

Stone Creek Psychiatry
7945 Stone Creek Dr, #130
Chanhassen, MN 55317

Phone: 952.241.4050
Fax: 952.241.4049



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 (First, MI, Last):

Age:

Date of Birth:

SS#:

Sex: Male Female Other

Marital Status: Married Single Partnered Widow Divorced

Address:

City:

State:

Zip:

Employer or School:

Parent/Guardian/Caretaker:

Emergency Contact Person:

Emergency Contact Phone:

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

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Insurance Information

Primary Insurance:	Phone:	
<hr/>		
ID #:	Group/ACC #:	
<hr/>		
Name of Policy Holder:	DOB:	
<hr/>		
SS#:	Relationship to PT:	
<hr/>		
Address:		
<hr/>		
City:	State:	Zip:
<hr/>		
Secondary Insurance:		
<hr/>		
ID #:	Group/ACC #:	
<hr/>		

Pharmacy Information

Pharmacy Name:		
<hr/>		
Address:		
<hr/>		
City:	State:	Zip:
<hr/>		
Phone:	Fax:	
<hr/>		

Authorization to Release Protected Health Information

Patient Name: _____ Date of Birth: _____
 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, 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.

<input type="checkbox"/> Discharge summary/note	<input type="checkbox"/> Psychological test/summaries	<input type="checkbox"/> Rehab records (PT/OT)	<input type="checkbox"/> Provider form
<input type="checkbox"/> History & physical exam	<input type="checkbox"/> Lab report	<input type="checkbox"/> Mental health records	<input type="checkbox"/> FMLA paperwork
<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Pathology reports	<input type="checkbox"/> AIDS/HIV records	<input type="checkbox"/> Chemical dependency/substance abuse records
<input type="checkbox"/> Progress/clinic notes	<input type="checkbox"/> Operative reports	<input type="checkbox"/> Genetic conditions record	
<input type="checkbox"/> Case manager reports	<input type="checkbox"/> Emergency records	<input type="checkbox"/> Medication records	<input type="checkbox"/> Other: _____

ALL DATES: _____ SPECIFIC DATES: _____

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

<input type="checkbox"/> Transfer of care with another provider	<input type="checkbox"/> Litigation/legal/attorney review	<input type="checkbox"/> Billing purposes
<input type="checkbox"/> Coordination of care	<input type="checkbox"/> Personal use	<input type="checkbox"/> Work related
<input type="checkbox"/> Insurance claim/application purposes	<input type="checkbox"/> Social security disability determination	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Social security appeal	<input type="checkbox"/> Verbal communication	

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 authorization release of your information as described above.

Signature of Patient/Authorized Person _____ Date _____

Authorized Person's Authority to Sign _____ Date _____

REASON PATIENT IS UNABLE TO SIGN: MINOR DECEASED OTHER:

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7945 Stone Creek Dr, #130
Chanhassen, MN 55317

Phone: 952.241.4050
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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

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 data 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 are 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 occur 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 may 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.

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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 hereby 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): _____

Initial Evaluation

Initial Evaluation Date: _____

Patient Name: _____

Date of Birth: _____

Marital Status: Married Single Partnered Widow Divorced ...for (____) 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 all that apply.

<input type="checkbox"/> Depression	<input type="checkbox"/> PTSD	<input type="checkbox"/> Obsessive-Compulsive Disorder
<input type="checkbox"/> Bipolar	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Addiction
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizo-Affective Disorder	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> ADHD	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Borderline Personality
<input type="checkbox"/> 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:

<input type="checkbox"/> Celexa	<input type="checkbox"/> Effexor	<input type="checkbox"/> Remeron	<input type="checkbox"/> Zoloft
<input type="checkbox"/> Cymbalta	<input type="checkbox"/> Prozac	<input type="checkbox"/> Wellbutrin	<input type="checkbox"/> Other:

Mood Stabilizers:

<input type="checkbox"/> Depakote	<input type="checkbox"/> Lamictal	<input type="checkbox"/> Lithium	<input type="checkbox"/> Other:
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Antipsychotics:

<input type="checkbox"/> Abilify	<input type="checkbox"/> Risperidone	<input type="checkbox"/> Seroquel	<input type="checkbox"/> Zyprexa
<input type="checkbox"/> Other:			

Sedatives:

<input type="checkbox"/> Ativan	<input type="checkbox"/> Buspar	<input type="checkbox"/> Clonazepam	<input type="checkbox"/> Xanax
<input type="checkbox"/> Other:			

Sleep:

<input type="checkbox"/> Ambien	<input type="checkbox"/> Lunesta	<input type="checkbox"/> Trazadone	<input type="checkbox"/> Other:
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ADHD:

<input type="checkbox"/> Adderall	<input type="checkbox"/> Ritalin	<input type="checkbox"/> Stimulants	<input type="checkbox"/> Strattera
<input type="checkbox"/> Vyvanse AND/OR Non-Stimulants	<input type="checkbox"/> 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? Yes No Other: _____

Has anyone, including a family member, friend, or healthcare provider been concerned about your drug use or suggested you cut down? Yes No Other: _____

Consequences of Use

Loss of employment: _____

Loss of relationships: _____

Pending legal issues: _____

Any DWIs: Yes No If yes, dates: _____

License returned: Yes No

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 Dependence: _____

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?

SIGNIFICANT LIFE EVENTS (Traumatic or Other):

Physical: _____
Sexual/Rape: _____
Emotional/Verbal: _____
Deaths/Illnesses: _____
Other: _____

EDUCATION AND WORK HISTORY

Highest level of education: High School (____ years) GED College (____ years)
 Vocational (____ years) Graduated Degree (____ years)

Occupational history: Full-Time Part-Time Unemployed Retired Disability

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): _____

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 all that apply for current physical complaints.

<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Unexplained weight gain or loss
<input type="checkbox"/>	Stomach aches	<input type="checkbox"/>	Chills	<input type="checkbox"/>	Loss of appetite
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Physical aches or pains	<input type="checkbox"/>	Problems urinating
<input type="checkbox"/>	Cough	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	Rashes or itching
<input type="checkbox"/>	Recent loss of taste or smell	<input type="checkbox"/>	Painful joints	<input type="checkbox"/>	Teeth problems
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Recent infections	<input type="checkbox"/>	Visual problems
<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	Colds or flu		

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 decision					
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 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:						

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

The Burn's Anxiety Inventory

Name _____

Date _____

Instructions: 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.		0 = Not At All	1 = Somewhat	2 = Moderately	3 = A Lot
Category I: Anxious Feelings					
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					
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, 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				
Category III: Physical Symptoms					
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	Rubbert 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					

Mood Disorder Questionnaire

Stable Resource Toolkit

Name _____

Date _____

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?

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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 rights?

No problems
 Minor problem
 Moderate problem
 Serious problem

Patient Health Questionnaire (PHQ-9)

Name _____

Date _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked off any problems 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

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

Name _____

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, 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
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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 difficult unwinding and relaxing when you have time to yourself?

15. How often do you have 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

Find your ACE score

Name	Date			
While you were growing up, during your first 18 years of life:		Yes	No	If yes, enter 1
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?				
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?				
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?				
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?				
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?				
6. Were your parents ever separated or divorced?				
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?				
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?				
9. Was a household member depressed or mentally ill or did a household member attempt suicide?				
10. Did a household member go to prison?				

Now add up your "Yes" answers
This is your ACE score: _____