

## 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: \_\_\_\_\_

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### 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. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

Last Seen: \_\_\_\_\_

Last Seen: \_\_\_\_\_

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 Faisal A. Munasifi, MD, Linda Smith, PhD, Sterling Corry, APRN, Amy McLaughlin, APRN, Kelly Sunshine, APRN, Jonathan Johnson, PA-C, Linda McKay, RN to provide me with services. I also assign directly to Faisal A. Munasifi, M.D. 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)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Depressed Mood              | <input type="checkbox"/> Racing thoughts          | <input type="checkbox"/> Excessive Worry  |
| <input type="checkbox"/> Unable to enjoy activities  | <input type="checkbox"/> Impulsivity              | <input type="checkbox"/> Anxiety attacks  |
| <input type="checkbox"/> Sleep pattern disturbance   | <input type="checkbox"/> Increased risky behavior | <input type="checkbox"/> Avoidance        |
| <input type="checkbox"/> Loss of interest            | <input type="checkbox"/> Increased libido         | <input type="checkbox"/> Hallucinations   |
| <input type="checkbox"/> Concentration/forgetfulness | <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Suspiciousness   |
| <input type="checkbox"/> Change in appetite          | <input type="checkbox"/> Excessive energy         | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Excessive guilt             | <input type="checkbox"/> Increased irritability   | <input type="checkbox"/> Nightmares       |
| <input type="checkbox"/> Fatigue                     | <input type="checkbox"/> Crying spells            |   |

**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).

<b>Antidepressants:</b>	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 (vortioxetine)	_____	_____	_____
Viibryd (vilazodone HCL)	_____	_____	_____
Pamelor (nortriptyline)	_____	_____	_____
Tofranil (imipramine)	_____	_____	_____
Elavil (amitriptyline)	_____	_____	_____
Fetzima (levomilnacipran)	_____	_____	_____
<b>Mood Stabilizers:</b>			
Tegretol (carbamazepine)	_____	_____	_____
Lithium	_____	_____	_____
Depakote (valproate)	_____	_____	_____
Lamictal (lamotrigine)	_____	_____	_____
Topamax (topiramate)	_____	_____	_____
Neurontin (gabapentin)	_____	_____	_____
Trileptal (oxcarbazepine)	_____	_____	_____
<b>Antipsychotics/Mood Stabilizers:</b>			
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) \_\_\_\_\_

Strattera (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:**

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**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:

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**Is there anything else you would like us to know?**

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Signature \_\_\_\_\_

Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone \_\_\_\_\_

# F.A. MUNASIFI, M.D.

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PHYSICIAN ASSISTANT, CERTIFIED

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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)

- |  |   |
|--|---|
| <input type="checkbox"/> HIV/AIDS Testing and/or Treatment | <input type="checkbox"/> Psychiatric Evaluation                                     |
| <input type="checkbox"/> Alcohol and/or Drug Treatment     | <input type="checkbox"/> Psychiatric Progress Notes                                 |
| <input type="checkbox"/> Medical Evaluation                | <input type="checkbox"/> Psychotherapy Notes  |
| <input type="checkbox"/> Medical Progress Notes            | <input type="checkbox"/> Summary of Care  |
| <input type="checkbox"/> Laboratory Test Results           | <input type="checkbox"/> Financial Information                                      |
| <input type="checkbox"/> Medication Information            | <input type="checkbox"/> 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.

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Patient or Legally Authorized Individual Signature

Date

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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 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	0	1	2	3

add columns  +  +

(Healthcare professional: For interpretation of TOTAL, TOTAL:   
please refer to accompanying scoring card).

<p><b>10.</b> If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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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?	<input type="radio"/>	<input type="radio"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="radio"/>	<input type="radio"/>
...you felt much more self-confident than usual?	<input type="radio"/>	<input type="radio"/>
...you got much less sleep than usual and found you didn't really miss it?	<input type="radio"/>	<input type="radio"/>
...you were much more talkative or spoke much faster than usual?	<input type="radio"/>	<input type="radio"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="radio"/>	<input type="radio"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="radio"/>	<input type="radio"/>
...you had much more energy than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more active or did many more things than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="radio"/>	<input type="radio"/>
...you were much more interested in sex than usual?	<input type="radio"/>	<input type="radio"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="radio"/>	<input type="radio"/>
...spending money got you or your family into trouble?	<input type="radio"/>	<input type="radio"/>
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	<input type="radio"/>	<input type="radio"/>
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? <i>Please circle one response only.</i>		
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?	<input type="radio"/>	<input type="radio"/>
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	<input type="radio"/>	<input type="radio"/>

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PHYSICIAN ASSISTANT, CERTIFIED

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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 request 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.***