Adult New Patient Paperwork

Full Name: _____

DOB: _____ Age: _____

Sex: Female Male

Address: _____

_____

_____

Phone Number: _____- _____- _____

Email Address: _____

Gender: Male Female Non-Binary Transgender MTF Transgender FTM

Preferred Pronouns: She/Her/Hers He/Him/His They/Their/Theirs Other

Preferred Pharmacy- Please provide the pharmacy name AND address

_____

Release of Information (ROI)- Please list below individuals with whom your provider can discuss your care or release your psychiatric medical records. If you do not want anyone to discuss your medical records, please write “N/A”.

Name	Relationship

What service are you looking to schedule?

- Medication Management (where medication can be prescribed)
- Talk Therapy (No medication prescribed)
- 1x Psychiatric Evaluation for Bariatric Surgery
- 1x Psychiatric Evaluation for Spinal Cord Stimulator
- Hospital Discharge
- Other: _____

Reason for appointment? _____

Circle which symptoms you are currently experiencing.

Sleep Difficulty	Anxiety	Stress	Bipolar Symptoms	Depression
Withdrawal from Substance Abuse		PTSD	ADHD	Panic Attacks

Have you ever seen a psychiatrist or counselor in the past? If yes, please provide the name of the psychiatrist, dates seen, treatment reason, and reason for seeking care elsewhere.

_____

_____

_____

Have you ever been a patient in a psychiatric hospital or in a rehab program within the past year for a drug/alcohol problem? If yes, please give the name of the facility, location, dates seen, type of program, and treatment reason.

_____

_____

_____

Office Policies- Initial and sign

- There is a new patient no-show fee of $100. This will be required before our staff is able to reschedule an initial appointment. _____
- We require 48 hours notice for any new patient appointment cancellations. Failure to do so may result in a $100 cancellation fee. This fee will be required before the initial appointment can be rescheduled. ____
- There is an existing patient no-show fee of $50 for medication management and $100 for talk therapy. ____
- There is an existing patient same-day cancellation fee of $25 for medication management.
- We require 48 hours notice for any therapy appointment cancellations. Failure to do so may result in a $100 cancellation fee. ____
- A urine drug screening is required for ALL medication management new patients and can be requested at any time at a follow-up visit at the discretion of your provider. The cost of this screening 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 must be approved by your provider. If approved without an appointment, there is a $25 refill fee. _____
- All insurance, address, phone number, and pharmacy changes need to be updated with our office. _____
- Any disability cases will NOT be filled out at an initial evaluation. _____

Financial Policies and Benefit Assignment

I authorize Georgia Psychiatry and Sleep to furnish information as necessary to my insurance carrier regarding my illness and treatment, and I assign to Georgia Psychiatry and 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.

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 to see if 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 also help to determine there are no dangerous

interactions between multiple drugs. The fee is normally covered by insurance, but there may be a copay 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.

Consent to Treatment with Telemedicine

By signing this form, you agree that you have read, understand, and agree with these terms if scheduled for a telemedicine appointment. By signing below, I acknowledge the following:

I am aware of the provider that I am scheduled to have my telemedicine appointment with.

I have been able to ask questions about telemedicine sessions with GPS staff.

I am aware that I can reach out to the office if I have any questions.

I understand that no guarantees have been made about the success or outcome, and I agree to take part in a telemedicine appointment.

I understand that the telemedicine consultation will be similar to a routine medical office visit.

I understand that this is an option on a temporary basis due to the COVID-19 Pandemic.

I give consent to retrieve and release records to care providers within my treatment circle. _____

I have received and read the full office policies, financial policy, and patients' rights and responsibilities documents.This is a separate series of documents that further outlines our full office policies. A copy of these forms has been emailed to you and can be provided on request.

Signature _____

Today's Date _____

Scales/Questionnaires

PHQ 9- Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not At All (0)	Several Days (1)	More than half of the days (2)	Nearly every day (3)
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people have noticed? Or the opposite- being so fidgety/restless that you have been moving around more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

Total Score (Add up your answers): _____

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?

	Not at all (0)	Several days (1)	More than half of the days (2)	Nearly every day (3)
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

Total Score (add up your answers): _____

MDQ	Yes	No
Has there ever been a period of time when you were not your usual self?		
You felt so good or so hyper that other people thought you were not your normal self or that you were so hyper that you got in trouble?		
You were so irritable that you shouted at people or started arguments/fights?		
You felt much more self confident than usual		
You got much less sleep than usual and found that 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?		
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?		
You were much more interested in sex than usual?		
You did things that were unusual for you or that other people thought were excessive, foolish, or risky?		
Spending money got you or your family in trouble?		

