STONE CREEK PSYCHIATRY
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7945 Stone Creek Dr. Suite 130
Chanhassen, MN. 55317
(952) 241-4050 (office) (952) 241-4049 (fax)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME:______________________________ BIRTHDATE:____________

ADDRESS:____________________ CITY____________ STATE_____ ZIP__________

PHONE NUMBER: (Home)____________ (Work)____________ (Other)____________

1. Please release my records/communications

FROM: _____Stone Creek Psychiatry: (listed above)
_____Clinic, Organization/Person:______________________________

Address:____________________ City:____________ State:____ Zip:__________

Phone:____________________ Fax:____________________

2. Or Check ___**EXCHANGE WITH**

TO: _____Stone Creek Psychiatry: (listed above)
_____Clinic, Organization or Person:______________________________

Address:____________________ City:____________ State:_____ Zip:______

Phone:____________________ Fax:____________________

3. Information to be released: ___Any and all pertinent records (including all items below) OR check all that apply

___Discharge summary/note
___History & Physical exam
___Consultation reports
___Progress/clinic notes
___Case manager reports
___Psychological tests/summaries
___Lab reports
___Pathology reports
___Operative reports
___Emergency records
___Rehab records (pt/ot)
___Other______________________________
___Mental Health records
___Chemical Dependency/Substance Abuse records
___AIDS/HIV records
___Genetic conditions record
___Medication records
___ Provider form
___ FMLA paperwork

ALL DATES:____________ SPECIFIC DATES:____________

4. I am requesting this information /authorization be released for the following purpose(s):

____Transfer of care with another provider
____Coordination of care
____Insurance claim/application purposes
____Social Security Appeal
____Litigation/Legal/Attorney review
____Personal use
____Social Security Disability Determination
____Other______________________________
____Verbal communication
____Billing purposes
____Work related

I understand the following:
I may revoke this authorization at any time by writing to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will automatically expire one year from the date of my signature or at the date I specified here_______. I understand that once information is released pursuant to this authorization Stone Creek Psychiatry cannot prevent the re-disclosure of this information to another third party.

A signed copy of this form is considered valid if it has not been altered. Your signature indicates that you have read and understand this form and authorize release of your information as described above.

______________________________ DATE:____________
Signature of Patient/Authorized Person

______________________________ DATE:____________
Authorized Person's Authority to Sign
REASON PATIENT IS UNABLE TO SIGN:_____MINOR_____DECEASED_____OTHER______

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Treatment Agreement

Client Rights and Responsibilities

- I affirm that I have read and signed the Patient Rights and Responsibilities document and am aware that I may request a copy at any time, or view it at www.stonecreek psychiatry.com.
- I affirm that I have been offered a copy of Stone Creek Psychiatry's Notice of Privacy Practices and am aware that I may request a copy at any time or view it a www.stonecreekpsychiatry.com.

Treatment Authorization

- I request Stone Creek Psychiatry to plan and provide treatment to me (or my minor child) with my participation. I understand that I may withdraw this consent and terminate treatment at any time, for any reason.
- I agree to have Stone Creek Psychiatry call me to confirm appointments.
- I authorize Stone Creek Psychiatry to leave a phone message regarding my appointments.

Payment Responsibility

- I authorize Stone Creek Psychiatry's billing service, MBBilling Services to process my claims and receive payment from my third party payer.
- I agree to pay all co-payments or co-insurance required by my health plan.
- If services I receive from Stone Creek Psychiatry are not covered by a third party payer, subject to the provisions of my third party payer contract, I agree to pay for these services myself. If balances extend beyond 120 days I understand a finance charge may be applied. If balances of services continue to be unpaid I understand that balances due may be sent to a collection service and are also grounds for being referred to another clinic.
- I agree to give Stone Creek Psychiatry 24 hour advance notice of any appointment cancellation. I understand that if I do not give this notice, I may be charged a fee. I am aware that insurance companies will not cover this cost.

____ Date:_______________

Patient's Signature (or parent/legal guardian of minor)

STONE CREEK PSYCHIATRY
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Chanhassen, MN. 55317
(952) 241-4050
(952) 241-4049 (fax)

PRINT NAME HERE:____

PATIENT'S MEDICARE AUTHORIZATION

PATIENT'S NAME:____

PATIENT'S MEDICARE NUMBER:______________________________

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to

____

for any services furnished me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

____
Patient's Signature

____
Date

STONE CREEK PSYCHIATRY
PATIENT RIGHTS AND RESPONSIBILITIES

This information is to inform you of your rights and responsibilities as a recipient of mental health services and to become familiar with our clinic policies.

