

NeuroPsychiatry Center - Ravi Kant, MD, P.C.

300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

REGISTRATION

Patient _____
Last Name First Name Middle Initial

Street Address _____

City _____ **State** _____ **Zip** _____ - _____

Phone Numbers: Home- _____ **Work:** _____ **Cell:** _____

Sex: _____ **Identified Gender:** _____ **Age:** _____ **Birth Date** _____

E-mail: _____

Race: White Black Asian Other _____ **Ethnicity** _____ **Preferred Language** _____

Emergency contact _____ **Phone #** _____ **Relationship** _____

If patient is a minor or has a legal representative or guardian, please fill out the information below.
(Guardian/Legal Representative is required to attach supporting legal documentation)

Responsible Party _____

Street Address (if different from patient) _____

City _____ **State** _____ **Zip** _____ - _____

Date of Birth _____ **Phone Number** _____ **E-mail** _____

Insurance Information

1. Primary Insurance _____

Policyholder Name _____ **Relationship to Patient** _____

Date of Birth _____ **Policy #** _____ **Group #** _____

2. Secondary Insurance _____

Policyholder Name _____ **Relationship to Patient** _____

Date of Birth _____ **Policy #** _____ **Group #** _____

√ **Can we leave a text or message at the phone number provided with family member/s or on the voicemail for appointment reminders or other information? – Yes No**

Name: _____ **Signature** _____ **Date:** _____

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ASSIGNMENT/RELEASE/CONSENT TO TREATMENT

Patient Name _____ **Date of Birth** ____/____/____

(All patients/guardians sign below)

I authorize and request treatment/s from **RAVI KANT, M.D.** and/or his associates to perform routine diagnostic procedures and to provide medical treatment as is medically necessary in his/their professional judgment.

I hereby authorize release of protected health information, including mental health and/or substance abuse (drug and alcohol), necessary to file a claim with my insurance carrier and assign benefits otherwise payable to me to **RAVI KANT, M.D. PC** as indicated on the insurance claim form. I understand that this facility and its providers are mandated reporters of any and all suspected or witnessed child abuse and/or neglect. (Section 6383 (b) of Title 23 of the Pennsylvania Consolidated Statutes/Act of July 1, 2015, P.L. 94, No. 15). I also understand that I am financially responsible for any balance not covered by my insurance carrier(s) (including but not limited to deductibles and/or co-payments) and agree to pay the full charges if payment is/are denied by my insurance carrier(s) for any reason or if no insurance coverage exists at the time of services. It is my responsibility to update any changes in insurance. I understand it is mandatory to notify the health care provider of any other party who may be responsible for payments (section 1128 B, Social Security Act and 31 U.S.C. 3801- 3812 provides penalties for withholding this information). Medicare regulations apply. I have received, read and agree with the billing and other office policies.

With my consent, Ravi Kant, M.D., his associates, and office staff can call my home and leave messages on an answering machine or with a person, text, or e-mail me regarding appointments and contact the designated emergency contact person if needed. I may revoke my consent in writing except to the extent that the practice has already acted upon in reliance upon my prior consent. If I do not sign this consent, Ravi Kant, M.D. and his associates may decline to provide services to me. I agree with the above.

All the information provided in this Registration-Assignment/Release/Consent to Treatment is true and current.

Notice of Health Information Practices - Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)

I have read and understood the above Notice of Health Information Practices. I recognize that this is a federal mandate that this facility must comply with. Patient Initials _____

Notice of Patient Rights and Responsibilities - Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)

I have read and understood the Patient Rights and Responsibilities provided at the office. Patient Initials _____

Notice of Grievance Procedure – Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)

I have read and understood the Grievance Procedure provided at the office. Patient Initials _____

Patient Signature _____ Date _____

(If patient is a minor (ages 14-18) he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name _____

Responsible Party Signature _____ Date _____

(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____

(Guardian/Legal Representative is required to attach supporting legal documentation)

Office use only

Witness _____ Name _____ Date _____

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OFFICE POLICIES

Patient Name _____ **Date of Birth** ____ / ____ / ____

Insurance Coverage:

Due to frequent changes in insurance coverage (benefits, exclusions, deductibles and/or prescription coverage, etc.), we cannot inform or advise you about your benefits. In some insurance policies, certain diagnoses may be excluded, such as ADHD, Autism, Mental Retardation and related conditions. We do not routinely do the paperwork for non-formulary medicines not covered by your insurance company. You are responsible for keeping track of number of visits allowed in your plan and how many visits you have used with your therapist and prescriber. You will be charged for additional visits. If you do not have insurance coverage, you are responsible for the full charges. Please inquire in advance about our charges if you do not have insurance.

