SP ASSOCIATES

Patient Registration Form

Patient Information

First Name:_____ Middle Name:_____ Last Name:_____

SSN:_____ DOB:_____ Gender:_____ AKA:_____

Mailing Address:_____ City/State/Zip:_____

Phone (H) #_____ Phone (W) #_____ Cell #_____

Preferred Phone for Messages:_____ Email:_____

Race:_____ Ethnicity:_____ Language:_____ Marital Status:_____

Employment:_____ Driver's License:_____

Primary Doctor:_____ Phone #_____

Referring Doctor:_____ Phone #_____

Pharmacy:_____ City:_____ Phone #_____

Responsible Party (Bill To)

First Name:_____ Last Name:_____

DOB:_____ SSN:_____ Gender:_____

Mailing Address:_____ City/State/Zip:_____

Phone (H) #_____ Phone (W) #_____ Cell #_____

Employment:_____

Relationship to Patient:_____

Emergency Contact

First Name:_____ Last Name:_____

Phone (H) #_____ Phone (W) #_____ Cell #_____

Relationship to Patient:_____

SP ASSOCIATES

Patient Name:

Primary Insurance **None:** ☐

Insurance Name:_____ ID:_____

Group No:_____ Group Name/Employer:_____

Insured Name:_____

Insured Address:_____ City/State/Zip:_____

Insured Relationship to Patient:_____ DOB:_____ SSN:_____

Secondary Insurance

Insurance Name:_____ ID:_____

Group No:_____ Group Name/Employer:_____

Insured Name:_____

Insured Address:_____ City/State/Zip:_____

Insured Relationship to Patient:_____ DOB:_____ SSN:_____

Statesboro Psychiatric Associates (SPA) does not participate with Medicare (or its commercial products), Tricare or Medicaid. I understand that if covered by any of these entities that I must sign a waiver in order to receive treatment at SPA. I understand that the waiver states that I may not file claims with Medicare, Tricare or Medicaid for services rendered by SPA, and that I am fully responsible for payment of these services. I also understand that neither I nor SPA will file with insurance that is secondary to Medicare, and that by signing the waiver I am fully responsible for office visits.

I understand that it is my responsibility to alert Statesboro Psychiatric Associates to any and all changes in my insurance coverage, and that failure to provide these updates in a timely fashion may result in denial of claims by my new insurance company, and that I will be fully responsible for payment of these services.

I understand that unpaid balances are cause for dismissal from the practice, and that in the event that my account is forwarded to an outside agency for collection, a charge of 33% will be added to the outstanding balance to cover this cost.

Signature of Patient/Responsible Party:_____ **Date:**_____
*Digital Signature

Legal Custody Information

Required only for Patients Ages 17 and under:

Does the patient live with both married parents? Yes ◯ No ◯

If No:

With whom does the patient live?

Who has legal custody of the patient?

If parents have joint custody, who has the medical tiebreaker?

If parents are divorced, we require a copy of the court custody order, including power of medical decision making.

If patient is in foster care and/or has a temporary guardian, we require a copy of the court custody order, including power of medical decision making.

SP ASSOCIATES

Patient Agreement/Office Policies

To Our Patients:

Welcome to Statesboro Psychiatric Associates! Our dedicated mental health practitioners and staff are committed to providing the highest quality care to each and every patient. Set forth below is our Patient Agreement, which establishes our office policies. Please read and sign, contacting us with any questions you may have.

Appointments: What to Expect

Evaluation: The purpose of the initial evaluation is to obtain a detailed history for an accurate assessment. At times, your provider may need to obtain additional information from other health care professionals and, in the case of minors from teachers, before generating a diagnosis and/or recommendations.

Upon the conclusion of the evaluation, your provider will discuss his/her assessment and impressions with you, and make recommendations regarding the need for follow-up, medications and/or psychotherapy. Often psychotherapy is a helpful adjunct to medication or an effective stand-alone treatment.

Follow Up: Based on the evaluation, your provider will have our staff schedule follow-up visits for you. These visits may be more frequent during the initial phase of treatment. If medication is prescribed, your provider will monitor your response to the medication, and monitor for side effects during follow-up visits.

Who Should Come: In order to ensure that you receive optimum care, we kindly ask that you do not bring friends or family members to your appointments unless their presence is requested. Please note that we cannot have children in our waiting area without the supervision of a parent, guardian or caretaker.

