



Largo Office

9500 Medical Center Dr Suite 270,
Largo, MD 20774

Office

400 Ballantyne Suite 25,
Office, MD 20755

Phone 301 272 0555 Fax 301 272 0555

PATIENT REGISTRATION:

First: _____ Middle: _____ Last: _____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Work #: _____
Employer: _____ Social Security #: _____
Birth Date: _____ Age: _____ Gender: _____ Marital Status: _____
Race: _____ Email: _____

EMERGENCY CONTACT: NAME _____ **PHONE:** _____

Legal Guardian Information (If patient is less than 18 years old)

Legal Guardian Name: _____ Relationship to Patient: _____
Home #: _____ Cell #: _____ Work #: _____

Financial and Policy Holder Information

Primary Insurance

Insurance Company: _____ Contract #: _____ Group #: _____
Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Phone #: _____ Sex: M or F

Secondary Insurance

Insurance Company: _____ Contract #: _____ Group #: _____
Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Phone #: _____ Sex: M or F

Date _____

Name _____ Age _____

Address _____

Home phone _____ Work phone _____ Cell phone _____

What issue(s) bring(s) you to the Psychiatry Clinic?

What has been stressing you of late (e.g. Family, job, recent loss of loved ones, financial issues)?

Are you currently having any of the following problems (please circle)?

Depression? Loss of interest in activities? Feeling hopeless, worthless? Poor energy? Poor self-esteem? Change in appetite? Increased or decreased? Fatigue? Poor focus? Problems going to sleep? Thoughts of not being alive? Periods of euphoria or unusually good mood? Having very high energy for no reason? Going days without needing to sleep? Thoughts racing? Talking too fast? Acting impulsively (spending, speeding)?	Worrying excessively? Having tense muscles? So anxious you feel you cannot rest? Having panic attacks? Traumatic events that come back in nightmares, flashbacks? Feeling awkward in public? Thoughts that replay? Repetitive or compulsive behaviors? Phobias or fears? Grunts, tics, or jerks? Inattentiveness at work or school? If so, since what age? Hyperactive or fidgety?	Hearing voices? Seeing things? Feelings people were trying to watch or harm you? Concerns about alcohol use? Drug use? Concerns about eating too much? Eating too little? Memory problems? Getting lost easily? Forgetting how to do tasks? Problems finding words? Problems caring for yourself (cooking, dressing)?
--	---	--

Past Psychiatric Care

Have you been ever diagnosed with a mental health condition by a medical provider (e.g. Depression, bipolar, schizophrenia, ADHD)? If so, please list.

Have you ever been seen by a psychiatrist or therapist/counselor? Please list and describe.

Date(s) seen? By whom?	For what problem?	What treatment (meds, ECT, therapy)?

Have you ever been hospitalized for psychiatric care? Please list and describe.

Date(s)	Where and for what?	What treatment (meds, ECT, therapy)?

Have you ever been treated with any of the following medications? Circle all that apply and list any good or bad effects of the medications.

Med	Good/bad effects	Med	Good/bad effects	Med	Good/bad effects
Abilify		Haldol		Ritalin	
Ambien		Klonopin		Saphris	
Adderall		Invega		Serax	
Anafranil		Lamictal		Seroquel	
Antabuse		Latuda		Serzone	
Ascendin		Lexapro		Soma	
Atarax		Librium		Sonata	
Ativan		Lithium		Stelazine	
Buspar		Lunesta		Strattera	

Campral		Luvox		Suboxone/ subutex	
Celexa		Marplan		Symmetrel	
Chloral hydrate		Mellaril		Tegretol	
Clonidine		Methadone		Thorazine	
Clozaril		Miltown		Tofranil	
Cogentin		Nardil		Topomax	
Concerta		Norpramine		Traxene	
Cymbalta		Orap		Trazodone	
Dalmane		Pamelor		Trileptal	
Depakote		Parnate		Valium	
Dexedrine		Paxil		Vibryd	
Doral		Prosom		Vistraril	
Effexor		Pristiq		Vivitrol	
Elavil		Prolixin		Wellbutrin	
Fanapt		Remeron		Xanax	
Geodon		Restoril		Zoloft	
Halcion		Risperdal		Zyprexa	

Any other psychiatric medications you have taken?

Past Medical Care

Do you have a primary care doctor? Name _____ Last Seen? _____

What medical illnesses do you have?

What surgeries have you had?

Please list all medications you are currently taking, including over-the-counter medications, herbals, and supplements.

Medication	Dosage	# times per day	For what condition	Who prescribes it

Describe any allergies you have (e.g. to medications, foods).

Are you currently having or have you recently had any of these physical symptoms?

