Neuropsychological Testing

Your upcoming appointment will be with _____.

Behavioral Health Specialists

4225 Baltimore Ave

Kansas City, MO 64111

Neurology

12330 Metcalf Avenue, Suite 420

Overland Park, KS 6621

Appointment Date/Time:

_____

_____

Arrival Time:

_____

Late arrivals may result in the rescheduling of your appointment.

Copayment Amount:

$ _____

Initial Visit Checklist:

- ☐ Bring the attached paperwork **FULLY COMPLETED** with you to your appointment.
- ☐ Bring a **current list** of your medications and allergies.
- ☐ If there are memory or cognition concerns we request you bring a family member or caregiver with you.
- ☐ Please make sure you bring any assistive devices, medical equipment, or medicine you may need such as eyeglasses, hearing aids, a glucometer, wheelchair, walker, etc.
- ☐ Bring the copayment amount listed above.

If for any reason you are unable to keep this appointment or have any questions regarding this appointment please contact our office at **816-932-1711** to reschedule.

Thank you for your cooperation.

Saint Luke's Neuropsychology Office Policy

Welcome to Saint Luke's Neuropsychology. Our goal is to provide you the best care, working with you to solve diagnostic issues, help guide treatment decisions, and maintain your wellness.

Office Hours and Appointments

This office is open **Monday through Friday from 8:30 a.m. to 4:30 p.m.** We request that you make an appointment in advance, as we do not accept walk-in appointments. Please update our office staff of any changes of address, phone number or insurance coverage prior to your visit or upon arrival. At each visit, we ask that you bring an updated list of your current medications.

If you are unable to keep your appointment, please call at least 24 hours in advance. **There may be a fee for missed appointments and a no-show or late cancellation (less than 24 hours) may not be rescheduled.** If you arrive more than 15 minutes late for your appointment time, you may be asked to reschedule. Cancellations more than 24 hours in advance will be rescheduled, though you should be aware that due to the demand for neuropsychological evaluations, the next available appointment may not be for 6-8 weeks or possibly longer.

Referrals and Authorizations

Neuropsychological evaluation requires a referral from your physician, and your insurance may require prior authorization for the evaluation. After receiving the referral, our office will attempt to work with your insurance to obtain prior authorization, if necessary. However, prior authorization is not a guarantee of payment. **If you miss your initial appointment without cancelling or cancel less than 24 hours in advance, the referral may be closed, in which case a new referral will need to be obtained prior to you being seen.**

Financial Policy

The Saint Luke's Physician Offices participate in the same health insurance plans as Saint Luke's Hospital. We will file claims with these companies and will fill out the necessary insurance forms. If you do not provide current and accurate insurance information at each visit, you may be financially responsible for the charges incurred.

> **Copayments/Other Charges:** While your insurance company may cover the majority of your medical costs, most plans include a deductible or copayment that must be paid at the time of service. If you are unable to provide required payment at the time of service you may be rescheduled until this is resolved. There may be additional fees for completing forms, such as disability or FMLA requests. We accept cash, check, or most major credit cards. We do not accept postdated payments. If a check is returned, we will only take payment through cash or credit card moving forward.

Thank you for choosing Saint Luke's Neuropsychology as your health provider.

Patient Registration Form

(Please Print)

Patient Demographics:

Last Name: _____ First Name: _____ MI: _____

Birth Date: _____ Sex: Male Female SSN:_____

Preferred Name: _____ Address: _____

City/St/Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Birth Place: _____ United States Citizen: Yes No

Marital Status: Single Married Divorced Legally Separated Widowed Other

Patient Language: English Spanish Other_____ Interpreter Needed: Yes No

Ethnic Group: Hispanic or Latino Not Hispanic or Latino Decline

Race: American Indian or Alaska Native Asian Black or African American White or Caucasian

Native Hawaiian or Other Pacific Islander Other Decline

Religion: _____ Place of Worship: _____

Education: _____

Patient Primary Care Physician Information:

Primary Care Physician: _____ Phone: _____

Practice Location/Address: _____

Patient Employment Information:

Employment Status: Full Time Part Time Self-Employed Full Time/Student Part Time/Student

Military Duty Not Employed Disabled Retired

Employer: _____

Consent Forms

Saint Luke's Health System
Saint Luke's Physician Group

Informed Consent for Neuropsychological Assessment

Patient name:_____**DOB:**_____

Nature, Purpose, and Benefits of Assessment: The goal of neuropsychological assessment is to determine if any changes have occurred in your attention, memory, language, problem solving, or other cognitive functions. A neuropsychological assessment may point to changes in brain function and suggest possible diagnoses as well as methods and treatments for rehabilitation. In addition to an interview where we will be asking you questions about your background and current medical and psychological symptoms, we may be using different techniques and standardized tests including but not limited to asking questions about your knowledge of certain topics, reading, drawing figures and shapes, viewing printed material, and manipulating objects.