If you answered yes to more than one of the above, have several of these ever happened during the same period of time?

Yes No

How much of a problem did any of these cause you? Like being unable to work, having family/money/legal troubles, getting into arguments, etc?

No problem Minor problem Moderate problem Serious problem

Have any of your blood relatives had manic-depressive illness or bipolar disorder?

Yes No

Has a healthcare professional ever told you that you have manic-depressive illness or bipolar disorder?

Yes No

RMS	Yes	No
Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?		
Did you have problems with depression before the age of 18?		
Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?		
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?		
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?		
Have you ever had a period of at least 1 week during which you needed less sleep than usual?		

ASRS	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the final detail of a project, once the challenging parts have been done?					
How often do you have difficulty getting things done when you have to do a task that requires organization?					
How often do you have trouble remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid/delay getting started?					
How often do you fidget or squirm with your hands/feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					

How often do you have drinks containing alcohol?

Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?

0 1-2 3-4 5-6 7-9 10 or more

How often do you have six or more drinks on one occasion?

Never Less than monthly Monthly Weekly Daily or almost daily

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

	Least likely (0)	Somewhat likely (1)	Likely (2)	Most likely (3)
Sitting and relaxing	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (like in a meeting or theater)	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

Sleep Routine Questionnaire

	Yes	No
Do you work shifts?		
Do you feel your work, home, social life is affected by your shifts?		
Do you feel sleepy/tired when you need to be awake?		
Do you snore loudly on most nights?		
Do you have morning headaches?		
Does anyone in your family snore loudly or have sleep apnea?		
Have you, as a driver, been in a car accident because of sleepiness?		
Have you ever sleepwalked as an adult?		
Do you have creepy, crawly legs at night that keep you awake most nights of the week?		
Do you have “sleep attacks” during the day while laughing or experiencing strong emotions?		

Any major medical (non-psychiatric) hospital admissions? If yes, please provide hospital name, dates seen, and reason.

_____

_____

Any major surgeries? If yes, what kind and when?

_____

_____

Do you ever hear voices or experience hallucinations? Or have you in the past? If so, please provide date of last occurrence and details.

Yes No

_____

_____

Do you have a history of addiction?

Yes No

What is/was your substance of choice?

	Yes	No
Alcohol		
Marijuana		
Opiates		
Cocaine		
Meth		
Kratom		

If other, please specify _____

Most recent use? _____

Have you ever experienced drug withdrawals/substance use-related seizures?

Yes No

If you have an active addiction, what is your longest period of sobriety?

_____

What was the age/year of your first time use of any substance? _____

Do you attend AA/NA/12 Step meetings?

Yes No

ROS

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

Family History

	Self	Mother	Father	Sibling
Bipolar disorder				
Depression				
Anxiety				
Addiction				
ADHD				
Schizophrenia				
Family history of completed suicide				
Heart disease/structural heart defects				
Sudden cardiac death (sudden heart attack in 20s/30s)				
Heart arrhythmias				
Seizures				
High blood pressure				
Thyroid disease				
Kidney disease				
Liver disease (Hepatitis/Cirrhosis)				
Sleep apnea				
Narcolepsy				
Autoimmune disease				
Diabetes				
Coronary Artery Disease				
Congestive heart failure				
Stroke				

Please list any other chronic medical conditions you have.

_____

Are you currently pregnant?

Yes No N/A

Are you currently breastfeeding or pumping breastmilk for infant feedings?

Yes No N/A

Do you smoke cigarettes? If yes, how many cigarettes per day do you smoke? If using other forms, please specify (e-cig, cigars, chewing tobacco, etc.)
Yes No Former Smoker I use other forms of tobacco.

_____

Current Height: ____' ____ Current Weight: _____

What time do you go to sleep and wake up on a typical work/school day?

___:___ AM/PM to ___:___ AM/PM

How long does it take you to fall asleep on most nights?

Less than 20 minutes 20-40 minutes More than 40 minutes

Marital Status: _____

Highest level of education? _____

Employment Status: _____

If employed, what is your position and employer? _____

If on disability, is it for…

Psychiatric condition Medical Condition I am not on disability.

Legal History

	Yes	No
No legal problems		
Spent time in jail		
On probation currently		
Court-ordered treatment		

If time spent in jail/prison, please give reason and total time served:

_____

Have you served in the US military? If yes, for how long and reason for discharge?

_____

Please list ALL current medications (prescriptions and over-the-counter medications). Please provide drug name, dose, frequency, and route.

Please list any psychiatric medications you have tried in the past. Please provide drug name, dose, prescriber, dates used, and why you stopped.

Are you allergic to any medications? If yes, please list.

_____

Patient Signature: _____

Today's Date: _____