GIA SWOPE F.N.P.
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Patient Information:

Last Name: _____ First Name: _____
Middle Name or Initial: _____
Social Security #: _____ Date of Birth: _____
Gender: Male / Female / Transgender
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell #: _____
Employer: _____ Work Ph #: _____
Marital Status: Married / Domestic Partnership /Single / Divorced / Widowed
If "Married or Partnered," please fill out the following information:
Spouse's Name:
_____
Spouse's Employer: _____
Spouse's Work Phone #: _____ Cell #:_____
In case of emergency, please contact the following individual:
_____
Emergency Contact Phone #: _____
Relationship to Emergency Contact: _____

Insurance Coverage Information:

Do you have insurance coverage? Yes / No
If you checked "Yes," please fill out the following information:
Primary Insurance Company: _____
Deductible Amount: _____Co-pay Amount: _____
Policyholder Name: _____ **Date of Birth**: ___/___/____
SS#:_____Group #: _____ Policy #: _____
Secondary Insurance Company: _____
Deductible Amount: _____Co-pay Amount: _____
Policyholder Name: _____ Group #: _____
Policy #: _____

Financial Responsibility Agreement: (initial the following statements)

_____I agree to pay my co-pay (if applicable) at the time of service.
_____I authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to the provider that rendered services.
_____I understand that I am financially responsible for all charges whether or not paid by insurance.
_____I realize that my account may be transferred to a collection agency and my credit rating may be negatively impacted if I do not satisfy my financial responsibilities.

Please sign below to verify that the above information is correct and that you agree to the terms of the Financial Responsibility Agreement:

Signature:
_____Date:_____
(If the patient is unable to sign, the parent/guardian/power of attorney may sign here instead)

PATIENT MEDICAL HISTORY

Caffeine Use:_____ Cups per Day of Coffee/Tea/Soda

Alcohol Use: _____ Drinks per Day/Week/Month

Tobacco Use:_____ Packs per Day Smokeless Tobacco Use: Yes/No

Are you presently taking any medications: Yes/No
(Prescribed or Over-the –Counter) If yes, Name, how much, how often:
_____

Do you have any current or ongoing medical problems: Yes/No
What/duration:_____
_____

Previous Medical Hospitalizations and Surgeries: _____
_____

Prior Therapy/Counseling: Yes/No
If yes, who, when, where, duration: _____
_____

Prior Psychiatric Hospitalizations: Yes/No
If yes, where, when, duration, diagnosis and medications:
_____

Family history of Mental Illness: Yes/No If yes, who? Mother, Father, Brother, Sister, Aunt, Uncle, Grandparents:
_____

Prior Substance Abuse Treatment: Alcohol/Drugs _____

Family History of Substance Abuse: Yes/No If Yes, Who? _____
_____

Allergies to Medications: (Please list) _____
_____

Why are you here today? _____

(I) THE BECK ANXIETY INVENTORY (BAI)

Name of the symptom	Not At All	Mildly, but it didn't bother much	Moderately – it was unpleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky/Unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint/lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
COLUMN SUM				
GRAND TOTAL				

Instructions: Read each item in the list carefully. Indicate how much have you been bothered by each of the symptoms during the last 1 month, including today. Circle on the corresponding number in each column.

THE BECK ANXIETY SCALE - INTERPRETATION OF SCORES

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

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		
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?	○	○

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 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
add columns:		+	+	
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 _____