Foreseeable Risks and Discomforts: For some individuals assessments can cause fatigue, frustration, and anxiousness. Other risks are generally minimal and can include headaches or mild discomfort from sitting.

Time Commitment: Assessments consist of an interview lasting 30-60 minutes and 2-3 hours or more of face-to-face testing and several additional hours for scoring, interpretation, and report preparation. This evaluation is estimated to take approximately 2 - 4 hours of face-to-face assessment time.

Limits of Confidentiality: Information obtained during assessments is confidential and will be shared only with your referring provider. As our medical records are electronic, other Saint Luke's providers involved in your care will also be able to review the written report if they have a legitimate reason to do so. Information can otherwise ordinarily only be released only with the written permission of you or your designated legal representative. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults; and c) issuance of a subpoena from a court of law.

☐ I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have had an opportunity to clarify any questions and discuss any points of concern before signing. I acknowledge that no guarantee has been made to me as to the results. I hereby authorize the providers of Saint Luke's Neuropsychology and whomever he/she may designate as his/her legal representative to conduct the evaluation.

DATE:_____ TIME:_____ A.M. P.M.

Patient Label:

Consent Forms

Saint Luke's Health System
Saint Luke's Physician Group

Informed Consent for Neuropsychological Assessment

Where patient is incapable of signing and another person signs in his stead, fill in the following information:

State why patient is not able to give consent personally (or to sign this form).

Explain: ☐ Minor ☐ Unconscious ☐ Other

Signature of witness Date Time

Signature of witness Date Time
(Phone permission requires two witnesses)

Patient/Other legally responsible signature Date Time

Relation of signer to patient: _____

Address of Witness(es): _____

Prior to the time of the procedure above described, I explained to the patient named above and to any person who has consented to the procedure on the patient's behalf, the nature, purpose, benefits, and risks of the procedure as stated as well as possible alternative methods of treatment. I have further discussed possible consequences of the procedure, the principal risks involved, and possible complications.

Physician/Provider Date Time

Patient Label:

Consent Forms

Saint Luke's Health System

Protected Health Information – Communication Preferences

Please communicate preferences about my health care with me in the following manner: (Check all that apply.)

- ☐ My home telephone number is:_____
  - ☐ Ok to leave a message with detailed information
  - ☐ Ok to leave a message with call-back information only
- ☐ My work telephone number is:_____
  - ☐ Ok to leave a message with detailed information
  - ☐ Ok to leave a message with call-back information only
- ☐ My cellular telephone number is:_____
  - ☐ Ok to leave a message with detailed information
  - ☐ Ok to leave a message with call-back information only
- ☐ Written communication
  - ☐ Ok to mail to my home address: _____
  - _____
  - ☐ Ok to mail to my work/office: _____
  - _____
- ☐ MySaintLuke's patient portal

Check applicable box:
☐ I was offered and made available, but I am electing not to receive a copy of SLHS Notice of Privacy Practices.
☐ I acknowledge receiving a copy of SLHS Notice of Privacy Practices.

You may discuss detailed information about my healthcare needs with the following individual(s):

Name of individual	Telephone number	Relationship to patient
1._____	_____	_____
2._____	_____	_____

Patient name:_____ Birthdate:_____ Patient Account #:_____

You will be asked to review and update your preferences on a yearly basis. You may change your preferences or withdraw permission for the individuals indicated above at any time by contacting your Saint Luke's provider. Your communication preferences applies to all providers and facilities within Saint Luke's Health System.

Note: ~~These preferences do not apply to behavioral health visits.~~
These preferences ONLY apply to the Saint Luke's Behavioral Health Specialists Clinic.