Cancellation Policy/Lateness: In order to ensure that all patients receive the time and attention they deserve, we do not double-book appointments. We reserve your appointment time specifically for you, and you alone. For this reason, our office charges for cancellations without 24-hour notice (one business day). Similarly, if you arrive late for your appointment, and need to be rescheduled, you will be assigned the cancellation fee. The fees are as follows:

- $50 for established patient MD/PA office visits
- Full charge for weekly and biweekly psychotherapy appointments of $130
- Patients who miss their initial, confirmed appointment cannot be rescheduled

One Appointment Per Day: Most insurance companies do not reimburse for two mental health visits at different offices on the same day. To avoid being charged for your appointment, please make sure that if you have an appointment at our office that you do not have an appointment with another office on the same day.

Emergencies and Urgent Consultations

For your benefit, a covering provider will be available for important issues after office hours via phone. The on-call provider can be reached by calling 912-531-4886. This number is also listed on our office voicemail message. For emergencies of an immediate nature, please call 911 or go directly to the emergency room at the nearest hospital.

SP ASSOCIATES

Prescriptions/Medications

Medication Changes: Our office does not routinely change/modify prescriptions over the phone. Please schedule an appointment if a medication change is needed.

Refills: To ensure that you have your medications in a timely fashion, please call your pharmacy at least 2 business days before it is needed. For these standard refills, please do not call the office. Please note, if you need a medication refill, but have are overdue for an appointment, you will most likely need to be seen before a refill request can be approved.

- **Controlled Substances/Stimulants:** Can now be requested by your pharmacy and e-prescribed. Please call your pharmacy for refills at least 2 business days before needed.

Weekend/After-Hour Refills: Please plan ahead to avoid running out of medications over the weekend or after hours. When necessary, emergency weekend prescriptions are given for no more than 7 days of medication. For controlled substance refill after hours, no more than a 5 day supply will be refilled by the on-call provider to cover you until you are able to contact your treating provider.

Mail-Order Prescriptions: We are glad to help you with your mail-order prescription services. Please note, as with other medication refills, we will only be able to provide these 90-day prescriptions if you are current with your appointments.

Side Effects: Always discuss any changes or side effects from medications with your provider. If problems occur with a medication, please contact our office.

Medical Forms

All medical forms, to include school forms, will be completed by your provider during your visit. Please notify your provider at the beginning of each session if you have forms to be filled out.

- **Disability Forms** For disabilities due to physical injuries, please ask your primary care physician to complete your paperwork. If the disability is based on a mental health issue, for clinical/therapeutic reasons our providers do not complete these forms, but will refer you to an outside provider who specializes in disability issues.

Acknowledgement of Patient Agreement

By signing below you state that you have read, reviewed, and agree to this Patient Agreement.

_____ _____

Print Patient's Name Patient's Date of Birth

_____ _____

Signature of Patient *Digital Signature Date

_____ _____

Signature of Parent/Guardian/Personal Representative *Dig Sig Date

SP ASSOCIATES

Consent for Treatment

I am voluntarily seeking psychotherapy and/or psychiatric treatment by the psychiatrists, physican assistants, and/or psychotherapists at Statesboro Psychiatric Associates for the purpose of diagnosis and treatment, and I do hereby consent to such examinations, treatments and/or diagnostic procedures as may be deemed advisable by my treating physician, physician assistant or psychotherapist. I am aware that all medical care, including psychiatric care and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such examinations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment or treatment of my child is designed to be helpful, it may at times be difficult or uncomfortable.

Minor Patients: By signing below, you agree that you have legal custody and authority to consent to the child's treatment. You further agree that if you share custody of the child, all parties who have legal custody of the child have been made aware of, and consent to treatment at Statesboro Psychiatric Associates.

Consent for Telepsychiatry/Psychotherapy Services: I understand that if I am scheduled for telehealth services that the software platform utilized by SPA to facilitate video sessions meets HIPAA privacy requirements, and I accept this treatment modality.

By signing below you state that you have read and agree to this **Consent for Treatment** in its entirety.

_____ _____

Print Patient's Name Patient's Date of Birth

_____ _____

Signature of Patient *Digital Signature Date

_____ _____

Signature of Parent/Guardian/Personal Representative Date
*Digital Signature

If not signed by the patient, please indicate:

Relationship:

◯ parent or guardian of minor patient

◯ health care surrogate or conservator of an incompetent adult or emancipated minor patient.

