1445 Wampanoag Trail
Unit 202
4014374116
(401) 433-0367
admin@wellnessri.com
wellnessri.co

Basic Information

1. First Name: | Middle Initials: | Last Name: | Suffix:

Gender:
○ Female ○ Male

Date of Birth:

Primary Phone:
○ Home ○ Mobile ○ Work

Phone number:

Email:

Social Security:

Street Address: | Apt./Unit #: | City: | State: | Zip Code:

Marital Status:

Maiden Last:

Driver's License State:

Driver's License #:

2. Demographics

Sexual Orientation:

Gender Identity:

Hispanic or Latino?
○ Yes ○ No ○ Decline to Specify

Ethnicity:

Race:

Language:

3. Emergency Contact

First Name: | Middle Initials: | Last Name: | Relationship to contact:

Primary Phone:
○ Home ○ Mobile ○ Work

Phone number:

Email:

Street Address: | Apt./Unit #: | City: | State: | Zip Code:

Financial Information

4. Responsible Party

Who will be financially responsible for you?
○ Myself ○ Someone else

5.If you chose "Someone Else", please fill out the following:

6. Relationship to Contact: _____ Name: _____

Primary Phone:
○ Home ○ Mobile ○ Work

Phone number: _____

7. Method of Payment

What will be your method of payment?
○ Insurance ○ Self-Pay

8.If you chose "Insurance", please fill out the following:

9. PRIMARY INSURANCE POLICY

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender
○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

10. If you are not the primary policy holder, please fill out the following:

First Name: _____ Middle Initials: _____ Last Name: _____ Date of birth: _____

Sex:
○ Male ○ Female
○ Unknown

Policy ID Number: _____ Social Security Number: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

11. If you are unable to provide your insurance information, please provide a reason before continuing.

_____

_____

_____

_____

12. **SECONDARY INSURANCE POLICY If you do not have a secondary insurance policy, you can leave this blank.**

Secondary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

13. **If you are not the secondary policy holder, please fill out the following:**

First Name: _____ Middle Initials: _____ Last Name: _____ Date of birth: _____

Sex:
○ Male ○ Female
○ Unknown

Policy ID Number: _____ Social Security Number: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Additional Information

14. **Please list your preferred pharmacies in order of preference**

	Pharmacy Name	Pharmacy Address
1		
2		
3		

15. **How did you hear about us?**

_____

16. **If under 18, please include Father and Mother's , Guardian name and phone number**

_____

_____

_____

_____

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Mood Disorder Questionnaire

1. First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

2. **Instructions: Please answer each question to the best of your ability.**

1. Has there ever been a period of time when you were not your usual self and...	Yes	No
...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 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?		

3.

	Yes	No
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		

4.

	No problem	Minor problem	Moderate problem	Serious problem
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?				

5.

	Yes	No
4. Have any of your blood relatives (ie, 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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COVID-19 HEALTH SCREEN

All patients must complete a health screen prior to your appointment. Please contact the clinic if you have any questions.

1. Please enter your information.

First Name: _____ Middle Initial: _____ Last Name: _____ Appointment Date _____

2. Have your or anyone in your home been suspected to have or diagnosed with COVID-19?

- ○ Yes
- ○ No
- ○ I don't know

3. In the last 14 days, have you or anyone in your home come into contact with anyone suspected to have or diagnosed with COVID-19? Select all that apply

- ○ Yes, I was within 6 feet of someone who's sick, or I was exposed to a cough or sneeze
- ○ Yes, I was at least 6 feet away from someone who's sick and was not exposed to a cough or sneeze
- ○ I've had no exposure to COVID-19
- ○ I don't know

4. If yes, please provide further details:

_____

_____

_____

_____

5. Have you ever been tested for COVID-19 or COVID-19 antibodies? Check all that apply

- ○ Yes, I've had a COVID-19 Molecular (Swab) Test
- ○ Yes, I've had a COVID-19 Antibody (Serology) Test
- ○ No

6. **Please list below the date and results of all COVID-19 tests you have taken.**

	Date	COVID-19 Molecular (Swab) Test	COVID-19 Antibody (Serology) Test
1			
2			

7. **Within the past 14 days have you started experiencing any of the following symptoms: fever, chills, unexplained shortness of breath or sustained loss of smell or taste?**

c Yes c No

YOUR APPOINTMENT MUST BE RESCHEDULED

Based on your answers, we recommend you talk to a doctor or a medical professional about your current symptoms.