_____/_____/_____
Signature of patient or personal representative* Date Time

*If signed by a personal representative, the following information must also be included:
Name of personal representative and description of their authority to act on behalf of patient: _____
_____
_____

Patient Label:

Saint Luke's Health System

Consent and Agreement of Health Care Services

CONSENT FOR TREATMENT I consent to and authorize Saint Luke's Health System's entities and physicians to provide healthcare services under the general and specific instructions of members of the medical staff. At the discretion of the professional staff, I further consent to any examinations, tests or procedures that may be deemed advisable or necessary in the diagnosis and treatment. I am aware that the practice of medicine is not an exact science. I understand that no promise, guarantee or warranty has been made regarding the results of medical treatment or examination. I authorize the Entity and my physicians to take photographs, or other images, of me or parts of my body to be used in medical evaluations, education or research. I also authorize the use of video/audio technology (e.g. eICU, eHospitalist, eConsults and other eHealth/telemedicine services) to monitor, assess and interact with me while under the care of the Entity to be used in medical evaluations, education or research.

PROFESSIONAL CARE The patient is under the professional care of an attending physician who arranges for services in the care and treatment of the patient. I realize that those who provide patient care at this Entity are medical, nursing and other health care personnel in training who may be participating in patient care as part of their education.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the release of all or any part of the patient's medical and accounting record which may include information relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges. I also authorize the Entity to release information needed for billing purposes to physicians or entities that provide services to me related to my admission to the Entity. I also authorize the System to review my medical records to gather data for research purposes. I understand that no information that will identify me in any way will be published. I also consent to the sharing of my health information within the Saint Luke's Health System for the purposes of treatment, payment, and healthcare operations.

ASSIGNMENT OF BENEFITS I hereby assign to Saint Luke's Health System's entities and any or all physicians; all of my interest and right to the insurance benefits otherwise payable to me for this hospitalization or outpatient services arising out of any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of hospital benefits (including major medical) directly to the hospital, which provided care. I assign payment of physician benefits (including major medical) to the physician or organization furnishing the services, or authorize such physician or organization to submit a claim for payment. I understand that I am responsible for satisfying the precertification requirements for any policy of insurance, self-insured health plan or government plan covering said hospitalization or outpatient service and that the Entity is not responsible for precertification. I further understand that I am financially responsible for any penalties imposed by the insurance company or self-insured health plan for lack of precertification and/or any charges not covered by this assignment of benefits.

AUTHORIZATION TO FILE AN APPEAL ON PATIENT'S BEHALF I understand at times the level of care or medical necessity for services determined appropriate by my physician may differ from the opinion of my insurance company and they may deny payment of a portion of my Entity billing. To assist me in resolving this dispute, I authorize the Entity to act on my behalf to file a grievance or appeal of such denial by my insurance company in accordance with applicable law and to notify the Entity directly of the determination of such grievances or appeals.

FINANCIAL RESPONSIBILITY In consideration of the Entity and the physicians supplying or furnishing hospitalization, Entity services and physician services; I promise to pay the Entity and the physicians for such hospitalization, Entity services and physician services supplied and furnished heretofore or to be supplied and furnished to said patient. I understand that the acceptance of insurance assignments does not relieve me from any responsibility concerning payment for said services and that I am financially responsible to the Entity and physicians for the charges not covered by the policy of the insurance or self-insured health plan. I also understand, pursuant to the hospital lien statutes of this state, if my injuries were caused by the negligence or wrongful act of another, Saint Luke's Health System may have a lien on any and all claims or rights of action I may have against the person causing my injuries, and Saint Luke's Health System may have the right to enforce the lien for payment of services rendered rather than seek payment from my insurance or self-insured health plan. In the event of collection, the cost of collection, including reasonable attorney fees and court costs shall be included as part of the obligation due Saint Luke's Health System's entities and physicians. Any correspondence or payments regarding disputed debts, or any payments that purport to be payments in full satisfaction of the debt owed, must be sent to Saint Luke's Health System Centralized Business Office at 901 E. 104th St., Kansas City, MO 64131.

FINANCIAL ASSISTANCE The hospital has a financial assistance policy for which you may qualify. The income guidelines are based on Federal Poverty Limits. If your income is less than the guideline for your family size, you may qualify for assistance.

GENERAL TERMS

Behavior Expectation: I agree that it is my responsibility to treat other patients, visitors and staff with respect. I understand that disrespectful behaviors will not be tolerated and may lead to evaluation for my discharge.

