a clerical staff member to obtain the records, review them completely and respond to the questions presented. They are then reviewed and signed by the physician.

TELEPHONE CONSULTATIONS

There will be a fee for telephone consults requiring physician/clinician intervention. To facilitate timeliness and maintain confidentiality the doctor or the nurse may communicate recommendations to you. These fees may or may not be covered by your insurance, so please contact your insurance provider if you would like to know if your plan will reimburse you for the cost. The base fee begins at $80 and will increase according to the complexity/length of the call.

We thank you for your patience, understanding, and cooperation in this matter.

Updated 09.01.2020-LPS for PAT, LLC