HEBE ESTRELLA-SCHULTZ M.D
Diplomate of the American Psychiatry and Neurology

FAMILY PSYCHIATRY

2530 DOUGLAS BLVD, STE 160
ROSEVILLE, CA 95661
PHONE (916) 749-2010

APPLICATION FOR SERVICE AND CONSENT FOR TREATMENT

I, consent to be evaluated and receive treatment voluntarily from Dr Hebe Estrella-Schultz.

PAYMENTS/ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to which I am entitled, including private insurance or any other health plan to Hebe Estrella-Schultz M.D.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original
I understand that I am financially responsible for all charges for rendered services. If I am using insurance to pay for services, I will be responsible to pay for rendered services if they are not paid for my insurance, regardless of the reason or cause and regardless of any insurance health plan objections.
I understand that co-pays are to be paid at the time of the visit.

I also understand that I am responsible for any fees incurred as a result of court testimony, deposition testimony, preparation or conferences with attorneys concerning my case, legal letters etc, even after Dr Estrella-Schultz is no longer my physician. There may be charges for other services that are not covered by my insurance. You can ask the doctor about this.

I am responsible to give 48 hours advance notice if I need to cancel or reschedule my visit to avoid charges.
Missed appointments or late cancellations are not paid by insurances

I understand that there will be penalties for returned checks (according to bank current rates).

I also understand that telephone conversations are limited and I could be charged a fee if they extend in the period of one week over 15 minutes.

I understand that there could be reduced charges for time used in consultations with other care providers or people whose input may be valuable for my care. Ask the doctor about this.

I understand that Dr Estrella-Schultz's care and treatment may consist of an evaluation process, psychotherapy and medication treatment if indicated. There are no warranties regarding outcomes for your treatment or the length of it. The doctor welcomes any questions that you may have regarding your evaluation and treatment

This consent does not waive my civil rights. I reserve the right to decline treatment against medical advice.

Please advice this doctor if there are any changes in your medical/psychiatric history, address, phone number or insurances as soon as possible.

I understand that my records are confidential, and will not be released to anyone without my written consent. However, certain information may be released without my authorization under the following situations:

1) Under a valid medical/psychiatric emergency.
2) If you are likely to harm yourself.
3) If you are likely to harm somebody else.
4) If there is any suspicion of child abuse, dependent adult or elder abuse.
5) To the courts if necessary for the administration of justice.
6) To your insurance company if required by them.

I will call the pharmacy if I need refills within 7 days in advance before I finish my medication.

I consent Dr Estrella-Schultz in case of an emergency for her to call: Phone #:

I consent Dr Estrella-Schultz to contact the following persons if needed for my treatment or follow-up: previous or current doctors, therapists, etc. You need to name them and provide phone numbers (if possible)

Patient signature: Date:

PATIENT INFORMATION

Date: _____/_____/_________
(Please PRINT clearly)

Patient Name: ____
Sex: [ ] Male [ ] Female

Social Security Number: _____- ____ - _______
Driver's License Number: _________________________

Address: _______________________________ City: _____________________
State: ____ Zip: _________

Birth Date: _____/_____/_________ Age: ________ Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Phone No: ( ) ______ - ________
Occupation: ____

Responsible Person: ____
_Occupation: ____________________

Employed by: ____
Phone No: ( ) ______ - ________

City: ________________________ State: ___ Zip: __________ OK to call the work phone? [ ] No [ ] Yes

Spouse: ____
Occupation: ____________________

Employed by: ____
Phone No: ( ) ______ - ________

Address: _______________________________ City: _____________________
State: ____ Zip: _________

Referring
Physician/therapist.