Patient Label:

Saint Luke's Health System

Consent and Agreement of Health Care Services

Consent to Contact: I consent to receive communications from SLHS, its contractors and collection representatives on any phone number I provide or later acquire (cell or landline). I may be contacted about an appointment, follow-up reminder, and assignment of benefits and/or financial responsibility. Contacts may be via live agent, voicemail, text message, auto dialer or other technology. I understand depending on my phone plan I may be charged for calls or text messages. I understand my consent to receive such calls or texts is not a condition of receiving healthcare services.

Exit agreement: I have been informed and agree that I will voluntarily exit from Saint Luke's Health System when it is determined in the medical judgment of my physician or the Hospital's Utilization Review Committee that I no longer need to remain under care.

Release of responsibility for valuables: I understand the Hospital strongly recommends that all personal belongings and valuables be sent home or placed in the hospital's security for safekeeping until discharge. I understand the Hospital shall not be liable for loss or damage to any personal property I may choose to keep with me and will not replace any personal items if they are lost or stolen.

Tobacco free policy: I understand that all Saint Luke's Health System campuses are tobacco free. I acknowledge that I may not smoke or use any tobacco products anywhere on the campus, including the parking lot or grounds of the facility. If I make the decision to go off campus to smoke or use tobacco products, I take full responsibility for my own safety. I agree not to hold the Entity or any of its employees or agents responsible if I am injured in any way because of my decision to smoke or use tobacco products. Minors will follow state and Federal laws regarding smoking. This tobacco free policy applies to e-cigarettes, vaping products and other alternative tobacco and nicotine products.

Patient satisfaction survey: Saint Luke's Health System may contact you regarding the care you received and use this information to improve the quality of care we deliver. This survey may be provided via a telephone call or by email with a link to a secure website where you may provide anonymous input. You may also receive an email from MySaintLuke's inviting you to enroll in our online patient portal, where you can securely communicate with your physician, get lab results and visit summaries, and more.

I also agree I have received or have been offered information on the topics listed below through signs, packets and/or brochures, which contain information about:

- Advanced Directives
- Patient Advocacy/Patient Rights/Grievance Procedure information
- Financial Assistance policy (FAP) Summary
- Notice of Privacy Practices
- Interpretive services
- Skilled Nursing Welcome Letter and Grievance Procedure (as applicable)

I/We hereby certify that I/we have read all parts of this Consent and Agreement and accept all terms and conditions and state that all representations made by me are true.

_____

Print Name of Patient

_____

Signature of Patient or Authorized Representative (include Relationship to patient) Date Time

If patient is unable to sign, explain:

☐ Minor ☐ Critical nature of illness ☐ Other:_____

If the patient is unable to sign and there is no Authorized Representative available OR if consent is being obtained via telephone, two witnesses are required.

_____ _____

Signature of Witness 1 Date/Time Print Witness 1 Name

_____ _____

Signature of Witness 2 Date/Time Print Witness 2 Name

Patient Label:

Consent MHC

Saint Luke's Health System

Health Information Exchange Network Consent

Please carefully read these statements: *(If you are a patient's legal representative, "me," "my" or "I" refers to the patient)*

By signing this form, I understand and agree that Saint Luke's Health System participates in one or more health information exchange networks. I understand and agree that the health information networks, all health care providers, and other health-related organizations, including payors, that participate in the health information exchange networks:

1. Will be able to see all of my health records from both before and after today's date.
2. May use or share my health information for treatment, payment, and health care operations purposes, but only as allowed by federal and state laws. This is the same as for my health records in paper form and only authorized health care professionals or others involved in your treatment or payment for your treatment will have access to your medical records.
3. May share all of my health records through the health information exchange network; including but is not limited to **illnesses or injuries (like diabetes or a broken bone), test results (like X-rays or blood tests), and medicines that I am taking or have taken**. This also may include, but is not limited to sensitive information such as **Alcohol or substance abuse problems, Genetic (inherited) diseases or tests, HIV/AIDS, Mental health and developmental disabilities, Head and spinal cord injuries, Family planning information (including abortions), and Sexually transmitted diseases.** May copy/include my health information in their records. Under current law, even if I later cancel my consent, such providers or organizations are not required to remove my health information from their records.
4. Have penalties in place for anyone sharing my information in the wrong way.
5. The health information exchange networks will keep track of who views my health records to make sure they are secure. I can ask my doctor or the health information exchange network for a list of who has looked at my records and if I suspect or learn that my data was shared or accessed in the wrong way, I should contact Saint Luke's Health System immediately.
6. I understand and agree that it may take up to five business days to process my decision regarding the sharing of my electronic health records with the health information exchange.
7. Using my health information for marketing or advertising purposes, or to determine employment eligibility is strictly prohibited.
8. My consent will remain in effect until the day I cancel my consent by "Opting Out" or the health information exchange network no longer exists, whichever comes first. To opt-out of the health information exchange networks in which Saint Luke's Health System participates, I must complete a form found at each of the following websites:
    - Missouri Health Connection: http://www.missourihealthconnection.org
9. ***I am not required to sign this form.*** Saint Luke's Health System will continue to treat me even if I do not sign this form. My consent to share my records with a Health Information Network is voluntary and I may ask for a copy of this form after I sign it.