A member of our administrative staff will contact you to review our COVID-19 prevention policies and to reschedule your appointment.

8. **Have you recently started experiencing any of the following symptoms: sore throat, new or worsening cough, or aching throughout the body?**

c Yes c No

YOUR APPOINTMENT MAY NEED TO BE RESCHEDULED.

In the interest of keeping our staff and patients healthy, we ask that you reschedule your appointment when you are no longer experiencing symptoms. All cancellation fees are waived for appointments rescheduled due to illness.

A member of our administrative team will contact you to review our COVID-19 prevention policies. However, your reported symptoms are also consistent with other non-COVID-19 illnesses. We recommend you talk to a doctor or a medical professional about your current symptoms.

THANK YOU FOR HELPING US PREVENT FURTHER SPREAD OF COVID-19

COVID-19 Prevention Policies

We are taking the following measures to ensure we can maintain proper social distancing in the clinic.

- **You should arrive no more than 5 minutes prior to your appointment.**
- **We request that you attend your visits alone.**

Anyone who accompanies you to the appointment will be asked to remain outside for the duration of the appointment. Patients who require assistance may have someone stay with them if prior arrangements with the clinic have been made.

We also ask that **hands be washed upon arrival at the clinic**, and that a **face mask or covering be worn at all times** in the clinic.

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OFFICE POLICIES

The first contact with a provider at the initial intake appointment is considered a consultation. This consultation is to assess your needs and to see if you are appropriate for treatment by the provider. If the provider deems you are not an appropriate patient for them, they will do their best to refer you to the proper place for treatment. In the case it is deemed you are an appropriate patient, you give your provider permission to develop a treatment plan and provide treatment with your participation.

CANCELLATION AND NO SHOW POLICY:

We understand that situations arise in which you must cancel your appointment. If you must cancel your appointment please provide at least 24 hours notice before your scheduled appointment. Appointments cancelled less than 24 hours notice or failure to show for your appointment will be considered a missed appointment.

Missed appointments will be charged a fee, at the discretion of the provider. Most providers charge $50 for the first missed appointment, $50 for the second, and the full amount of the session for the third. After missing three appointments without notification the provider may reserve the right to dismiss you from their care. The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. By signing below you are agreeing to pay for missed appointments.

NON-PAYMENT:

Balances must be paid in full within 30 days of service, including missed appointment fees. Payment arrangements can be made by calling 401-437-4116. Until the first payment of any payment arrangement is received, you will not be permitted to schedule future appointments. If payment arrangements are not kept. future appointments will be cancelled until payments are received.

RETURNED CHECKS:

All checks are to be written out to the provider. Any returned checks are subject to a $3o service fee. Any returned check must be resolved before any future appointments can be arranged.

IN CASE OF EMERGENCY:

Your provider will do their very best to return urgent phone calls in a timely fashion. If you are experiencing a life threatening emergency, or are in need of immediate, urgent care, call 911 or proceed to your nearest emergency care center.

_____ _____

Client Signature Date

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PATIENT RESPONSIBILITIES AND APPOINTMENT REMINDER POLICY

It is our office policy that when a patient is going to be late 15 minutes or more that they will not be able to be seen and will need to reschedule. We try to accomodate our patients as best as possible but unfortunately we are not always able to.

Wellness Rhode Island does not tolerate any of our patients to be confrontational or disrespectful to our office staff or clinicians. It is our policy that in situations where this occurs those patients are discharged from the practice.

Appointment reminders are sent out at four (4) different times. The first reminder is sent via email at the time the appointment is scheduled, second reminder is emailed seven (7) days prior to the appointment, third reminder is sent out via email and text message two (2) days prior to the appointment and last reminder is sent out via email and text message one (1) hour prior to the appointment.

It is your responsibility to ensure that our office has up to date contact information for you at all times and it is your responsibility to know when your appointment is scheduled for and to arrive to your appointment on time. It is also your responsibility to contact our office if you are going to be late to see if your clinician will be able to accommodate you or not.