Evaluation/Treatment Aims

Stone Creek Psychiatry evaluations are for the purpose of determining if treatment is necessary and what appropriate treatment might be included. Your signed consent indicates you are being seen by your choice and that treatment could include psychotherapy and/or medication management. We do not conduct custody evaluations, pre-sentencing evaluations or others that fall outside our treatment aims.

Course of Treatment

In the course of your treatment at this office you may be prescribed medication. If this occurs it may be necessary to share health information with your pharmacy by fax, mail or phone to facilitate your medication or refills. If prior authorization or clarification on orders is needed by your insurance company to cover your medication it may also be necessary to share health information with your insurance provider. For quality of care issues, the Prescription Monitoring Program (which allows prescribers to review all controlled substances prescribed) is also reviewed. Your signature below acts as a release and authorization to share this information in the capacity described above.

Patient Privacy Rights and Responsibilities

Please refer to Stone Creek Psychiatry's Notice of Privacy Practices for a complete explanation of your privacy rights and responsibilities. This is posted on our website www.stonecreekpsychiatry.com, in our office and also provided to you with this notice. By signing our clinic notice you acknowledge that we have provided it to you.

Patient Rights

1. You have the right to considerate and respectful care.
2. You have the right to be informed of diagnosis, treatment recommendations and alternatives, medication risks and side effects, approximate length, cost and anticipated outcome of the treatment. When it is not advisable to give the information to the patient it may be available to the appropriate person on his/her behalf according to guidelines provided by statute 144.335.
3. You have the right to request a second opinion if you disagree with the recommendation.
4. You have the right to know the name and speciality of any provider responsible for your care.
5. You have the right to be free from verbal, physical or sexual abuse from the practitioner.
6. You have the right to be free from chemical or physical restraint except in emergencies as authorized by provider for a specified period of time when necessary to protect the patient from injury to himself/herself or to others.
7. You have the right to participate in your treatment planning and to know the assessment of your condition on which the treatment plan is based. It is your responsibility to discuss with provider if you disagree with the plan or need clarification. You have the right to refuse treatment and to ask for another provider.
8. You have the right to expect reasonable continuity of care. This shall include, but, not be limited to available appointment times according to provider's schedule.

9. You have the right to refuse to give information that is not, under the law, considered necessary for your participation in a program.
10. You have the right to reasonable advance notice of any referral, transfer or termination of clinic services that occur for medical reasons regarding patient welfare, non-compliance of provider recommendations, multiple missed appointments or non-payment of services.

Patient Responsibilities

1. You are responsible for being considerate of other patients
2. You are responsible for keeping appointments. A 24 hour cancellation fee is required or else a cancellation charge may be made.
3. You are responsible for notifying your provider of any unexpected symptoms or changes in your mental health.
4. You are responsible for letting us know immediately if you do not understand instructions or feel you are unable to follow through with them.
5. You are responsible to know the names of the medications that you have been prescribed and their purpose. You are responsible for letting the office know 5 to 7 days prior when you will be needing a medication refill.
6. You are responsible for letting the office know of any changes in your insurance, address, phone or contact information for proper communication, billing and quality of services.
7. You are responsible for fulfilling the financial obligations as required by your health care plan.

Emergency Treatment

You can be treated without your consent (i.e. involuntary hospitalization) only if there is an emergency and in your provider's opinion, failure to act immediately would cause harm to you or someone else.

Emergency Procedures

Stone Creek Psychiatry provides emergency after- hours and weekend telephone coverage. For acute medical emergencies please dial 911. To connect with Stone Creek Psychiatry's after hours service call 952-241-4050 and follow the prompts.

Staff Privacy and Security

The providers and office staff have the right to privacy and security from direct or implied harm. Should a patient violate these rights, the treatment will be terminated.

By signing below I acknowledge receiving and understanding my rights and responsibilities.

Name:____Date:_________________________

Print Name:_______________________________________

STONE CREEK PSYCHIATRY
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CONTACT INFORMATION

HOME PHONE: ____

CELL PHONE: _______________**WORK:** _______________ **EXT:** _____

If we are unable to speak to you directly, may we leave a message? _____ Yes _____ No

ALLERGIES: ____

REACTIONS: ____

PATIENT INFORMATION

DATE: ______________ **REFERRED BY:** ______________________________

NAME (Print First, MI, Last): ______________________________________

AGE: _______ **DATE OF BIRTH:** ________________ **SS#:**____________________

SEX: ___M ___F ___ Other Marital Status: ___ M ___ S ___ Partnered ___ Widow ___ Divorced

ADDRESS: ____

CITY: ______________________________ **STATE:** _________ **ZIP:** ____________

EMPLOYER or SCHOOL: ______________________________________

PARENT/GUARDIAN/CARETAKER: ______________________________

EMERGENCY CONTACT PERSON: ____________________ **PHONE:** __________________

By naming above contact person I authorize exchange of information with Stone Creek Psychiatry.

