STEVEN MACHLIN M.D., LLC
6820 Porto Fino Circle, Ste 1
Fort Myers, Florida 33912

PATIENT INFORMATION FORM **ACCT#** ____________________

Last Name________________________ First Name____________________ Middle__________

Social Security____________________DOB________________Age______

Phone #'s Home________________ Cell________________ Work________________

Email Address ____

Address____

City________________ State__________ Zip_________

Marital Status:___________ Spouses Name ___________

Employer/Occupation______________________________

How did you hear about us? _________________________

*Alternate Address*___________________________ *City*___________ *State*________ *Zip*__________

(if applicable) *When will you be at this address?*___________________ *Phone#* ________________

INSURANCE

Primary Ins. Co.___________________Secondary Ins. Co.____________________Self Pay_____

*Last Name of Cardholder(if not yourself)*__________________________ *First*________________

*Relationship to You*________________ *SS#*_____________________ *DOB*________________

EMERGENCY CONTACT INFORMATION

Name__________________________________ Home #____________ Work/Cell#_____________

Relationship to you_________________________

MEDICAL INFORMATION

Pharmacy______________ Pharmacy#____________________ or Mail Order? Y______ N________

Primary Care Physician__________________________ Phone#______________ Last Visit__________

Therapist(if applicable)__________________________ Phone#______________ Last Visit__________

Medication Allergies____________________Physical Problems______________________________

Current Medication List____

____

Payment for office visits is expected at the time of service. If you are submitting to your insurance company for reimbursement, receipts for service will be available to you. For medical services, I hereby authorize my insurance company to pay all benefits directly to the doctor. I understand that this does not relieve me of my financial responsibility. I understand that I am, and remain financially responsible for these charges.

I HAVE READ AND AGREE TO THE ABOVE.

SIGNED____ **DATE**________________________

Dr. Steven Machlin, MD. LLC
Health Questionnaire

Name________________________________ Date___________________

Allergies – Also list your response to this substance: ____________________

____

____

Current medication and dosages:

____

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Current Health Problems:

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Past Psychiatric Treatments- List Types of Therapies, ECT, etc..

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Please list medications that you have tried before.
List Good Effects and Bad effects of each:

____
____
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____
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____

Hospitalizations and past surgeries - Please give dates if possible

____
____
____
____
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____

Describe Alcohol Use:
Kind of beverage____________, # of Glasses _______________
# of days per week______________; Total glasses per week _______________
Social only_____________________

Recreational Drugs: Substance of choice and frequency:

____
____
____

Describe your sleep: # of hours, trouble falling asleep, early wakening, is it restful?, do you awake refreshed?

____
____
____
____
____

Your goals for seeking treatment in our office:

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Reviewed by__________________________________ Date ____________________

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than 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 is 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

(*For office coding: Total Score T____ = ____ + ____ + ____*)

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PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

Over the <u>last 2 weeks</u>, 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 in some way	0	1	2	3

FOR OFFICE CODING ___0___ + ______ + ______ + ______

=Total Score: ______

If you checked off <u>any</u> problems, how <u>difficult</u> 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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THE MOOD DISORDER QUESTIONNAIRE

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 much faster than usual?	❍	❍
...thoughts raced through your head or you couldn't slow your mind down?	❍	❍
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❍	❍
...you had much more energy than usual?	❍	❍
...you were much more active or did many more things than usual?	❍	❍
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❍	❍
...you were much more interested in sex than usual?	❍	❍
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❍	❍
...spending money got you or your family into trouble?	❍	❍
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	❍	❍

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem   Minor Problem   Moderate Problem   Serious Problem

	YES	NO
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	❍	❍
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	❍	❍