Signature: ____ Date: _____/_____/_________

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. ____ B. ____ C. ____ D. ____

E. ____ F. ____ G. ____ H. ____

I. ____ J. ____ K. ____ L. ____

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Hebe Estrella-Schultz M.D
2530 Douglas Blvd., Ste#160, Roseville, CA 95661

MEDICAL/SOCIAL QUESTIONAIRE

PATIENT NAME: ---------------------------------

CURRENT MEDICATIONS

____

____

ALLERGIES;--

PRIMARY CARE
PHYSICIAN:--

PREVIOUS OR CURRENT PSYCHIATRIST;

PREVIOUS OR CURRENT THERAPIST;

OTHER MEDICAL QUESTIONS;

. Have you ever had :

1 .Surgeries ?
2. Seizures ?
3. Injuries ?
4. Loss of consciousness ?
5. Dizziness
6. Migraines?
7. Problems with your eyes, nose, ears, mouth or throat?
8. Cough, asthma
9. Problems with your heart?
10. Problems with your digestive system?
11. Problems with your liver?
12. Problems with your kidneys?
13. Arthritis?, weakness of your limbs?, back pain?
14. Abnormal movements of your face like tics? or tremors in your hands, arms, legs?
15. Cancer?
16.Anemia ?
17. Diabetes ?
18. Thyroid problems?
19. High blood pressure?
20. High cholesterol/Triglycerides?
21. Problems with your weight?
22. Problems of your reproductive System?

23. Problems of your skin?

24. Do you drink coffee or caffeinated drinks?

25. Do you smoke cigarettes?

26. Do you have alcoholic drinks? How often? How much?

26. Have you experimented or use marijuana?, other substances like methamphetamines, cocaine, etc?

27. In your family has anybody has or had diabetes? Heart problems? Other?

Social History:

1.Who do you live with? names?, ages?

2. Do you attend School? Name? Year?

3. Do you work? When was the last time that you worked?

4. Have you ever had problems with the law?

5.Have you ever had a traumatic experience?

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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A2663B 10-04-2005

Zung Self-rating Anxiety Scale

Name: ______________________________ Date: ____________________

Listed below are 20 statements. Please read each one carefully and decide how much the statement describes how you have been feeling **during the past week**. Circle the appropriate number for each statement.

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. I feel more nervous and anxious than usual.	1	2	3	4
2. I feel afraid for no reason at all.	1	2	3	4
3. I get upset easily or feel panicky.	1	2	3	4
4. I feel like I'm falling apart and going to pieces.	1	2	3	4
5. I feel that everything is all right and nothing bad will happen.	4	3	2	1
6. My arms and legs shake and tremble.	1	2	3	4
7. I am bothered by headaches, neck and back pains.	1	2	3	4
8. I feel weak and get tired easily.	1	2	3	4
9. I feel calm and can sit still easily.	4	3	2	1
10. I can feel my heart beating fast.	1	2	3	4
11. I am bothered by dizzy spells.	1	2	3	4
12. I have fainting spells or feel faint.	1	2	3	4
13. I can breathe in and out easily.	4	3	2	1
14. I get feelings of numbness and tingling in my fingers and toes.	1	2	3	4
15. I am bothered by stomachaches or indigestion.	1	2	3	4
16. I have to empty my bladder often.	1	2	3	4
17. My hands are usually dry and warm.	4	3	2	1
18. My face gets hot and blushes.	1	2	3	4
19. I fall asleep easily and get a good night's rest.	4	3	2	1
20. I have nightmares.	1	2	3	4

Score Total*: ________

*Score is for healthcare provider interpretation.

Adapted from Zung WWK. A rating instrument for anxiety. *Psychosomatics.* 1971;XII:371-379.
Reprinted with permission from *Psychosomatics*, ©1971. American Psychiatric Association.