INSURANCE INFORMATION

PRIMARY INSURANCE: ______________________________ PHONE: ________________________

ID #: __________________________________ GROUP/ACC #: __________________________________

NAME OF POLICY HOLDER: ___________________________ DOB: ________________________

SS#: ___________________________________ RELATIONSHIP TO PT: _______________________

ADDRESS: _____________________________ City/State/Zip: _____________________________________

SECONDARY INSURANCE: ____

ID#: _____________________________________ GROUP/ACC.#: ______________________________

PHARMACY INFORMATION

PHARMACY NAME: ____

ADDRESS: ____________________________ CITY/STATE: ____________________ ZIP: ______________

PHONE: _____________________________________ FAX: ____

STONE CREEK PSYCHIATRY

Thomas Winegarden, M.D., Molly Silas, M.D., Terri Russell, SPRN, CNS, Michael Keegan, APRN, CNP, Jake Moore, PS_C, Molly Stommes, APRN, DNP
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INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name:____Date of Birth:________________________

Provider Name:____Location:___________________________

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. Information may be used for diagnosis, therapy, follow up and/or education, and may include any of the following: Patient medical records, medical imaging, live two-way audio and video, output date from medical services and sound and video files. Electronic systems used will incorporate network and software security protocols to protect confidentiality of patient identification and imaging data will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

Promoting the safety and protection of patients and staff from obtaining and/or spreading Covid-19. Improve access to medical care by enabling the patient and provider to interact from distant locations. More efficient medical evaluation and management. Obtaining expertise of a distance specialist.

Possible Risks:

As with any medical procedure, there ae potential risks associated with the use of telemedicine. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (poor resolution of images or sound) to allow for appropriate medical decision-making by the provider. Delays in medical evaluation and treatment could occure due to the deficiencies or failures of the equipment. In very rare instances, security protocols could fail, causing a breach of privacy of medical information. In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By signing this form, I understand the following:

- I understand the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
- I understand that I will have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting the right to future care of treatment.
- I understand that I have the right to expect all information obtained and recorded in the course of the telemedicine interaction and may receive copies of this information
- I understand that a variety of alternative methods of medical care my be available to me to choose from at any time and that my provider has explained the alternatives to my satisfaction.
- I understand that it is my duty to inform my provider of electronic interactions regarding my care, that I may have with other healthcare providers.
- I understand I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine and have discussed with my provider all of my questions, which have been answered to my satisfaction. I hear by give my informed consent for the use of telemedicine in my medical care.

I hereby authorize____(name of provider) to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient or Authorized person for patient:______________________________________Date:_________

If authorized signer, relationship to patient:____

I have been offered a copy of this consent form (patient initials):__________________________________

Stone Creek Psychiatry

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NEW PATIENT PACKET

INITIAL EVALUATION

Initial Evaluation Date: ________________

Patient Name: ____ **Date of Birth:** ____________________________

Martial Status: _____ **M** _____ **S** _____**Partnered** _____ **Widow** _____ **Divorced** ________________ **years**

Race: ____ **Number of Children:** ________________________

Current Residence: ______________________________ **City:** ___________________ **State:** _____ **Zip:** ___________

Primary Care Physician: ____

Psychiatric Providers (Current/Past) : ____

Therapists (Current/Past) : ____

CHIEF COMPLAINT: (Briefly describe the current symptoms/stressors you are currently experiencing. Why are you seeking psychiatric services?)

____

____

____

CURRENT SYMPTOMS: (How are you feeling now? Depressed, Anxious, Agitated, Angry, Irritable, Tired, Not sleeping, Hopeless, Overwhelmed, Suicidal, etc.…)

____

____

____

PAST PSYCHIATRIC DIAGNOSES: (What were you being treated for in the past?) Please check mark all that apply**:** _____ Depression _____ Bipolar _____ Schizophrenia _____ADHD _____PTSD _____Panic Attacks _____ Schizo-Affective Disorder _____Insomnia _____Obsessive-Compulsive Disorder _____Addiction _____ Eating disorder _____Borderline Personality

Other:____

PAST PSYCHIATRIC HISTORY: Please list names/dates of any: Hospitalizations/ Psychiatric Treatment History/ Commitments/ Self injury/ Suicide attempts

