Acct#________________

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

Please complete all lines or put N/A-Thank you. How did you hear about us?________________________

Last Name______________________________ First Name_____________________ Middle________

Social Security______________________________DOB_______________________Age__________

Phone #'s Cell___________________________ Home _____________________ Work________________
(Appointment Reminder Text Messages may be sent-though you are responsible to know your next appt)

Email _______________________________________**CHECK (No)__ if NOT okay to use email for clinical exchanges.**

Address____

City______________________________ State____________ Zip_____________
*(If applicable) Alternate Address*________________________________ *City*_____________ *State*_________
*Zip*___________ *When will you be at this address?*_______________________ *Phone#* ____________________

Employer/Occupation_____________________ Marital Status:_____________ Spouses Name _____________

If applicable-WEB TPA INSURANCE:
Last name of card holder (if not yourself)_________________ First____________
Relationship to you _____________ SS#__________________ DOB: _____________________

EMERGENCY CONTACT INFORMATION-Mandatory

Name____ Cell #______________ Alternate#_______________

Their email address if known____________________________ Relationship to you_________________

MEDICAL INFORMATION

Pharmacy (Local) Pharmacy name ______________ Pharmacy#________________________
90 day Mail Order? Y_______ N________ Pharmacy _____________________ ID#__________________
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. I understand that I am, and remain financially responsible for these charges. I give permission for text appointment reminders and office exchanges on treatment concerns via email between appointments as needed (unless I've checked NO above).
I HAVE READ THIS SECTION AND AGREE TO CONTENT.
SIGNED____ **DATE**________________________ 2/2022

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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____
____

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 ________________

THE MOOD DISORDER QUESTIONNAIRE

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

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...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?	○	○

GAD-7

Over the <u>last 2 weeks</u>, 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____ = ____ + ____ + ____*)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* + ______ + ______ + ______

=Total Score: ______

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
☐	☐	☐	☐

NAME_____________ Please check the medications that you have taken in the past.**(Updated 2/2/22)**

Antidepressants

- Zoloft (Sertraline)
- Wellbutrin (Bupropion)
- Prozac (Fluoxetine)
- Paxil (Paroxetine)
- Lexapro (Escitalopram)
- Celexa (Citalopram)
- Cymbalta (Duloxetine)
- Effexor (Venlafaxine)
- Pristiq (Desvenlafaxine)
- Viibryd (Vilazodone)
- Trintellix (Vortioxetine)
- Nortriptyline (Pamelor)
- Remeron (Mirtazapine)

Stimulants

- Adderall (Amphetamine)
- Vyvanse (Lisdexamfetamine)
- Methylphenidate (Ritalin, Concerta)
- Dexmethylphenidate (Focalin)
- Strattera (Atomoxetine)

Mood stabilizers

- Lithium
- Depakote (Divalproex)
- Trileptal (Oxcarbazepine)
- Lamictal (Lamotrigine)
- Tegretol (Carbazepine)
- Topamax (Topiramate)
- Neurontin

Antipsychotics

- Abilify (Aripiprazole)
- Seroquel (Quetiapine fumarate)
- Zyprexa (Olanzapine)
- Risperdal (Risperidone)
- Latuda (Lurasidone)
- Vraylar (Cariprazine)
- Geodon (Ziprasidone)
- Saphris (Asenapine)
- Rexulti (Brexpiprazole)
- Caplyta (Lumateperon)
- Clozaril (Clozapine)
- Haldol (Haloperidol)
- Invega (Paliperidone)

Anxiolitics/Hypnotics/

- Xanax (Alprazolam)
- Ativan (Lorazepam)
- Klonopin (Clonazepam)
- Valium (Diazepam)
- Buspar (Buspirone)
- Restoril (Temazepam)
- Trazodone
- Ambien(Zolpidem)
- Lunesta
- Doxepin (Elavil)
- Ramenlteon (Rozerem)
- Sonata (Zaleplon)

Other

- Provigil (Modafinil)
- Nuvigil (Armodafinil)
- Synthroid or Cytomel
- Pramipexole (Mirapex)
- Ropinerole (Requip)

List any other psych meds you have taken:

-
-

Payment Information
Steve Machlin, LLC.

Credit Card Authorization: I, ______________________________________ (printed name) authorize the maintenance of valid credit card information to guarantee my chosen payment option. Charges will appear on your credit card statement as "Steve Machlin, LLC ".

Cardholder Name: ______________________________________

Circle Card Type: Visa MC Discover AmEx

Billing Address: ______________________________ **City:** ___________ **Zip:** _________

Credit Card # ________________________________ **3 digit CVV code:** ____

Expiration date: __/__/___ **Email Address:** ____________________________

Cardholder/Patient Signature: __________________________ **Date:** __/ /___

Please check your payment preference

_____ 1. I will pay in the office at the time services are rendered via check, cash, or credit card. If I do not pay, miss an appointment, or have a virtual appointment my balance will be processed via automatic billing.

_____ 2. Automatic billing to credit card on file.

Insurance Receipts: Superbills can be requested at the time of each visit. Patients are responsible for submitting all claims to their insurance provider.

Payment Guarantee:

☐ I understand that I am individually responsible for all incurred charges.

☐ I understand there is a 24-hour cancellation policy and that **without providing 24 hours advance notice** to cancel or reschedule a session I will be charged the *full fee* for hour long appointments and an $80/$95 late cancellation fee for *20 or 30* minute appointments in accordance with the Automatic Billing option mentioned above.

☐ I consent to text message appointment reminders. I understand that text message appointment reminders are a curtesy, but failure to receive a message does not waive the missed appointment fee.

I have read, understand and agree to the information authorization and guarantee stated above.

Signature: __________________________________ **Date:** ______________

Printed Name: ________________________________