Payments:

It is our policy to collect all **co-payments and/or deductibles** at the time of service unless arrangements are made ahead of time. **We accept checks, cash, and debit or credit cards (Visa, MasterCard American Express or Discover).**

A service charge of **\$10.00** plus interest (1.5%/month) will be added to any outstanding balance over 30 days past due. Also, all delinquent accounts (over 90 days past due) may be turned over to a collection agency. An additional **\$40.00** as a handling fee and the costs of collection (including attorneys' fees and costs) will be added to the total amount due.

Attendance Policy:

We understand that it is not always possible to keep a scheduled appointment or give 24 hours notice of cancellation. If a pattern of same day cancellation or "No Shows" develop, we reserve the right to bill you **\$50.00** fee for the missed appointment time. Your insurance company is not responsible for this charge. Prescriptions may not be called in for No Show or Canceled appointments. Additionally, if there are frequent No Show for appointments or non-compliance with treatments, you may be discharged from the practice.

Lost Prescription Fee:

A service fee of **\$20.00** will be charged to replace lost scripts. Scripts will need to be picked up from the office after payment of the fee.

Returned checks – Fee of **\$40.00** will be charged for checks returned for any reason.

****Fees may be changed without notice.**

I have read and agree to be legally bound by the terms of these office policies including the financial responsibility provisions hereof. I understand that I am financially responsible for any amounts not covered or paid by my insurance carrier and that I am responsible for providing current insurance information and inform the office of any address and/or insurance changes.

Patient Signature _____ Date _____
(If patient is a minor (ages 14-18), he/she must sign this Office Policy Form)

Print Name _____

Responsible Party Signature _____ Date _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative is required to attach supporting legal documentation)

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____
Phone Number: _____ **Email:** _____

I consent to and authorize to disclose my protected health information relating to my identity, diagnoses, prognosis, and/or treatment. These records may include information related to medical conditions, tests, mental or behavioral health, substance abuse (drug and alcohol), and HIV-related. These records are called protected health information and are protected by federal and/or state law.

From: Ravi Kant, MD, P.C.
(Name and address of provider or facility releasing records)

To: PCP Family Member Other Medical Provider Other _____

Name: _____
Address: _____
Phone Number: _____
Fax Number: _____

The purpose for this disclosure is: Coordination of Care Disability Application Other _____

I understand that the specific types of records to be released (identify all records or all that apply) are:

All records including psychiatric/psychological evaluation Scheduling appointments/Medication refills Insurance claims and payments only Other _____

****Mental or behavioral health, substance abuse, and HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.****

DO NOT RELEASE: Mental/Behavioral Health (Psychiatric) HIV-Related Substance Abuse (Drug and Alcohol)

I understand that this authorization is revocable upon my written request and that this consent will remain in force unless revocation from the patient or legal guardian is received. I also understand that any revocation of this authorization must be in writing and sent or delivered to my health care provider's office. I also understand that my decision to revoke this authorization may result in my insurance company not being able to pay for my medical care and I will be liable for payment for the services rendered.

Patient Signature _____ **Date** _____
(If patient is a minor (ages 14-18) he/she must sign this Authorization for Release of Protected Health Information Form)

Print Name _____

Responsible Party Signature _____ **Date** _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only

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CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

Patient Name: _____ Date of Birth: ____ / ____ / ____

Parent/Legal Guardian Name: _____ Relationship _____

By signing below, I permit NeuroPsychiatry Center to communicate protected health information for the above patient via e-mail at _____@_____.

E-MAIL RISKS AND YOUR RESPONSIBILITY:

You and your provider/s at NeuroPsychiatry Center (NPC) and its employees and staff have agreed to correspond using e-mail. These e-mails may contain personal protected health information including, mental health issues. You need to be aware of the risks and your responsibilities.