By signing this form, I give all participating health care providers and other organizations in health information exchange networks in which, Saint Luke's Health System, participates the right to share all my health records, including sensitive data, through the relevant health information exchange network and that the health information exchange will share my health information with providers and others who are treating me or involved in the provision or payment of my care. (** If I am the parent or guardian of a child, I can consent on behalf of the child only until he or she turns 18. At that time, the child will need to provide his or her consent to share records with a health information exchange network.)*

Patient Full Name (Print) _____ Name of Legal Representative _____

Patient Signature _____ Signature of Legal Representative's Signature _____

Date of Signature _____ Time of Signature _____ Patient Date of Birth _____

Patient Label:

Initial Health History Packet

Behavioral Health Specialists
4225 Baltimore Ave
Kansas City, MO 64111

Neurology
12330 Metcalf Avenue, Suite 420
Overland Park, KS 66213

816-932-1711

GENERAL INFORMATION

Name: _____ DOB: _____ Age: ____

Male ☐ Female ☐ Education level: _____

Reason for visit_____

Referring doctor_____

Thank you for taking time to fill out these forms. Please answer these questions to the best of your knowledge.

PSYCHIATRIC HISTORY

Have you ever been diagnosed with any of the following disorders?

Mood Disorders	**Psychotic Disorders**
Major Depression	Schizophrenia
Postpartum Depression	Schizoaffective Disorder
Dysthymic Disorder	Any other Psychotic Disorder
PMS/Premenstrual Depression	**Eating Disorders**
Bipolar Disorder/Manic Depression	Anorexia Nervosa
Anxiety Disorders	Bulimia Nervosa
Generalized Anxiety Disorder	Any other Eating Disorder
Panic Disorder	**Substance Use Disorders**
Obsessive Compulsive Disorder	Alcohol abuse or dependence
Social Anxiety Disorder	Cocaine abuse or dependence
Post-Traumatic Stress Disorder (PTSD)	Opiate abuse or dependence
Any other Anxiety Disorder	Any other substance abuse Disorder
Personality Disorder	**Other Disorders**
Antisocial Personality Disorder	Attention Deficit Hyperactivity Disorder
Borderline Personality Disorder	Migraine Headaches
Any other Personality Disorder	Seizure Disorder/Epilepsy
	Other, please specify:

Please list any past or current Psychiatrist, Psychologist or Mental Health Provider (name/address/phone number):

_____

_____

Please list any other doctors/specialists you see regularly (name, address, phone number)

_____

_____

Please list all current prescription, over the counter medications, vitamins and their dosages that you are currently taking:

Medication/Vitamin/Supplement	Dosage	Timing (in the morning, how many times per day)

Do you currently:

Smoke? _____ **If yes, how much? _____**

Drink alcohol? _____ **If yes, how much? _____**

What Psychiatric Medicines have you ever taken in the past? List medication, years taken and effect:

Medication	Years Taken	Effect
Antidepressants		
Anafranil (Clomipramine)		
Torfranil (Imipramine)		
Desyrel (Trazodone)		
Amytriptyline (Elavil)		
Nortriptyline (Pamelor)		
Norpramin (Desipramine)		
Doxepin		
Celexa (Citalopram)		
Lexapro (Escitalopram)		