SP ASSOCIATES

Acknowledgment of Responsibility for Payment

- I hereby authorize payment of my insurance benefits directly to Statesboro Psychiatric Associates for payment of medical services. I understand that I am financially responsible to Statesboro Psychiatric Associates for all charges not covered by my insurance including (but not limited to) deductibles, and co-payments, which are due at the time of my visit.
- I further understand that my insurance company may not cover two mental health visits on the same day. Accordingly, I understand that if I schedule a visit at SPA on the same day that I meet with another mental health professional, I am responsible for the appointment if not covered by insurance.
- I agree that in cases of divorce, as the parent accompanying the minor to visits, I am responsible for full payment of incurred office fees and charges. Reimbursement from the non-present parent is my responsibility.
- I have been informed of the office cancellation policy and acknowledge that I am financially responsible for missed or canceled appointments if I miss or cancel without a 24-hour notice (1 business day). I understand that insurance does not cover missed or canceled appointments.
- In the event that my insurance coverage ends, I understand that it is my responsibility to notify Statesboro Psychiatric Associates before utilizing further services. I agree that I am financially responsible for all services utilized after my insurance coverage ends.
- I understand that unpaid balances are cause for dismissal from the practice.
- I understand that in the event that my account is forwarded to an outside agency for collection, a charge of 33% will be added to the outstanding balance to cover this cost.

By signing below, you state that you have read and agree to this **Responsibility for Payment** in its entirety.

_____ _____

Print Patient's Name Patient's Date of Birth

_____ _____

Signature of Patient *Digital Signature Date

_____ _____

Signature of Parent/Guardian/Personal Representative Date
*Digital Signature

SP ASSOCIATES

Insurance Disclosure Authorization

I,_____ authorize staff of Statesboro Psychiatric Associates (SPA) to exchange
(Name of Patient or Guardian)

information with:_____
(Name of the Insurer)

- The information described below that pertains to my treatment or treatment of my child/ward as necessary. The purpose of disclosure is to permit SPA and my insurer to conduct billing and payment activities in connection with treatment by SPA.

- The specific information I authorize to be disclosed is information regarding my (or my child's/ward's) diagnosis, presence/participation in treatment, psychiatric evaluation, assessment/evaluation report, treatment recommendations, treatment plan, progress notes, treatment progress, continuing care plan, discharge/transfer summaries, physician orders, lab results, physical exam, billing statements, and scheduling, confirming and cancelling appointments.

- I understand that I may revoke this authorization by providing written notification to SPA at any time except to the extent that action has been taken in reliance on it.

- I understand that unless I have specifically requested in writing that the disclosure be made in a specific format, SPA reserves the right to disclose information in any manner that they deem appropriate and consistent with applicable law including, but not limited to, verbally, in paper format, fax or computer technology.

- I understand that if I refuse to sign this authorization, no information will be disclosed to my insurer. In such event, SPA will not be able to bill my insurer for treatment and I will be responsible for payment for services in full at SPA standard rates.

- Though unlikely, there is always the potential that the disclosed information will be predisposed by the authorized entities and no longer protected by HIPAA Privacy Rules. SPA is not responsible for the conduct of those entities.

By signing below, you state that you have read and agree to this **Insurance Disclosure Authorization** in its entirety.

_____ _____
Print Patient's Name Patient's Date of Birth

_____ _____
Signature of Patient * Digital Signature Date

_____ _____
Signature of Parent/Guardian/Personal Representative Date
* Digital Signature

SP ASSOCIATES

Credit Card Authorization Form

Name of Patient: _____ Date: _____

Full name on Credit Card: _____

American Express: ◯ Discover: ◯ Master Card: ◯ Visa: ◯

Card Number: _____

Expiration Date on Card: _____ CVV Code: _____

Payee Phone Number: _____

Billing Address on Card: _____

_____

(City) (State) (Zip)

- I give Statesboro Psychiatric Associates permission to charge the above credit card for payments due after each visit, and for any balances to include charges incurred due to appointments missed or canceled without appropriate notice.

Signature of Cardholder: _____ Date: _____

*Digital Signature

- If I have any questions about these charges, I agree to contact Statesboro Psychiatric Associates. I agree that I will not pursue a refund directly through my credit/debit card company, bank or financial institution. If any of my actions yield a charge back fro any reason, I agree to pay any and all penalty fee(s) incurred by Statesboro Psychiatric Associates. I also understand that my card information will be kept secure.

Signature of Cardholder: _____ Date: _____
*Digital Signature

STATESBORO PSYCHIATRIC ASSOCIATES
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: April 14th, 2003, updated January 1st, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information.** However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
    - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
    - is not part of your medical or billing records;
    - is not available for inspection as set forth above; or
    - is accurate and complete.

