Adult New Patient Paperwork
Georgia Psychiatry & Sleep, LLC

Patient Name:
Age:
DOB:

Reason for Visit: _____

Who referred you to us:

Physician / Other Name:	Physician / Other Fax Number:

Release of medical information: Please list below other individuals (family, spouse, and parents) with whom your provider can discuss your care or release your psychiatric medical records.

Name	Relationship

Pharmacy- All your medication with the exception of controlled substances will be e-scribed to your pharmacy. Please provide your pharmacy information below.

Pharmacy Name	Full Address including **zip**	Phone	Fax

Patient Information

Home Address:

_____

Contact Number: _____
Email Address: _____

Financial Policies and Benefit Assignment- Read and Sign

I authorize Georgia Psychiatry & Sleep to furnish information as necessary to my insurance carrier regarding my illness and treatment, and I assign to Georgia Psychiatry & Sleep all insurance payments for medical services rendered. I understand that I am responsible for providing all necessary information to the office or submitting charges to the insurance company for payment. If I fail to provide this information, I accept the financial responsibility of payment for services rendered. This office has a cancellation policy that requires 24 - hour advance notification. I understand that if I cancel with less than 24 hour notice, a charge will be made for the time reserved. This charge is not covered by insurance and is not payable from any insurance company.

Consent to treatment with psychotropic medications

The indications for the medication(s) that are a part of my treatment plan have been discussed with me. I understand that, on occasion, some psychotropic medications may be used for psychiatric conditions or symptoms, despite a lack of FDA approval for these uses. I accept this, and accept the advantages and disadvantages of this treatment. Based on the information provided, I agree to comply with the instructions provided by my physician.

If I have further questions or concerns about the medication(s)or treatment, I understand that I should contact the prescribing physician as soon as possible.

Office policies

Listed below are all office policies. All office policies must be acknowledged and agreed to prior to the initial evaluation. Compliance with office policies are required. Please check each box after reading for acknowledgement.

- New patient no-show fee of $100 will be required before our staff is able to reschedule an initial evaluation ☐
- New patient same-day cancellation fee of $100 will be required before the initial appointment is rescheduled ☐
- Existing patient no-show fee of $50 for medication management & $100 for talk therapy ☐
- Existing patient same-day cancellation fee of $50 for talk therapy, and $25 for medication management ☐
- A urine drug screen is required for **ALL medication management new patients** and can be requested at any time at a follow-up visit for medication management, at the discretion of your provider. The UDS cost is $15 ☐
- Patients with 3 or more missed/cancelled appointments may be considered for possible termination from our practice ☐
- Patient responsibility is due at the time of service ☐
- Any medication refill requests will be considered on a case-to-case basis, and if approved by the provider, will be a cost of $25 if refilled without an appointment. ☐
- Insurance, address, phone number and pharmacy changes need to be updated with our office. ☐
- Any disability cases must be discussed in session and may require additional treatment programs. Disability paperwork will not be filled out at initial evaluations. ☐

I have received and read the office policies, financial policy and patients' rights and responsibilities. A copy of these forms have been emailed and can be provided by request.

_____ _____

Patient Signature Date

Patient Health Questionnaire- PHQ 9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	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 hurting yourself in some way	0	1	2	3

Please total your score. 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:

Mood Disorder Questionnaire – MDQ-9

Instructions: Please answer the questions to the best of your ability. This is based on a period of time, lasting atleast 3-4 consecutive days, where these symptoms occurred together:

	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 in trouble?		
Total Number of "Yes" responses		
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 care professional ever told you that you have manic-depressive illness or bipolar disorder?		

Name:

Rapid Mood Screener (RMS)

Please select one response for each question

	Yes	No
1. Have there been at least 6 different periods for time (at least 2 weeks) when you felt deeply depressed?		
2. Did you have problems with depression before the age of 18?		
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?		
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?		
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?		
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?		

Score: _____

Are you living with Adult ADHD?

Many adults have been living with Adult Attention Deficit/Hyperactive Disorder (Adult ADHD) and don't recognize it. These symptoms are often mistaken for a stressful life. If you've felt this type of frustration most of your life, you may have Adult ADHD - a condition your doctor can help diagnose and treat.

