Psychiatry and Wellness of Georgia

Practitioner Name:

Patient Name:
Today's Date:
Phone:

DEMOGRAPHIC INFORMATION

Name:_____ Address:_____
Sex:_____ Phone:_____
Date of Birth: _____ Preferred Pronouns: _____
Guardian Name (if applicable):_____ Marital Status:_____
Weight:_____ Height:_____

EMERGENCY CONTACT INFORMATION

Name of emergency contact: _____ Relationship: _____
Phone: _____

Please list below individuals with whom your provider can discuss your care or release your psychiatric medical records.

Release of Information (ROI): Name: _____ Relationship: _____

If you do not want the provider to discuss your medical records, indicate. N/A

	Yes	*No*	*N/A*
	☐	☐	☐

Preferred Pharmacy:_____
Insurance Name:_____ Copay amount:_____
Insurance ID#_____ Group #_____
Guarantor's name:_____ Relation to patient:_____

CHIEF COMPLAINT / DURATION

Presenting Problem (include onset, duration, intensity)

Precipitating Event (Why treatment now):

Please list any allergies you may have

Current Medication(s) / OTCs:	Dose:	Frequency:	Medication purposes:

MEDICAL HISTORY

	Yes	No	Comments
Allergic / Immunologic			
Cancer			
Constitutional (ex: weight loss, fever)			
Cardiovascular / Hypertension			
Endocrine (ex: Diabetes, thyroid)			
GI / Liver			
GU			
Head Trauma			
HEENT			
Hematologic / Lymphatic			
Hospitalizations			
Neurological (ex: Epilepsy, Stroke, Seizure)			
Musculoskeletal (ex: Tendonitis)			
Psychiatric			
Respiratory (ex: COPD, asthma)			

Significant DX's			
Skin			
Surgeries			

BIOLOGICAL FAMILY MEDICAL HISTORY **Yes** **No** **Comments**

Sudden deaths (cardiac)	☐	☐	
Allergic / Immunologic			
Cancer			
Constitutional (ex: weight loss, fever)			
Cardiovascular / Hypertension			
Endocrine (ex: Diabetes, thyroid)			
Head Trauma			
HEENT			
Hematologic / Lymphatic			
Neurological (ex: Epilepsy, Stroke, Seizure)			
Psychiatric			
Respiratory (ex: COPD, asthma)			
Significant DX's			
Surgeries			

SOCIAL HISTORY

Pregnant: Y/N, # Weeks Pregnant:		Breastfeeding/Pumping: Y/N/ N/A:	
Smoke Cigarettes:	Former Smoker:	Vape:	
Are your parents divorced? Y/N		Specifics:	
Members in household:			
Marital status / relationship status:			
Single:	Married:	Divorced:	Widowed:
How long?	How Long?	When?	When?
Children: Yes No	Number of daughters:	Number of sons:	
Education:		Problems:	
Job description:			
How long have you worked there?		Problems at work?	
Military history:			

PAST PSYCHIATRIC HISTORY

Substance use history:

Substance	Amount	Frequency	Duration	First Use	Last Use	Comments
Caffeine						
Tobacco						
Alcohol						
Marijuana						
Opioids/Narcotics						
Amphetamines						
Cocaine						
Hallucinogens						

History of emotional, physical, or sexual abuse:

Current stressors (ex: legal, financial, relational)

Past Psychiatric History (Mental Health and Chemical Dependency):

Psychiatric Hospitalizations:

Prior Outpatient Therapy

include previous practitioners, dates of treatment, previous treatment interventions, response to treatment interventions (including responses to medications), and the source(s) of clinical data collected:

Additional comments:

BIOLOGICAL FAMILY PSYCHIATRY HISTORY	YES	NO	INDICATE FAMILY MEMBER
Sudden deaths (cardiac)			
Completed suicide			
Bipolar disorder			
Depression, Anxiety			
Schizophrenia/ Psychosis			
Seizures			
Addiction			
Any other			

Please note what symptoms that you are experiencing:

	Yes	No	Comments
Appetite			
Concentration			
Energy			
Hopelessness			
Interest / Motivation			
Memory			
Sleep			

Manic Symptoms:

	Yes	No	Comments

Anxiety Symptoms:

	Yes	No	Comments
Autonomic Symptoms			
Generalized Anxiety			
Panic			
Phobias			

Psychotic Symptoms:

	Yes	No	Comments
Auditory Hallucinations			
Visual Hallucinations			
Paranoia			
Delusional Ideas			

Suicidal or Self-Injury Behaviors	Yes	No	Comments
Current Behaviors			
Past Behaviors			

Homicidal or Assaultive Behaviors:

	Yes	No	Comments
Current Behaviors			
Past Behaviors			

Eating Disorders

	Yes	No	Comments
Anorexia			
Binge Eating			
Bulimia			

ADD Symptoms

	Yes	No	Comments

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____Patient Name:_____Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**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 the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all	**Somewhat difficult**	**Very Difficult**	**Extremely Difficult**
☐	☐	☐	☐

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over 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's 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
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all	**Somewhat difficult**	**Very Difficult**	**Extremely Difficult**
☐	☐	☐	☐

UHS Rev 4/2020

Mood Disorder Questionnaire

Patient Name_____Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...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 that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raved 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 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?	☐	☐
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?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

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, click 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.

PART A

	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 B

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?	☐	☐	☐	☐	☐

Source:
Kessler, R.C., Adler, L., Ames, M., Demler, O., Faraone, S., Hiripi, E., Howes, M.J., Jin, R., Secnik, K., Spencer, T., Ustun, T.B., Walters, E.E. (2005).
The World Health Organization Adult ADHD Self-Report Scale (ASRS). Psychological Medicine, 35(2), 245-256

Reset Form

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing oz, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.

8: You have an average amount of daytime sleepiness.

0-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5.