

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 _____

Dr. Steven Machlin, MD. LLC
Health Questionnaire

Name _____ Date _____

Allergies – Also list your response to this substance: _____

Current medication and dosages:

Current Health Problems:

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

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

Hospitalizations and past surgeries - Please give dates if possible

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?

Health Questionnaire

Your goals for seeking treatment in our office:

Reviewed by _____ Date _____

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
☐

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 ____ = ____ + ____ + ____)

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?	<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 much 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 into 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?	<input type="radio"/>	<input type="radio"/>
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? <i>Please circle one response only.</i>		
No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. 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"/>

NAME _____

Check the medications that you have taken in the past (Updated 9/1/22)

Antidepressants

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

Stimulants

- Adderall (Amphetamine) IR and XR
- Azstaryz (serdexmethylphenidate and dexamethylphenidate)
- Focalin (Dexmethylphenidate) IR and XR
- Jornay PM (methylphenidate)
- Mydayis (longer acting Adderall xR)
- Ritalin, Concerta (Methylphenidate)
- Strattera (Atomoxetine)
- Sunosi (solriamfetol)
- Vyvanse (Lisdexamfetamine)

Mood stabilizers

- Depakote (Divalproex)
- Lamictal (Lamotrigine)
- Lithium
- Neurontin (Gabapentin)
- Tegretol (Carbamazepine)
- Topamax (Topiramate)
- Trileptal (Oxcarbazepine)
- Verapamil

Antipsychotics

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

Anxiolytics/Hypnotics/

- Ambien (Zolpidem)
- Ativan (Lorazepam)
- Belsomra (suvorexant)
- Buspar (Buspirone)
- Dalmane (Flurazepam)
- Doxepin (Elavil)
- Halcion (Triazolam)
- Klonopin (Clonazepam)
- Lunesta (eszopiclone)
- Restoril (Temazepam)
- Rozerem (Ramelteon)
- Sonata (Zaleplon)
- Trazodone
- Valium (Diazepam)
- Vistaril (hydroxyzine)
- Xanax (Alprazolam)

Other

- Deplin
- Electroconvulsive Therapy
- Ketamine or Spravato or Trans Cranial Stim
- Nuvigil (Armodafinil)
- Phentermine
- Pramipexole (Mirapex)
- Provigil (Modafinil)
- Ropinerole (Requip)
- Synthroid or Cytomel

PHONE: (239)225-1364 FAX: (239)225-7337

Authorization to Release/Obtain Protected Health Information

(Pursuant to the Health Insurance Portability and Accountability Act (HIPAA))

PATIENT: _____ DOB: _____
(Print)

This information should only be () released to and/or () obtained from: Check appropriate boxes

PERSON/ENTITY: _____ FAX# _____

ADDRESS:- _____ PHONE# _____

CITY/STATE/ZIP _____

This form, when completed and signed by you, provides authorization to Dr. Machlin (or his staff) to Release and/or obtain protected health information from the person/entity you've designated above.

To Release: Check applicable boxes:

- | | |
|------------------------|---|
| () Initial Evaluation | () Verbal Exchange of treatment issues |
| () Office Visit Notes | () Other _____ |
| () All records | |

To Obtain: Check applicable boxes:

- | | |
|------------------------------|------------------------------|
| () Discharge summary | () EKG/Labs(specify) _____ |
| () H & P/Initial Evaluation | () Neuropsych testing |
| () Office Notes | () Verbal clinical exchange |
| () MRI/Cat Scans | () Other _____ |

This information is to be used for:

- () Coordination of Treatment () Legal purposes () Other _____

This authorization remains in effect for:

- () Duration of treatment between Dr. Machlin and above named party.
() Single disclosure.
() Ninety days from this date.
() Other _____

I understand that I may revoke this authorization in writing, except to the extent that Dr. Machlin has taken action or has relied on the authorization. It will go into effect, at any time of this office receiving the written revocation. Once the uses and disclosures have been made pursuant to this authorization, they may be subject to redisclosure by any recipient and no longer protected. Dr. Machlin, and his employees are hereby released from any legal liability for the disclosures of the above information to the extent indicated and authorized herein.

I fully understand and accept terms of this authorization.

(Signature of Patient or Legal Representative)

(Date)