The following questionnaire can be used as a starting point to help you recognize the signs/symptoms of Adult ADHD but is not meant to replace consultation with a trained healthcare professional. **An accurate diagnosis can only be made through a clinical evaluation.** Regardless of the questionnaire results, if you have concerns about diagnosis and treatment of Adult ADHD, please discuss your concerns with your physician.

This Adult Self-Report Scale-V1.1 (ASRS-V1.1) Screener is intended for people aged 18 years or older.

Adult Self Report Scale

Check the box that best describes how you have felt and conducted yourself over the past 6 months. Please give the completed questionnaire to your healthcare professional during your next appointment to discuss the results.	Never	Rarely	Sometimes	Often	Very Often
1.How often do you have trouble wrapping up the final detail of a project, once the challenging parts have been done?					
2.How often do you have difficulty getting things done 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 yu were driven by a motor?					

GAD-7 Name:

Over the last 2 weeks, how often have you been bothered by the following problems?

	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

Please total your score. Total Score_____ = _____ + _____ + _____ + _____

Audit – C Questionnaire

1. How often do you have drinks containing alcohol?
   a. Never
   b. Monthly or Less
   c. 2-4 times a month
   d. 2-3 times a week
   e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
   a. 0
   b. 1 or 2
   c. 3 or 4
   d. 5 or 6
   e. 7 to 9
   f. 10 or more

3. How often do you have six or more drinks on one occasion?
   a. Never
   b. Less than monthly
   c. Monthly
   d. Weekly
   e. Daily or almost daily

1. Have you been a patient in a psychiatric hospital or in a rehab program for a drug/alcohol problem? Yes No

Name of Hospital	City, State	Dates of treatment	Partial Hospital/intensive outpatient or inpatient	Treatment reason

2. Have you ever seen a psychiatrist or counselor in the past? Yes No

Name of counselor/psychiatrist	City, State	Dates Seen	Treatment reason

3. Any prior major medical (non-psychiatric) hospital admissions:

Hospital Name	City, State	Dates	Reason

4. Major Surgeries: _____

5. Do you have a history of addiction? Yes No Ongoing Past

	Yes	No
Alcohol		
Marijuana		
Opiates		
Other Substances		

What is/was your substance or drug of choice: _____

a. Most recent use: _____
b. Have you experienced drug withdrawals/substance use-related seizures? Yes No
c. If you have an active addiction, what is your longest period of sobriety? _____
d. What was the age or year of first time use of any substances? _____
e. Do you attend AA/NA/12-Step Meetings? Yes No

6. Marital Status:
   a. Married for ___ years
   b. Divorced for ___years
   c. Single (Never Married)
   d. Divorce in progress
   e. Number of prior marriages:___
   f. Number of Children_____

7. Describe your employment status?
   a. Position_____ Employer_____
   b. Unemployed
   c. Disabled for: Medical_____ Psychiatric Condition_____
   d. Currently a student

8. Legal History
   a. No legal problems
   b. Spent time in jail for _____
   c. Now on probation
   d. Court – ordered treatment
   e. Total time in jail/prison: _____

9. Have you served in the US Military? Yes No
   a. Number of years_____
      i. Honorable discharge
      ii. Other discharge: Please explain_____

10. Cultural Identity (Ethnicity/Religion)_____

11. What is your highest level of education?
    a. High school/GED
    b. Some college
    c. College degree
    d. Graduate degree

Review of Systems Name:

Generally healthy.	Yes	No
Changes in weight or changes in strength or exercise tolerance.	Yes	No
Headaches, vertigo, injury.	Yes	No
Change in hearing, ringing in ears, bleeding, vertigo.	Yes	No
Nose bleeds, colds, obstruction, discharge.	Yes	No
Dental difficulties, gingival bleeding, use of dentures.	Yes	No
Difficulty breathing, wheezing, coughing up blood, cough.	Yes	No
Chest pains, palpitations, fainting, shortness of breath, irregular heartbeat.	Yes	No
Change in appetite, abdominal pains, bowel habit changes. .	Yes	No
Urinary urgency, painful urination, change in nature of urine.	Yes	No
Change in menses, cramping, pelvic pain.	Yes	No
Pain in muscles or joints, limitation of range of motion, tingling or numbness.	Yes	No
Weakness, tremor, seizures, changes in mental function, problems with muscle coordination.	Yes	No
Changes in sleep habits, difficulty sleeping, insomnia.	Yes	No