_____ _____

Client Signature Date

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CONSENT TO TREATMENT

I do hereby seek and consent to take part in the treatment by the provider named below. I understand that regularly reviewing our work together and jointly working toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I also understand that the first initial appointment with the provider is a consultation and legally they do not have to care for me if they see reason/s not to. I also understand that the provider may dismiss me of their care if I violate this agreement in any way. I understand at which time arrangements will be made for me to have one month's time to find another physician/provider either on my own time or from the possible physicians referred to me by my dismissing physician/provider. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this provider.

I understand the following:

- I have read and fully understand the Patient Rights form.
- This consent is given voluntarily.
- I am legally competent and have the authority to provide consent for treatment for myself or a minor under my guardianship.
- I have the right to withdraw my consent for this treatment at any time.
- If payment for the services I receive is not made, the provider may stop my treatment.
- I will still be responsible for paying for the services I have already received.
- I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.
- Withdrawing consent for this treatment will not prejudice my continued treatment relationship.
- I had the opportunity to have my questions answered to my satisfaction.

Please sign that you have read, understand and agree to the above information.

Parent or Guardian

_____ _____

Patient Signature Date

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PATIENT RIGHTS

This notice (Notice of Privacy Practices) describes how medical information about you may be used and disclosed and how you can get access to this information. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. Please review it carefully.

Your provider is a solo practitioner who is a business associate of Wellness Rhode Island Management, LLC. (WRIM) In order to enable WRIM to perform its services for your provider, they will disclose Protected Health Information about you to WRIM. Your provider is a Covered Entity. WRIM agrees to follow all federal and Rhode Island state laws concerning the use, protection and disclosure of protected health information.

YOUR RIGHTS:

You have the right to:

- Get a copy of your paper or electronic medical record/Correct your electronic medical record
- Request confidential communication/Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

OUR USES AND DISCLOSURES:

We may use and share your information as we:

- Treat you/Coordinate care between providers
- Run our organization /Bill for your services
- Help with public health and safety issues
- Comply with the law- Respond to lawsuits or legal actions, report child/elderly neglect or abuse
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests

Please sign that you have read, understand and agree to the above information.

Parent or Guardian

_____ _____

Patient Signature Date

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INSURANCE AUTHORIZATION AND RESPONSIBILITY FOR PAYMENT

- I hereby authorize my provider to furnish all information to insurance carriers concerning my illness, and/or treatments, and I hereby assign to the physician(s) all payments for medical services rendered.
- I understand that I am responsible for any amount not covered by insurance; this includes any course of treatment that is not a covered benefit.
- I understand that I am responsible for notifying my provider of any changes in my insurance coverage. If I am delinquent in updating this information and the charges are denied, I understand that I will be held responsible for these charges. I agree to be financially responsible for all visits not covered.
- I authorize my provider to bill and receive payment from third party payors, if any, for coordination of benefits. I understand that I am fully responsible for obtaining the proper authorization prior to my first appointment.
- If I am covered by a third party payor and have no other healthcare, I agree to pay all copayments as required by the health plan at the time of service.
- I further authorize any third party to pay my provider for services provided to me. If these services are not paid by the third party payor within 60 days, I agree to make payment myself.
- My provider does not participate with Medicaid. I understand that I will be fully responsible for any fees not covered.
- My provider may, at any time, dismiss a patient from our practice should a patient fail to adhere to their agreed treatment plan.

Please sign that you have read, understand and agree to the above information.

Parent or Guardian

_____ _____

Patient Signature Date

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PRESCRIPTION REFILLS

Prescription refills should be obtained during appointment times when possible. You may also call your pharmacy and instruct them to fax any prescription refill requests to our secure fax line, 401-433-0367.

If you are running low on medications or do not have refills remaining, call and schedule an appointment as soon as possible. Should you run out of medications prior to your appointment, your provider will authorize phone requests for medication at their discretion, based on the patient's best interest and safety. The provider may charge a fee for this service. (please contact the office for further information) Please allow 3 business days to complete the medication refill request.

PROVIDER COMPLETED FORMS AND LETTERS

Due to additional time and cost incurred, the provider will only fill out forms during appointment times. These include, but are not limited to Disability forms, Employee forms, Medical Records requests, Medication prior authorizations, Report preparation, or Letter writing. If you have forms you need your provider to fill out please make a separate appointment. Please sign that you have read, understand and agree to your provider's office policies.