- A.) As the internet is not secure or private, unauthorized people may be able to intercept, read, and possibly modify e-mail/s you send or receive from NPC. You must protect your e-mail account and password against unauthorized use. Hackers can get access to your account.
- B.) Viruses can be spread via e-mail and some may cause e-mail messages to be sent to unintended people.
- C.) E-mails can be copied, printed, and forwarded by recipients; be careful with whom you send or share e-mails.

1. CONDITIONS FOR THE USE OF E-MAIL:

By consenting to the use of e-mail with NPC you agree that:

- A.) NPC may forward e-mails, as appropriate, for diagnosis, treatment, billing, and other related reasons. Employees and medical staff other than the intended recipient may have access to your e-mails.
- B.) Although NPC will try to read and respond to your e-mail, we may not read your e-mail immediately. If you do not receive a response within a reasonable time, it is your responsibility to contact us to follow up.
- C.) You should carefully consider the use of e-mail for the communicating sensitive medical and personal information.
- D.) E-mail messages should be **short, clear, and concise**.
- E.) NPC reserves the right to save your e-mail including the information contained there in the medical records.
- F.) You agree not to abuse the right to communicate with your physician's office and your communications will be professional in content.
- G.) E-mail access to staff is being provided as a convenience to our patients and NPC has the right to restrict your ability to communicate with us via e-mail at any time for any reason, including cases where NPC reasonably believes that it is not in your best interest to continue to seek advice via e-mail and an in person appointment is needed or that e-mail is being used excessively in lieu of in person care.

2. INSTRUCTIONS:

- A.) You should immediately inform the staff at NPC of any changes in your e-mail address.
- B.) **E-mail should be used only for non-sensitive and non-urgent issues such as prescriptions, scheduling, general questions or advice. E-mail is not a substitute for psychotherapy or medication management appointments.**
- C.) Please put the patients name and date of birth in the body of the e-mail for proper identification.
- D.) If you wish to withdraw your consent to communicate via e-mail, you must inform NPC in writing.

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CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

ACKNOWLEDGEMENT AND AGREEMENT

NeuroPsychiatry Center will use reasonable means to protect the privacy of the patient’s health information. However because of the risks outlined above, NPC cannot guarantee e-mails will be confidential. Also NPC will not be liable in an event that you or anyone else inappropriately uses or accesses your e-mail. NPC will not be liable for improper disclosure of your health information that is not caused by our intentional misconduct.

NPC is not responsible for e-mail messages that are lost due to technical failure during composition, transmission and/or storage. NPC may impose restrictions to communicate with me by e-mail. I have read and understand the information above, and had any questions answered to my satisfaction. I have received the copy of this consent form. I agree to the guidelines for e-mail communication. I understand that this consent is valid until such time as I revoke the consent outlined above, except to the extent that a staff has already acted in reliance upon this authorization.

Patient Signature _____ **Date** _____
(If patient is a minor (ages 14-18) he/she must sign this Release of Protected Health Information via Electronic Communication Form)

Print Name _____

Responsible Party Signature _____ **Date** _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

DO NOT SEND E-MAIL FOR EMERGENCIES

**GO TO THE NEAREST HOSPITAL, CALL 911, OR CONTACT YOUR COUNTY’S
EMERGENCY CRISIS NUMBER**

We will not read e-mails on weekends, holidays, or when on vacation.

Office Use Only

Witness _____ Name _____ Date _____

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PRESCRIPTION REFILL POLICIES AND PROCEDURES

Patient Name: _____ **Date of Birth:** _____

Parent/Legal Guardian Name: _____ **Relationship** _____

In order to make the prescribing medication and requesting temporary refills process efficient, we will follow the procedures listed below. Patients or a parent/legal guardian should initial and sign below.

- Check which medications need refilled before coming to your appointment. It is **YOUR** responsibility to get your medications refilled during your visit. Schedule your next visit at least **1 week prior** to running out of your current refill(s).
- If you require a medication refill in-between scheduled appointments, it is **YOUR** responsibility to request it from our website - www.drkant.com and fill in the "Medication Refill Request" online. Refill requests are **NOT** accepted via phone. We need at least **72** hours notice (excluding weekends or holidays) to respond to your request. Please note that we do **NOT** accept medication refill requests from pharmacies.