Medical History				
Myself	Mother	Father	Sibling	Please check the following medical history conditions for yourself or close family members indicated.
				Bipolar disorder
				Depression
				Anxiety
				Addiction
				Attention Deficit Disorder
				Other psychiatric illness, describe:
				Family History of completed suicide
				Heart disease/Structural cardiac heart defects
				Sudden Cardiac Death (sudden heart attack in their 20's or 30's)
				Heart arrhythmias
				Seizure disorder
				High Blood Pressure
				Thyroid Disease
				Kidney Disease
				Liver Disease (Hepatitis/Cirrohsis)
				Sleep Apnea
				Narcolepsy
				Autoimmune disease, if yes specify:
				Diabetes
				Coronary Artery Disease
				Stroke
				Chronic Kidney Disease
				Congestive Heart Failure

Do you have any other chronic medical conditions, please describe:_____

Do you smoke cigarettes? Yes No Former Smoker How many per day? 1/2 pack per day 1 pack a day, other_____

Medication List Name:

Please list all current and past prescribed and over the counter medication:

Medication	Strength	Prescriber	Dates used

List any psychiatric medications you have tried in the past or that you are currently on.

Medication	Strength	Prescriber	Dates used	Why did you stop the medication?

If applicable, are you currently pregnant? ☐ Yes ☐ No ☐ N/A

If applicable, are you currently breast-feeding or pumping breast milk for infant feedings? ☐ Yes ☐ No ☐ N/A

Are you allergic to any medications?: _____

_____

I give consent to retrieve all medication records from pharmacy and/or prescribers? ☐ Yes ☐ No

Current Height: _____ Feet _____ inches

Current Weight: _____ lbs

Name:

Sleep Questionnaire

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

Situation	**0- Least Likely 3- Most Likely**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Please total your score. Total=_____

1. Do you work "shifts"?	**Yes**	**No**
2. What shift do you work?	**Am**	**Pm**
3. Do you feel your work, home, or social life is negatively affected by the above?	**Yes**	**No**
4. Do you feel tired or sleepy when you need to be awake?	**Yes**	**No**
5. Do you snore loudly on most nights?	**Yes**	**No**
6. Do you have morning headaches?	**Yes**	**No**
7. Does anyone in your family snore loudly or have sleep apnea?	**Yes**	**No**
8. Have you, as a driver, been in a car accident, because of sleepiness?	**Yes**	**No**
9. Do you have sleep walking as an adult?	**Yes**	**No**
10. Do you have creepy, crawly, legs at night that keep you awake on most nights of the week?	**Yes**	**No**
11. Do you have "sleep attacks" during the day while laughing or experiencing strong emotions?	**Yes**	**No**

12. What is your usual sleep schedule:

What time do you go to sleep on a typical school/work day?_____

What time do you awaken on a typical school/work day?_____

13. How long does it take you to fall asleep on most nights:

a. less than 20 minutes
b. 20-40 minutes
c. greater than 40 minutes

Drug Screen Policy

At the initial evaluation and from time to time during treatment, patients may be asked to submit a urine specimen for analysis for drugs. The results of these look for both to see in fact the patient is taking medications prescribed and also to verify that the patient is not using other unauthorized substances. For the wellbeing and health of our patients the screening will help to determine there are no dangerous interactions between multiple drugs.

This fee is normally covered by insurance, but there may be a co-pay or balance owed after the insurance pays. It is the responsibility of the patient to take care of these fees owed. If you do not have insurance or your insurance does not cover it, we will collect $15 as a charge for this urine drug screen test.

By your signature below, you indicate that you have read, understand, and agree with this policy. This document will be scanned into your permanent medical records and you may request a copy of it for your own files.

_____ _____

Patient Signature Date