Parent or Guardian

_____ _____

Patient Signature Date

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INFORMED CONSENT FOR TELEMEDICINE SERVICES

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow?up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two?way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,

3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. _____ has explained the alternatives to my satisfaction,

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that it is my duty to inform _____ of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize _____ to use telemedicine in the course of my diagnosis and treatment.

_____ _____

Client Signature Date

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AUTHORIZATION TO OBTAIN AND/OR RELEASE CONFIDENTIAL INFORMATION

Client Name: _____ DOB: _____

Street address: _____ City, State & Zip: _____

I hereby authorize Wellness Rhode Island to;

Obtain from: ☐ Release to: ☐

First Name: _____ Last Name: _____

Street Address: _____ City, State & Zip: _____

Phone: Fax:

Information to release/request includes:

All Medical Records Dates of Service: From: _____ To: _____

Please fax records to 401-433-0367 whenever possible.

This Information is needed for the following purposes(s):

☐ Client Care ☐ Continuation of Care ☐ Other: _____

I understand that my records are protected under RI General Law and cannot be disclosed without any written consent except as otherwise specifically provided by law. I am aware that I can refuse to sign this authorization. I also understand that if my records involve alcohol, drug abuse, or HIV (AIDS) testing, they arc processed under Federal Regulation 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse, if relevant, and RI Public Law 88-405. Section 23.

This authorization shall be in effect for one (I) year from the date signed. I understand that I have the right to revoke this authorization, in writing, at anytime; revocation does not have any effect on any actions already taken prior to the revocation being received.

I understand once the information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it.

_____ _____

Client Signature Date

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Behavioral Health Questionnaire

1. First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Marital Status: _____ Occupation: _____

Children: _____ Who currently lives in your household? _____

2. Who referred you here, or where did you hear about us?

_____

Present History

3. Describe the reason for your visit today.

_____

_____

_____

_____

4. Are you currently depressed?

○ Yes ○ No

5. Have you had past episodes of depression?

○ Yes ○ No

6. Describe any current symptoms that you have regarding the following:

Sleep:

_____

Appetite:

_____

Mood/crying spells:

_____

Irritability/mood swings:

_____

Anxiety/Panic attacks:

Energy/Motivation:

Interest in normal activities:

Guilt feelings:

Libido:

Concentration/Memory:

Hearing Voices:

Paranoia:

7. Do you presently have suicidal thoughts?

c Yes c No

8. Have you ever had suicidal thoughts?

c Yes c No

9. Have you ever attempted suicide?

c Yes c No

10. Do you or have you had homicidal thoughts?

c Yes c No

11. Do you have any blood relatives who have committed suicide?

c Yes c No

12.

13. Please list the current stresses in your life:

14. Please list your current psychiatric medications.

	Medication	Dose	How long?	Side effect?
1				
2				
3				

Past Psychiatric History

15. Prior Psychiatrists

	Prior Psychiatrists	When?	Why?
1			
2			
3			

16. Past Therapists

	Past Therapists	When?	Why?
1			
2			
3			

17. Have you ever been hospitalized in the past for any psychiatric reasons? Please list. Include Alcohol or Drug Treatments.

	Date	Place	Reason
1			
2			
3			

18. Please List all psychiatric medications that you have tried in the past. This includes any medications taken for your nerves, anxiety, depression or insomnia, such as Prozac, Paxil, Zoloft, Celexa, Lexapro, Effexor, Pristiq, Cymbalta, Wellbutrin, Buspar, Remeron,Trazodone, Elavil, Luvox, Xanax, Klonopin, Valium, Ativan, Risperdal, Zyprexa, Seroquel, Ability, Geodon, Lithium, Depakote, Tegretol, Trileptal, Lamictal, Neurontin, Topamax,Ambien, Lunesta, Rozerem, Restoril, Adderall, Concerta, Ritalin, Focalin, Vyvanse, Strattera, Provigil, Namenda, Aricept.