Zoloft (Sertraline)		
Paxil (Paroxetine)		
Prozac (Fluoxetine)		
Luvox (Fluvoxamine)		
Viibryd (Vilazodone)		
Nefazodone		
Effexor (Venlafaxine)		
Pristiq (Desvenlefaxine)		
Savella (Milnacipran		
Cymbalta (Duloxetine)		
Wellbutrin/Zyban (Buproprion)		
Remeron (Mirtazepine)		
Marplan (Isocarboxazid)		
Nardil (Phenelzine)		
Parnate (Tranylcypromine)		
Em Sam (Selegiline)		
Anti-Anxiety		
Buspar (Buspirone)		
Neurontin (Gabapentin)		
Atarax/Vistaril (hydroxyzine)		
Ativan (Lorazepam)		
Xanax (Alprazolam)		
Klonopin (clonazepam)		
Valium (Diazepam)		
Librium (Chlordiazepoxide)		
Pindolol		
Inderal (Propranolol)		
Tenex/Intuniv (Guanfacine)		
Clonidine /Kapvay,(Catapress)		
Antipsychotics		
Abilify (Ariprprazole)		
Saphris (Asenapine)		
Clozaril (Clozapine)		
Fanapt (Iloperidone)		
Latuda (Lurasidone)		
ZYprexa (Olanzapine)		
Antipsychotics cont.		
Invega (Paliperidone)		
Seroquel (Quetiapine)		
Risperdal (Risperidone)		
Chlorpromazine (Thorazine)		
Haldol (Haloperidone)		
Loxapine (Loxitane)		
Thioridizine (Mellaril)		
Mood Stabalizers		
Lithium (Eskalith)		
Depakote (Valproic Acid)		

Tegretol (Carbamazepine)		
Trileptal (Oxcarbazepine)		
Lamictal (Lamotrigine)		
Topamax (Topirimate)		
Neurontin (Gapapentin)		
Dilantin (Phenytoin)		
Stimulants/ ADHD Meds		
Provigil		
Nuvigil		
Adderall (Amphetamine)		
Vyvanse		
Ritalin		
Concerta/Metadate (Methylphenidate)		
Sleep Medications		
Ambien (Zolpidem)		
Lunesta (Eszopiclone)		
Pro-Som (Estazolam)		
Resotril (Temazepam)		
Sonata (Zaleplon)		
Trazodone (Desyrel)		
Rozerem (ramelteon)		
Over the counter or Herbal Supplements:		
Tylenol PM		
Melatonin		
Fish oil/Oemga-3 fatty acids		
St. John's Wort		
SamE		
5HTP		
Other		
Dementia/Cognitive		
Aricept (Donezpril)		
Excelon		
Namenda (Memantine)		

Please mark if you have experienced any of the following:

General				**Genitourinary**		
Appetite loss	Yes	No		Pain with urination	Yes	No
Weight loss/gain	Yes	No		Frequent urination	Yes	No
Fever/Chills	Yes	No		Difficulty starting or maintaining urine stream	Yes	No
				Sexual difficulties	Yes	No
EENT						

Hearing loss	Yes	No		**Musculoskeletal**		
Vision change	Yes	No		Muscle pain	Yes	No
Nasal congestion	Yes	No		Joint pain	Yes	No
Trouble swallowing	Yes	No		Back pain	Yes	No
Cardiovascular				**Skin**		
Chest pain	Yes	No		Rash	Yes	No
Shortness of breath	Yes	No		Itching	Yes	No
Swelling in hands or feet	Yes	No				
				Neurologic		
Respiratory				Headaches	Yes	No
Cough	Yes	No		Dizziness	Yes	No
Wheezing	Yes	No		Falls	Yes	No
				Tremor/shaking	Yes	No
Gastrointestinal				Weakness	Yes	No
Nausea	Yes	No		Numbness	Yes	No
Vomiting	Yes	No				
diarrhea	Yes	No		**Endocrine**		
constipation	Yes	No		Feeling hot or cold	Yes	No
heartburn	Yes	No		Excessive thirst or urination	Yes	No
Hematologic	Yes	No		**Psychiatric**		
Abnormal bruising	Yes	No		Depression	Yes	No
Abnormal bleeding	Yes	No		Anxiety	Yes	No
				Hallucinations	Yes	No

FAMILY PSYCHIATRIC HISTORY

Have any of your family members been diagnosed with any mental illness, substance abuse disorder, dementia or neurologic disorder? Please specify

_____

_____

_____

OTHER CONCERNS:

Is there anything else that you would like to tell us?

_____

_____

_____

_____

_____

To be filled out by patient ONLY

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 figety 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	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 _____

To be filled out by patient ONLY

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	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

(For office coding: Total Score T____ = ____ + ____ + ____)