I understand the above: X _____

- Regular office visits are required for monitoring and prescribing medications as determined by your provider. Medications will not be called in without required office visits.

I understand the above: X _____

- Blood work is needed for some medications to assess the safety and effectiveness. For patients who do not get the blood work done in a timely fashion, we will refuse to fill their prescriptions.

I understand the above: X _____

- If prescribed a controlled substance as identified by the DEA, per office policy, patients must be seen at least every 4-8 weeks, at the discretion of the provider. Refills for controlled substances will only be provided during appointments. Random urine screens may be requested to assess the use of narcotics or abuse of illicit drugs.

I understand the above: X _____

I have read the **Prescription Refills Policies and Procedures** and by initialing above and signing below, I agree to abide by them in full and have been given a copy if requested.

Patient Signature _____ **Date** _____
(If patient is a minor (ages 14-18) he/she must sign this Prescription Refill Policies and Procedures Form)

Print Name _____

Responsible Party Signature _____ **Date** _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

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E-PRESCRIBING MEDICATION HISTORY CONSENT

Patient Name _____ **Date of Birth** ____ / ____ / ____

I understand that NeuroPsychiatry Center utilizes e-prescribing. I understand that e-prescribing allows the practice to send prescriptions electronically to pharmacies, eliminating the need for prescribing via paper, phone, or fax. E-Prescribing is fast, convenient, legible, secure, cost-effective and safe. In some cases, it also allows the health care provider to access critically important information about patient’s current and past medications from pharmacy benefit managers and community pharmacies. This helps to alert the provider to other potential medication interactions or if patient is getting same or similar medications from multiple providers.

I have been given an opportunity to ask questions about the e-prescribing process and have had those questions answered to my satisfaction. I hereby consent to the practice requesting and using my medication history from other health care providers, pharmacies, or third party pharmacy benefit payers for treatment purposes.

Patient Signature _____ **Date** _____
(If patient is a minor (ages 14-18) he/she must sign this Authorization for E-Prescribing Medication History Consent Form)

Print Name _____

Responsible Party Signature _____ **Date** _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only

Witness _____ Name _____ Date _____

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300 Old Pond Rd., Suite 201, Bridgeville, PA 15017 Tel. 412-220-7323

Name _____ DOB ____ / ____ / ____ Date _____

PERSONAL CRISIS PLAN

My Triggers: _____

Thoughts/Inside Warnings: _____

Outside Warning Signs: _____

When Notice My Triggers I will: _____

When Others Notice I'm Upset I'd like them to: _____

Things That Help Me Stay Better Now: _____

Things That Help Me Stay Well on a Regular Basis: _____

Things That Make Me Feel Worse: _____

*If I'm feeling unsafe, I will go to the ER of local hospital, call Suicide Hotline 1-800-273-8255, or call my county's crisis number.

Patient Signature _____ Date _____
(If patient is a minor (ages 14-18) he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name _____

Responsible Party Signature _____ Date _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative is required to attach supporting legal documentation)

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NeuroPsychiatry Center

300 Old Pond Rd., Suite 201, Bridgeville, PA 15017 Tel. 412-220-7323

Name _____ DOB ____ / ____ / ____ Age _____

You will be responsible for full payment if your insurance company denies payment for any reasons

Co-Payments are due at each visit. Bring all relevant medical records with you. (No X-Ray)

Current healthcare providers	Address	Phone	Fax
General Practitioner:			
Therapist/Psychologist:			
Other Health Care Provider:			

Who can we thank for recommending our practice? _____

Current Pharmacy: Name _____ City _____ Zip _____ Phone _____

Allergies: Y N If yes what? _____

Reaction(s) _____

Height - _____ **Weight -** _____

Chief Complaints (Please circle)

Depression	Y	N	Psychosis	Y	N
Anxiety	Y	N	Attention/Concentration	Y	N
Panic Attacks	Y	N	Eating Disorder	Y	N
Hypomanic/Manic Episodes	Y	N	Drugs/Alcohol	Y	N
Anger	Y	N	Headaches	Y	N

Other: _____

Current stressors (Please circle)