    In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
    - to carry out treatment, payment and health care operations as provided above;
    - to persons involved in your care or for other notification purposes as provided by law;
    - to correctional institutions or law enforcement officials as provided by law;
    - for national security or intelligence purposes;
    - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
    - incidental to other permissible uses or disclosures;
    - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
    - made to patient or their personal representatives;
    - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) most uses and disclosures of psychotherapy notes (ii) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of your health information; and (iv) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Stephanie Lichtman, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Statesboro Psychiatric Associates or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

Statesboro Psychiatric Associates
Stephanie Lichtman
Privacy Officer
116 Hill Pond Lane, Statesboro, GA 30458
912-489-1629, x225
912-489-1630

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site, statesboropsych.com for downloading.

By signing below, you state that you have read and been offered this HIPAA Policy

_____ _____
Print Patient's Name Patient's Date of Birth

_____ _____
Print Patient's Name *Digital Signature Date

_____ _____
Signature of Parent/Legal Guardian Date
*Digital Signature

SP ASSOCIATES

Notice of Privacy Policies: Acknowledgment of Receipt

I have received and reviewed a copy of Statesboro Psychiatric Associates' Notice of Privacy Policies. **In addition to my emergency contacts,** I authorize Statesboro Psychiatric Associates to talk with the following parties regarding my treatment and appointments, to pick up prescriptions per my request, and bring minor children to their appointments as applicable:

Name:_____ Relationship:_____

Phone:(H)_____(W)_____(C)_____

Address:_____

Name:_____ Relationship:_____

Phone:(H)_____(W)_____(C)_____

Address:_____

Name:_____ Relationship:_____

Phone:(H)_____(W)_____(C)_____

Address:_____

Name:_____ Relationship:_____

Phone:(H)_____(W)_____(C)_____

Address:_____

- I understand that in addition, SPA can provide treatment information to other providers for the purpose of coordination of care. This includes my primary care physician, referring physician, and other health care providers involved in my care.
- In the case of a child, I understand that in many circumstances, a custodial parent or legal guardian other than the person bringing the child to appointments may have legal right to obtain the medical records of the minor.

*******************YOUR SIGNATURE IS REQUIRED EVEN IF NOT LISTING ANYONE ON THE PRIVACY FORM*********************

_____ _____

Print Patient's Name Patient's Date of Birth

_____ _____

Signature of Patient * Digital Signature Date

_____ _____

Signature of Parent/Guardian/Personal Rep *Digital Signature Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ AGE:_____ DATE:_____

16+

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

	0 Not at all	1 - 2 Several days	3 - 4 More than half the days	> 5 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	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). 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 ◯

A2663B 10-04-2005

MEDICAL HISTORY
REVIEW OF SYSTEM FORM

DATE:_____ NAME:_____ DATE OF BIRTH:_____

__O__MARRIED __O__ SINGLE __O__WIDOWED; OCCUPATION:_____

NO. OF CHILDREN:____ TOBACCO USE: Y O/O D HOW MUCH? ____/DAY HOW LONG?DATE QUIT_____

ALCOHOL USE: HOW MUCH PER DAY? ____ CAFFEINE (COFFEE,TEA, COLAS) PER DAY _____

PAST ILLNESSES OF YOURSELF AND FAMILY:

YOU/YOUR FAMILY		YOU/YOUR FAMILY		YOU/YOUR FAMILY	
☐	☐ ALCOHOLISM	☐	☐ HIGH BLOOD PRESSURE	☐	☐ STROKE
☐	☐ ANEMIA	☐	☐ KIDNEY DISEASE	☐	☐ SUICIDE ATTEMPT
☐	☐ ASTHMA	☐	☐ LIVER DISEASE	☐	☐ THYROID DISEASE
☐	☐ CANCER/TUMOR	☐	☐ HEPATITIS	☐	☐ TUBERCULOSIS, TB
☐	☐ DIABETES	☐	☐ LUNG DISEASE	☐	☐ ULCER IN GI TRACT
☐	☐ DRUG ABUSE	☐	☐ MENTAL ILLNESS	☐	☐ VENEREAL DISEASE
☐	☐ DEPRESSION	☐	☐ OSTEOARTHRITIS	☐	☐ HIGH CHOLESTEROL
☐	☐ EPILEPSY/SEIZURES	☐	☐ OSTEOPOROSIS	☐	☐ HIV/IMMUNE DISEASE
☐	☐ GLAUCOMA	☐	☐ PHLEBITIS	☐	☐ OTHER_____
☐	☐ HEART DISEASE	☐	☐ RHEUMATIC ARTHRITIS		