____

____

____

CURRENT PSYCHOTROPIC MEDICATIONS: (Please list name, dosage, frequency taken)

____

____

____

PAST PSYCHOTROPIC/MEDICATIONS TRIED: (Check mark ones tried previously)

Anti-depressants: _____ Prozac _____ Zoloft _____ Celexa _____ Wellbutrin _____Effexor _____Cymbalta _____ Remeron, Other ____

Mood Stabilizers: _____ Lithium _____ Depakote, _____ Lamictal, Other ______________________

Antipsychotics: _____ Seroquel _____ Zyprexa _____Abilify _____ Risperidone,

Other____

Sedatives: _____ Xanax _____ Ativan _____ Clonazepam _____Buspar,

Other____

Sleep: _____ Ambien _____ Trazodone _____Lunesta, Other _______________________

ADHD: _____ Stimulants _____Adderall _____Ritalin _____ Vyvanse AND/OR Non-Stimulants

_____Strattera, Other ____

If application were there any side effects from previously prescribed medications?

____

____

____

CHEMICAL HEALTH HISTORY

Age of onset drug/alcohol use: ____
Please list **age of onset and frequency of use** for each chemical listed below. Leave blank if no use:

Alcohol: ____

Marijuana/Synthetic Marijuana (K2): _________________________________

Amphetamines/Cocaine: _______________________________________

Opiates/Prescription/Illegal/Heroin: _________________________________

Sedatives/Benzodiazepines: ____________________________________

Hallucinogens/LSD/Mushrooms: ____

PCP/Ecstasy/Ketamine: ____

IV Drug Use (Frequency and Drug): ____

Nicotine: ____

Caffeine: ____

Previous CD Treatment: (When and Where/Drug of Choice):

____

____

____

Have you ever been concerned about your drug use? _____ Y _____ N

Other: ____

Has anyone, including a family member, friend, or healthcare provider been concerned about your drug use or suggested you cut down? _____ Y _____ N Other: __________________________

Consequences of Use:

Loss of employment: ____

Loss of relationships: ____

Pending Legal Issues: ____

Any DWIs: _____ Y _____ N, If yes, date(s): ______________________________

License Returned _____ Y _____ N

FAMILY PSYCHIATRIC HISTORY:

Please list any family members (mother, father, paternal/maternal aunts, uncles, grandparents, etc) where applicable, otherwise leave blank. Please list each relative for every disease that applies.

Depressions: ____

Anxiety/Panic: ____

Bipolar: ____

ADHD: ____

Low IQ/Learning Disability: ____

Suicide Attempts: ____

Dementia/Alzheimer's ____

Schizophrenia: ____

Alcohol Dependency: ____

Illegal Drug/Prescription Abuse: ____

SOCIAL HISTORY:

Where were you born and raised? ____

How many siblings did you have growing up? _____ Where were you in Birth order? _______

Were you adopted? ____________ If yes, how old were you? _________________________

Did you grow up with both parents? ______ If not, how old were you when they separated? _________

What was it like growing up? Were your parents supportive? Abusive? Neglectful?

____

____

____

SIGNIGICANT LIFE EVENTS (Traumatic or Other):

Physical: ____

Sexual/Rape: ____

Emotional/Verbal: ____

Deaths/Illnesses: ____

Other: ____

EDUCATION AND WORK HISTORY:

Highest level of education complete: _____ High School (_____ years) _____GED _____College (_____ years) _____ Vocational (_____ years) _____ graduate degree (_____ years)

Occupational History: _____ Full-time _____ Part-time _____ Unemployed _____ Retired Disability: ___________________ Last worked: _______ Type of Work: _______________________________

Length employed: ___________ Spouse or Partner Employment: ___________________________

Living Situation: _____ House _____ Townhome _____Apartment _____ With parents _____ Group home _____ Assisted Living _____ Homeless

CURRENT STRESSORS:

Financial Status/Stressors

(Current/Past): ____

____

____

Legal Issues

(Divorce / Bankruptcy / Criminal Charges): ___________________________________

____

____

(Legal Guardian / Conservator / Power of Attorney / PO Officer) If Applicable: ____________

____

Loss of Employment (When/how): ____

____

Moving: ____

Death of Friend/Family Member: ____

MILITARY SERVICE HISTORY: _____ None _____ Army _____ Navy _____ Air Force _____ Marines _______________ Length of time

REVIEW OF SYMPTOMS: Please check mark all that apply

Any current physical complaints: _____ Headaches _____ Stomach aches _____Shortness of breath _____Cough _____ Recent loss of taste or smell _____Fatigue _____ Lack of energy _____ Fever _____Chills _____ Physical aches or pains _____ Back pain _____Painful joints _____ Recent Infections _____ Colds or flu _____ Unexplained weight gain or weight loss _____ Loss of appetite _____ Problems urinating _____Rashes or itching _____ Teeth problems _____ Visual problems