	Medication	Dosage	When?/How long?	Did it help?	Reason for stopping or side effects
1					
2					
3					

19. Are you frequently nervous or anxious?

c Yes c No

20. Are you a worrier?

c Yes c No

21. Do you have panic attacks or hyperventilation?

c Yes c No

22. Have you had panic attacks in the past?

c Yes c No

23. Have you had a fear of objects or situations?

c Yes c No

24. Do you do a lot of hand washing or going back and checking doors, stoves, lights, etc?

c Yes c No

25. Are you bothered by recurrent nightmares or flashbacks from a previous traumatic event?If yes, please explain

_____

_____

_____

_____

26. Are alcohol or drugs currently a problem?

c Yes c No

27. Has alcohol or drugs ever been a problem?

c Yes c No

28. Have you ever had a DUI or blackout?

c Yes c No

29. Have loved ones been concerned about your alcohol/drug use?

c Yes c No

30. Do you have any blood relatives with alcohol/drug problems?

c Yes c No

31. Have you been arrested?

c Yes c No

32. Have you had an eating disorder or caused yourself to vomit or lose weight? If yes, please explain.

Medical History

33. Please list any medical problems or diagnoses that you have?

34. Any history of head trauma?

c Yes c No

35. Any history of seizures?

c Yes c No

36. Any history of developmental disorders?

c Yes c No

37. Do you smoke?

c Yes c No

38. Do you exercise regularly?

○ Yes ○ No

39. For women:

Do you still have regular periods?
○ Yes ○ No

Do you use birth control?
○ Yes ○ No

Are you taking any hormones?
○ Yes ○ No

40. Please give the name of your primary care doctor

Name: Phone:

Street Address: Apt./Unit #: City: State: Zip Code:

41. Please give the name of any other medical doctor from whom you receive regular treatment.

	Name	Specialty
1		
2		
3		

42. Medical/Surgical Hospitalizations:

	Date	Reason
1		
2		
3		

43. Please list all current medications:

	Name	Dose	Reason taking
1			
2			
3			

44. Are you allergic to any medications?

○ Yes ○ No

Family/Social History

45. Who in your family has a psychiatric history? Include history of alcohol or drug problem.

	Relationship	Problem
1		
2		
3		

46. Where were you born and raised?

_____

47. Were you raised by your biological parents?

c Yes c No

If no, describe:

_____

48. Do you have siblings?

c Yes c No

If so, how many?

_____

49. Significant religious/cultural beliefs:

_____

_____

_____

_____

50. Primary emotional sources of support:

_____

_____

_____

_____

51. Have you ever been physically, emotionally, or sexually abused?

c Yes c No

52. Please list any significant losses or deaths in your life:

	Date	Description
1		
2		
3		

53. Education:

54. Work History:

55. Are you currently married?

c Yes c No

If yes, how long?

56. Are you having marital or relationship problems?

c Yes c No

If yes, describe:

57. If you have children, do they have any significant psychiatric or medical problems?

c Yes c No

If yes, describe:

58. Previous marriages?

c Yes c No

59. If yes, answer below:

	When?	How long?	Reason for divorce/separation
1			
2			
3			

60. Accompanied by:

HPI:

61.

	Neg	Pos
1. Const		
2. Eyes		
3. ENT		
4. Cardio		
5. Resp.		
6. GI		
7. GU		
8. Musc.		
9. Skin/Breast		
10. Neuro		
11. Endo		
12. Hem/Lymph		
13. Allergies		
14. Immune		

Signature

Date

Patient Health Questionnaire (PHQ-9)

62. **Over the last 2 weeks, 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				
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 figety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself				

63. Total:

_____

64.

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
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?				

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Generalized Anxiety Disorder Screener (GAD-7)

1. First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

2.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Feeling nervous, anxious 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 is is hard to sit still				
6. Becoming easily annoyed or irritated				
7. Feeling afraid, as if something awful might happen				

3.

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
8. If you checked off any problem on this questionnaire so far, 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?				

4. When did the symptoms begin?

_____

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Adult ADHD Self-Report Scale

1. First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

2. **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
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or at work?					
How often are you distracted by activity or noise around you?					
How often do you leave your seat in meetings or other					

situations in which you are expected to remain seated?					
How often do you feel restless or fidgety?					
How often do you have difficulty unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much when you are in social situations?					
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?					
How often do you have difficulty waiting your turn in situations when turn taking is required?					
How often do you interrupt others when they are busy?					