Fevers	Headache	Constipation	Hot/cold flashes
Chills	Chest pain	Acid reflux	Decreased sex drive
Night sweats	Shortness of breath	Joint pains	Problems reaching orgasm
Unexplained weight loss/gain	Heart palpitations	Muscle pains or tension	Easy bruising or bleeding
Weakness in arms/legs	Cough	Pain or difficulty urinating	Rashes
Numbness in arms/legs	Sore throat	Dental problems	
Episodes of passing out	Nausea or vomiting	Changes in vision	
Problems walking	Diarrhea	Changes in hearing	

For women-

Last menstrual period? _____

Usually regular? Yes/no

Do you use any birth control? Yes/no

If yes, please list. _____

Have you been pregnant before? Yes/no

If yes, how many times? _____

Miscarriages? Yes/no

Elective abortions? Yes/no

Any depression or unreal thoughts around pregnancies? Yes/no

Substance Use History

How often have you used the following substances?

	Last time used?	Approximately how often (# of times per week, month or year)?	How much do you use in a sitting if/when you do use?
Tobacco			
Alcohol			
Marijuana or K2/"spice"			
Cocaine			
Opiates (e.g. Heroin, morphine, Percocet,			

oxycodone, Tylenol #3, Dilaudid/hydromorphone)			
Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)			
PCP or LSD			
Mushrooms			
Others			

Family History

Please list blood relatives who have been diagnosed with the following conditions.

- Alcoholism _____
- Anxiety disorders _____
- Bipolar disorder _____
- Cancer _____
- Depression _____
- Diabetes _____
- Drug abuse _____
- Heart disease/high blood pressure/arrhythmias _____
- Osteoporosis _____
- Seizures _____
- Schizophrenia _____
- Strokes _____
- Suicides _____
- Thyroid disease _____

Social History

Where do you live? _____

Who lives with you? _____

How far did you go in school/highest level of education? _____

What is your current job/occupation? _____

What jobs have you had in the past?

Are you married? Yes/no If so, for how long? _____

Have you been married in the past? Yes/no # of times? _____
Do you have children? Yes/no If so, how many, what are their ages? _____

What do you do in your free time to relax?

Do you have any religious beliefs? Yes/ No
How important are your religious/spiritual beliefs to your life? _____

Have you had any legal issues (arrests, charges, time in jail)? If so, please describe.

Have you ever been the victim of a violent crime? Yes/No
Have you ever been a victim of physical abuse? Emotional? Sexual abuse or rape? If so, please explain.

Safety

Do currently have thoughts of hurting yourself? Yes/no Please explain.

Have you tried to hurt yourself in the past? If so, please explain.

Do you currently have thoughts of hurting anyone else? Yes/no Please explain.

Have you tried to hurt anyone in the past? If so, please explain.

Do you own any guns or knives? _____

CHECKLIST: Review of Systems

Patient Name: _____ Date of visit: _____

CONSTITUTIONAL:

Yes No

- Weight Loss
- Fatigue
- Fever

EYES:

Yes No

- Glasses/Contacts
- Eye Pain
- Double Vision
- Cataracts

EAR, NOSE, THROAT:

Yes No

- Difficulty Hearing
- Ringing in Ears
- Vertigo
- Sinus Trouble
- Nasal Stuffiness
- Frequent Sore Throat

CARDIOVASCULAR:

Yes No

- Murmur
- Chest Pain
- Palpitations
- Dizziness
- Fainting Spells
- Shortness of Breath
- Difficulty lying Flat
- Swelling Ankles

ENDOCRINE:

Yes No

- Loss of Hair
- Heat/Cold Intolerance

RESPIRATORY:

Yes No

- Cough Easy
- Coughing Blood
- Wheezing
- Chills

GASTROINTESTINAL:

Yes No

- Heartburn/Reflux
- Nausea/Vomiting
- Constipation
- Change in BMs
- Diarrhea
- Jaundice
- Abdominal Pain
- Black or Bloody BM

GENITOURINARY:

Yes No

- Burning/Frequency
- Nighttime
- Blood in Urine
- Erectile Dysfunction
- Abnormal Discharge
- Bladder Leakage

ALLERGIC/IMMUNOLOGIC:

Yes No

- Hives/Eczema
- Hay Fever

PSYCHIATRIC:

Yes No

- Anxiety/Depression
- Mood Swings
- Difficult Sleeping

HEMATOLOGY/LYMPH:

Yes No

- Easy Bruising
- Gums Bleed Easily
- Enlarged Glands

MUSCULOSKELETAL:

Yes No

- Joint Pain/Swelling
- Stiffness
- Muscle Pain
- Back Pain

SKIN:

Yes No

- Rash/Sores
- Lesions
- Itching/Burning

NEUROLOGICAL:

Yes No

- Loss of Strength
- Numbness
- Headaches
- Tremors
- Memory Loss

FEMALES ONLY:

Date Last Mammogram _____

Normal _____ Abnormal _____

Date last PAP _____

Normal _____ Abnormal _____

Age Onset Periods _____

Age Onset Menopause _____

Periods Regular? _____

Yes _____ No _____

Number _____

Pregnancies _____

Patient Health Care Questionnaire

Name _____ Date _____

Provider _____ Patient ID # _____

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?		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

add columns: + +

TOTAL:

<p>10. If you checked off <i>any</i> problems, 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>	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

The Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following 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	CHANGE OF DOZING (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL SCORE	

SCORE RESULTS:

- 1-6 Congratulations, you are getting enough sleep!
- 7-8 Your score is average
- 9 and up Very sleepy and should seek medical advice

Johns, M.W. (1991). A new method for measuring daytime sleepiness: The Epworth sleepiness scale. *Sleep, 14*, 540-545. Permission for single-use of the information contained in this material was obtained from the Associated Professional Sleep Societies, LLC, September 2006.