Medical Conditions (High Blood Pressure, Diabetes, Heart Disease, etc): __________________________

____

____

____

Head Trauma/Concussions/Seizures: ____

____

____

If female, are you pregnant or possibility of pregnancy? _____ Yes _____ No

OTHER CURRENT MEDICATIONS: ____

____

____

MEDICATION ALLERGIES: ____

____

____

Burn's Depression Checklist

Name: Date:

Instructions: Put a check ☑ to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.		0 = Not At All	1 = Somewhat	2 = Moderately	3 = A Lot	4 = Extremely
Thoughts and Feelings						
1	Feeling sad or down in the dumps					
2	Feeling unhappy or blue					
3	Crying spells or tearfulness					
4	Feeling discouraged					
5	Feeling hopeless					
6	Low self-esteem					
7	Feeling worthless or inadequate					
8	Guilt or shame					
9	Criticizing yourself or blaming others					
10	Difficulty making decisions					
Activities and Personal Relationships						
11	Loss of interest in family, friends or colleagues					
12	Loneliness					
13	Spending less time with family or friends					
14	Loss of motivation					
15	Loss of interest in work or other activities					
16	Avoiding work or other activities					
17	Loss of pleasure or satisfaction in life					
Physical Symptoms						
18	Feeling tired					
19	Difficulty sleeping or sleeping too much					
20	Decreased or increased appetite					
21	Loss of interest in sex					
22	Worrying about your health					
Suicidal Urges						
23	Do you have any suicidal thoughts?					
24	Would you like to end your life?					
25	Do you have a plan for harming yourself?					
	Please Total Your Score on Items 1-25 Here:					

Total Score	Level of Depression
No Depression	0-5
Normal but unhappy	6-10
Mild depression	11-25
Moderate depression	26-50
Severe depression	51-75
Extreme depression	76-100

The Burns Anxiety Inventory

Place a check mark in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.

Category I: Anxious Feelings	**0 Not at all**	**1 Somewhat**	**2 Moderately**	**3 A Lot**
1. Anxiety, nervousness, worry or fear				
2. Feeling that things around you are strange or unreal				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stressed, “uptight” or on edge				
Category II: Anxious Thoughts	**0 Not at all**	**1 Somewhat**	**2 Moderately**	**3 A Lot**
7. Difficulty concentrating				
8. Racing thoughts				
9. Frightening thoughts				
10. Feeling that you’re on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of physical illnesses or heart attacks or dying				
14. Concerns about looking foolish or inadequate				
15. Fears of being alone, isolated, or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible is about to happen				

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Category III: Physical Symptoms	0 Not at all	1 Somewhat	2 Moderately	3 A lot
18. Skipping, racing or pounding of the heart (palpitations)				
19. Pain, pressure, or tightness in chest				
20. Tingling or numbness of toes and fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or “jelly” legs				
29. Feeling dizzy, lightheaded or off balance				
30. Choking or smothering sensations or difficulty breathing				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak, or easily exhausted				
Total score on items 1-33				

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Mood Disorder Questionnaire

Stable Resource Toolkit

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 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 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

This instrument is designed for screening purposes only and not to be used as a diagnostic tool. *All rights reserved. Used with permission.*

Patient Health Questionnaire (PHQ-9)

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. 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.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, 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 ☐

Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all (#) _____ x 0 = ______
Several days (#) _____ x 1 = ______
More than half the days (#) _____ x 2 = ______
Nearly every day (#) _____ x 3 = ______

Total Score: ____________

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Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

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, place an X in 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.	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 A
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?					

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
____Yes ____ No If yes enter 1 _______

2. Did a parent or other adult in the household **often** … Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
____Yes ____ No If yes enter 1 _______

3. Did an adult or person at least 5 years older than you **ever**…
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
____Yes ____ No If yes enter 1 _______

4. Did you **often** feel that …
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
____Yes ____ No If yes enter 1 _______

5. Did you **often** feel that …
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
____Yes ____ No If yes enter 1 _______

6. Were your parents **ever** separated or divorced?
____Yes ____ No If yes enter 1 _______

7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
____Yes ____ No If yes enter 1 _______

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
____Yes ____ No If yes enter 1 _______

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
____Yes ____ No If yes enter 1 _______

10. Did a household member go to prison?
____Yes ____ No If yes enter 1 _______

Now add up your "Yes" answers: ________ This is your ACE Score