School	Y	N	Social	Y	N	Financial	Y	N
Marital Issues	Y	N	Family	Y	N	Medical	Y	N
Pain/Disability	Y	N	Work/Job	Y	N	Legal	Y	N

Other: _____

Describe in your own words your current symptoms:

General Intake – 2018

Physical Changes (If Yes, Describe Symptoms and Identify Treatment)

Neurological Changes	Y	N	_____
Changes in Thyroid	Y	N	_____
GI Symptoms	Y	N	_____
Gynecological	Y	N	_____
Sexual Dysfunction	Y	N	_____
Severe PMS	Y	N	_____
Neck Pain	Y	N	_____
Back Ache	Y	N	_____
Headache	Y	N	_____
Migraines	Y	N	_____
Other:			_____

Family Member Observations:

How is this person different now? Please describe.

Past Psychiatric History:

Out Patient Treatments (where and for what reason): _____

Inpatient Treatments (where and for what reason): _____

Therapists/Psychiatrist(s) seen: _____

Medications tried in the past: _____

History of suicide attempt(s)? _____ Y _____ N

If yes provide details: _____

Family History:

Medical problems _____ Y _____ N _____ If yes, who?

Diagnosis: _____

Emotional problems _____ Y _____ N _____ If yes, who?

Diagnosis: _____

Alcohol/Drug Abuse _____ Y _____ N _____ If yes, who?

Describe: _____

General Intake – 2018

Medical History

<u>Diabetes</u>	<u>Y</u>	<u>N</u>	<u>Asthma</u>	<u>Y</u>	<u>N</u>	<u>High Blood Pressure</u>	<u>Y</u>	<u>N</u>
<u>Heart Disease</u>	<u>Y</u>	<u>N</u>	<u>Multiple Sclerosis</u>	<u>Y</u>	<u>N</u>	<u>Fibromyalgia</u>	<u>Y</u>	<u>N</u>
<u>Seizures</u>	<u>Y</u>	<u>N</u>	<u>High Cholesterol</u>	<u>Y</u>	<u>N</u>	<u>Hypothyroidism</u>	<u>Y</u>	<u>N</u>
<u>Other</u> _____								

Surgeries Y N Please describe: _____

Hospitalizations Y N Please describe: _____

Have you ever suffered a stroke, head bleed, concussion or other type of head injury? Y N

If yes, please explain: _____

Test results (if any)

<u>X-Rays</u>	<u>Y</u>	<u>N</u>	<u>Results:</u>	_____
<u>CT / MRI</u>	<u>Y</u>	<u>N</u>	<u>Results:</u>	_____
<u>Psychological Tests</u>	<u>Y</u>	<u>N</u>	<u>Results:</u>	_____
<u>Blood Work</u>	<u>Y</u>	<u>N</u>	<u>Results:</u>	_____

Social History

Marital Status (circle one) Single / Married / Divorced / Separated / Other

Who are you currently living with? _____

Do you have any children? Y N Ages: _____

Are you currently working? Y N

Current Job _____ For how long? _____

Highest level of education: < HS ___ HS ___ GED ___ College ___ Tech./Vocational ___

Type of degree/certification you hold: _____

Currently in school? Y N If yes, where? _____

Average Grades Y N Anticipated Graduation Date: _____

Hobbies _____ Last enjoyed _____

Are you involved in community and social activities? Y N

Please Circle: Church/Temple Clubs Sports AA/NA Volunteer work Other: _____

General Intake – 2018

Do you have a history of past physical/psychological/sexual abuse, neglect, trauma, domestic violence, or have you witnessed domestic violence? Y N

If yes, please describe: _____
_____ If

yes, have you had treatment for the trauma? Y N

If you have not received treatment, would you like to address the trauma during treatment? Y N

Caffeinated Drinks Y N _____ cups per day
Current Tobacco Use Y N If yes, do you want to quit? Y N

Type of Usage: _____
Amount Per Day: _____ How Often? _____ How Long? _____
Have you ever received treatment? Y N Do you want treatment? Y N

Former Tobacco Use Y N
When Did You Start? _____ When Did You Quit? _____

Drink Alcohol Y N _____ drinks per day/week for _____ years
Have you ever received treatment? Y N Do you want treatment? Y N