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
Add the score for each column	+	+	+	
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 _________

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Please check if you have ever taken any of the medications listed below:

☐ fluoxetine (Prozac)	☐ nefazodone (Serzone)	☐ clozapine (Clozaril)	☐ amph/dextroamp (Adderall)	☐ flurazepam (Dalmane)
☐ paroxetine (Paxil)	☐ buspirone (Buspar)	☐ risperidone (Risperdal)	☐ dextroamphetamine (Dexedrine)	☐ triazolam (Halcion)
☐ sertraline (Zoloft)	☐ fluvoxamine (Luvox)	☐ olanzapine (Zyprexa)	☐ methylphenidate (Ritalin, Concerta)	☐ chlodiazepox de (Librium)
☐ citalopram (Celexa)	☐ carbamazepine (Tegretol)	☐ quetiapine (Seroquel)	☐ dexmethylphenidate (Focalin)	☐ temazepam (Restoril)
☐ escitalopram (Lexapro)	☐ valproic acid (Depakote)	☐ ziprasidone (Geodon)	☐ pemoline (Cylert)	☐ zolpidem (Ambien)
☐ venlafaxine (Effexor)	☐ lithium(Eskalith/ Lithobid)	☐ aripiprazole (Abilify)	☐ atomoxetine (Strattera)	☐ zaleplon (Sonata)
☐ duloxetine (Cymbalta)	☐ oxcarbamazepine (Trileptal)	☐ paliperidone (Invega)	☐ alprazolam (Xanax)	☐ eszopiclone (Lunesta)
☐ desvenlafaxine (Prestiq)	☐ topiramate (Topomax)	☐ haloperidol (Haldol)	☐ lorazepam (Ativan)	☐ ramelteon (Rozerem)
☐ bupropion (Wellbutrin)	☐ lamotrigine (Lamictal)	☐ fluphenazine (Prolixin)	☐ diazepam (Valium)	☐ trazadone (Desyrel)
☐ mirtazapine (Remeron)	☐ doxepin (Adapin/ Sinequan)	☐ thiothixene (Navane)	☐ clonazepam (Klonopin)	☐ noxiptiline (Agedal/ Elronon)
☐ clomipramine (Anafranil)	☐ amoxapine (Asendin)	☐ pipofezine (Azafen)	☐ amitriptyline(Endep /Elavil/Tryptozol)	☐ maprotiline (Ludiomil)
☐ Nomifensine (Merital)	☐ desipramine (Norpramin/ Pertofrane)	☐ nortriptyline (Pamelor/Aventyl)	☐ trimipramine (Surmontil)	☐ imipramine (Tofranil)
☐ protriptyline (Vivactil)	☐ milnacipram (Savella)	☐ selegiline (Eldepryl/ Emsam)	☐ isocarboxazid (Marplan)	☐ phenelzine (Nardil)
☐ tranylcypromine (Parnate)	☐ reboxetine (Edronax/ Vestra)	☐ opipramol (Insidon)	☐ tianeptine (Stablon)	☐ agomelatine (Valdoxan)
☐ vilazodone (Viibryd)	☐ L-methylfolate (Deplin)	☐ iloperidone (Fanapt)	☐ lurasidone (Latuda)	☐ asenapine (Saphris)
☐ pinodolol (Visken)	☐ lisdexamfetamine (Vyvanse)	☐ thyroid hormone (Triiodothyronine)	☐ thyroid hormone (Levoxyl)	☐ Other

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

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

Name________________________ Date________________________

Mood Disorder Questionnaire

The questions you are about to answer will help you assess your mood and help your doctor educate you about the need for additional evaluation. Please discuss the results of this questionnaire with your doctor.

Instructions for patients: Please check ONE BOX ONLY for each of the questions below.

The following three questions will ask you about a history of mania. *

1. Has there 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 and/or spoke much faster than usual?	☐	☐
...thoughts raced through your head and/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 and/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?	☐	☐

	YES	NO
2. If you checked YES to more than one of the above, have you experienced several of these during the same period of time?	☐	☐

3. How much of a problem did any of these situations cause you (like being unable to work; having family, money, or legal problems; and/or getting into serious arguments or fights)?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

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Two questions about yourself

These questions will ask you about current feelings of depression.

	YES	NO
1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?	☐	☐
2. During the past month, have you often been bothered by little interest or pleasure in doing things?	☐	☐

This questionnaire is intended to help you assess your mood and help your doctor educate you about the need for additional evaluation. Only your health care provider can properly diagnose and recommend treatment for bipolar disorder.

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