Copyright © MW Johns 1990-1997. Used under license.

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.

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?	<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 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 in 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? <i>Please check 1 response only.</i>	<input type="radio"/>	<input type="radio"/>
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? <i>Please check 1 response only.</i>		
<input type="radio"/> No problem <input type="radio"/> Minor problem <input type="radio"/> Moderate problem <input type="radio"/> Serious problem		
4. Have any of your blood relatives (ie, 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"/>

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these 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 _____

Asten Behavioral Health

PRIVACY OF PROTECTED HEALTH INFORMATION

I consent to the use of disclosure of my protected health information by **Asten Behavioral** (hereinafter referred to as "ABH") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of BH.

Health I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. ABH is not required to agree to the restrictions that I may request. However, if ABH agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that ABH has taken action in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ABH 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of ABH. The Notice of Privacy Practices also describes my rights and ABH 's duties with respect to my protected health information.

If you have asked us to file health insurance for you, we send only the minimum information required to obtain payment from your insurance company. We do not release any information to anyone about your treatment nor do we acknowledge that you are a patient here (even to your immediate family or other healthcare providers) without your expressed written consent. If you wish us to communicate with anyone about your treatment, please ask for a release of information form.

ABH reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent by email or asking for one at the time of my appointment.

Initial _____

Date _____

Asten Behavioral Health

EXCEPTION TO PRIVACY, PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY

Any unusual circumstances information that the client discloses may be released without consent to the appropriate parties involved if:

- There exists a danger of harm to the client or someone else
- The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance abuse
- The client is required to undergo a court-ordered examination
- The client discloses information about abuse, neglect, or exploitation of a minor
- The client discloses information about abuse, neglect, or exploitation of an aged or disabled adult
- The client's mental or emotional condition is used as a legal defense
- A civil, criminal, or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional in which case the disclosure and release of information shall be limited to that action

I hereby give my consent for service to be provided under these conditions.

Asten Behavioral Health INFORMED CONSENT FOR TREATMENT

- I understand the concepts and conditions of informed consent, privacy and confidentiality.
- I understand that I can discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
- I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and counseling/treatment.
- I understand that the process of counseling, psychotherapy, and evaluation is an interview process requiring self-disclosure, self-exploration, and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable. At other times, it can be very fulfilling. I also understand that there are no guarantees of positive outcome for the therapy/treatment.
- I have the right to refuse or withdraw from any counseling, psychotherapy, or evaluation procedure unless otherwise specified by law.
- I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.
- I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with a specified release of information. I understand that if my provider is a resident or inter, then the treatment will be discussed with a supervising professional.
- I understand that this consent may be withdrawn by me at any time without prejudice and has to be completed in writing.

Initial _____

Date _____

Asten Behavioral Health

AUTHORIZATION FOR CONTACTING PATIENT

Should a circumstance arise when it becomes necessary for the office to call you for any reason (such as to verify or change your appointment), every effort will be made to notify you in a timely manner. Please indicate your preference for being contacted.

Telephone Yes No (Circle One) HOME # _____
 Telephone Yes No (Circle One) WORK # _____

Client Signature

Date

Parent/Guardian Signature

Date

Witness Signature

Date

INFORMATION FOR CLIENTS

Our Practice

We are a group of licensed mental health professionals in private practice. We see clients by appointment only. Appointments are scheduled according to the individual doctor/therapist recommendation. If there is an emergency during office hours, which requires immediate attention, please contact the office by phone. If an appointment cannot be kept, please contact the receptionist at least 24 hours in advance. There will be a *\$50 service charge for late cancellations and a \$50 service charge for no shows*. You are responsible for this fee and your insurance companies **WILL NOT** pay for this fee. If unforeseen circumstances arise and you are able to give notice that is less than 24 hours we will do our best to fill the vacancy. If we are able to do so, you will not be charged. The more notice you can give the better we are to accommodate other patients who need to be seen.

Confidentiality

Communications between the provider and the patient are strictly confidential and protected under Maryland Law and by the ethics of our profession. In order to communicate with others about your case, your provider must have permission in writing. Our registration form and our Notice of Privacy Practices explain the limits of confidentiality.

After Hour Emergencies

Our telephone number is **301-272-1055**. If you need to speak with your doctor or therapist, please make your calls brief. Calls of more than 5 minutes will be billed at the provider's hourly rate. Calls are answered 24 hours each day, 7 days a week. After office hours, you can leave a message on the voice mail or in an urgent situation; leave a message with the answering service operator who will contact your doctor/therapist/provider or the person on call. You may leave a voicemail or call during business hours for all prescription refill request or appointment change/cancellation request. **If immediate services are required or you have an emergency, please call 911 or go to the nearest Emergency Department.**