Impact social/family life Y N
Have you ever felt that you should cut down on your drinking? Y N
Have people annoyed you by criticizing your drinking? Y N
Have you ever felt bad or guilty about your drinking? Y N
Have you ever had a drink first thing in the AM to steady your nerves? Y N
Do your family/friends complain about your alcohol/drug use? Y N

Current Drug Use/Misuse Y N
IV drug use Y N
Type of Usage: _____
Amount Per Day: _____ How Often? _____ How Long? _____
Have you ever received treatment? Y N Do you want treatment? Y N

Former Drug Use/Misuse Y N
Type of Usage: _____
Amount Per Day: _____ How Often? _____ How Long? _____

Legal History:

Do you have any past or current legal problems (e.g. DUI's, arrests, etc.)? Y N

If yes, please describe: _____

Have you ever been on Disability or Workers' Comp Y N

If yes, please describe: _____

General Intake – 2018

Current Disability Status- None _____ Short term _____ Long term _____ Work. Comp _____ SSDI _____

Current litigation status, if any _____

Military Service - Service _____ How long? _____

Any combat exposure? Y _____ N _____ Describe: _____

Any service related medical conditions? Y _____ N _____ Describe: _____

Discharge- Honorable Y _____ N _____

Any other relevant information _____

Current Medications (bring the bottles with you)

<u>Name</u>	<u>Dose</u>	<u>How Long</u>	<u>For What</u>	<u>Who Prescribed</u>
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				

Do you take any over the counter and/or herbal/natural products? Y _____ N _____

If yes, please list: _____

Do you take any medications that belong to a friend/family member? Y _____ N _____

If yes, please list: _____

What do you identify as your strengths? - _____

What do you identify as your weaknesses? - _____

What are your perceived barriers to treatment, if any? - _____

General Intake – 2018

I certify that I have reviewed the above information provided by me, and to the best of my knowledge it is true and complete. I am aware that this information may be released to other parties such as insurance co., attorneys, and other medical professionals/hospitals as per my consent/authorizations, or via court orders as allowed by prevailing federal, state and/or local laws. This information may be shared with treating professionals and/or law enforcement authorities without your consent in case of an emergency, when relied upon in good faith. I will hold Dr. Kant and/or his designees harmless for any loss, injuries, damage that may arise from the actions taken.

I/We will be responsible for payment of charges billed if payments are denied by the insurance company/ies for any reason/s. It is my responsibility to update my insurance information for billing whenever there are any changes.

Signature _____

Date _____

Name _____

Office use only:

This information was reviewed with patient and/or guardian by

1. _____ Signature _____ Date _____

2. _____ Signature _____ Date _____

Patient Health Questionnaire (PHQ-9)

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

Name _____ Date _____

		Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1	Little interest or pleasure in doing things				
2	Feeling down, depressed or hopeless				
3	Trouble falling asleep, staying asleep or sleeping too much				
4	Feeling tired or having little energy				
5	Poor appetite or overeating				
6	Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
7	Trouble concentrating on things such as reading or watching TV				
8	Moving or speaking so slowly that others have noticed or being so fidgety or restless that you have been moving around a lot more than usual				
9	Thinking that you will be better off dead or that you want to hurt yourself in some way				

If you have checked off any problems, how difficult have these problems made it for your 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

Today's Score _____ Past scores _____

PHQ9 Copyright© Pfizer Inc. All rights reserved.

BAI

NAME _____ DATE _____

General Intake – 2018

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the **PAST WEEK INCLUDING TODAY**, by placing an X in the corresponding space next to each symptom.

	Not at All-0	Mildly-1	Moderately-2	Severely-3
1. Numbness or tingling				
2. Feeling hot				
3. Wobbliness in legs				
4. Unable to relax				
5. Fear of the worst happening				
6. Dizzy or lightheaded				
7. Heart pounding or racing				
8. Unsteady				
9. Terrified				
10. Nervous				
11. Feelings of choking				
12. Hands trembling				
13. Shaky				
14. Fear of losing control				
15. Difficulty breathing				
16. Fear of dying				
17. Scared				
18. Indigestion or discomfort in abdomen				
19. Faint				
20. Face flushed				
21. Sweating (not due to heat)				

Total Score: _____