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

_____

_____

_____

_____

REVIEW OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

CONSTITUTIONAL:	YES/NO	None
WEIGHT LOSS	O O	☐
FATIGUE	O O	
FEVER	O O	

EYES:		None
GLASSES/CONTACTS	O O	☐
EYE PAIN	O O	
DOUBLE VISION	O O	
CATARACTS	O O	

EAR,NOSE,THROAT:		None
DIFFICULTY HEARING	O O	☐
RINGING IN EARS	O O	
VERTIGO	O O	
SINUS TROUBLE	O O	
NASAL STUFFINESS	O O	
FREQUENT SORE THROAT	O O	

CARDIOVASCULAR:		None
MURMUR	O O	☐
CHEST PAIN	O O	
PALPITATIONS	O O	
DIZZINESS	O O	
FAINTING SPELLS	O O	
SHORTNESS OF BREATH	O O	
DIFFICULTY LYING FLAT	O O	
SWELLING ANKLES	O O	

ENDOCRINE:		None
LOSS OF HAIR	O O	☐
HEAT/COLD	O O	
INTOLERENCE	◘ ◘	

RESPIRATORY:	YES/NO	None
COUGH	O O	☐
COUGHING BLOOD	O O	
WHEEZING	O O	
CHILLS	O O	

GASTROINTESTINAL:		None
HEARTBURN/REFLUX	O O	☐
NAUSEA/VOMITING	O O	
CONSTIPATION	O O	
CHANGE IN BMs	O O	
DIARRHEA	O O	
JAUNDICE	O O	
ABDOMINAL PAIN	O O	
BLACK OR BLOODY BM	O O	

GENITOURINARY:		None
BURNING/FREQUENCY	O O	☐
NIGHTTIME	O O	
BLOOD IN URINE	O O	
ERECTILE DYSFUNCTION	O O	
ABNORMAL DISCHARGE	O O	
BLADDER LEAKAGE	O O	

ALLERGIC/ IMMUNOLOGIC:		None
HIVES/ECZEMA	O O	☐
HAY FEVER	O O	

PSYCHIATRIC:		None
ANXIETY/DEPRESSION	O O	☐
MOOD SWINGS	O O	
DIFFICULTY SLEEPING	O O	

HEMATOLOGY/LYMPH:	YES/NO	None
EASY BRUISING	O O	☐
GUMS BLEED EASILY	O O	
ENLARGED GLANDS	O O	
	◘ ◘	

MUSCULOSKELETAL:		None
JOINT PAIN/SWELLING	O O	☐
STIFFNESS	O O	
MUSCLE PAIN	O O	
BACK PAIN	O O	

SKIN:		None
RASH/SORES	O O	☐
LESIONS	O O	
ITCHING/BURNING	O O	

NEUROLOGICAL:		None
LOSS OF STRENGTH	O O	☐
NUMBNESS	O O	
HEADACHES	O O	
TREMORS	O O	
MEMORY LOSS	O O	

FEMALES ONLY:

DATE LAST MAMMOGRAM _____

NORMAL___O___ ABNORMAL_O____

DATE LAST PAP_____

NORMAL___O___ ABNORMAL_O____

AGE ONSET PERIODS _____

AGE ONSET MENOPAUSE _____

PERIODS REGULAR? YES _O_ NO _O_

NUMBER PREGNANCIES _____

SIGNATURE/REVIEWING PHYSICIAN:_____

Name:_____ Date: _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

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

Not difficult at all ____
Somewhat difficult ____
Very difficult ____
Extremely difficult ____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

CONTENT OF SCHEMAS

Listed below are some of the typical beliefs associated with each specific personality disorder. Although there is some inevitable and necessary item overlap between nosological categories, these lists are helpful in making a diagnosis. Further, they will aid the therapist in targeting key beliefs for therapeutic intervention.

CHECK ALL THAT APPLY

- ☐ 1. I am socially inept and socially undesirable in work or social situations.
- ☐ 2. Other people are potentially critical, indifferent, demeaning, or rejecting.
- ☐ 3. I cannot tolerate unpleasant feelings.
- ☐ 4. If people get close to me they will discover the "real" me and reject me.
- ☐ 5. Being exposed as inferior or inadequate will not be tolerated.
- ☐ 6. I should avoid unpleasant situations at all cost.
- ☐ 7. If I feel or think something unpleasant, I should try to wipe it out or distract myself- for example, think of something else, have a drink, take a drug, or watch television.
- ☐ 8. I should avoid situations in which I attract attention, or I should be as inconspicuous as possible.
- ☐ 9. Unpleasant feelings will escalate and get out of control.
- ☐ 10. If others criticize me, they must be right.
- ☐ 11. It is better not to do anything, that to try something that might fail.
- ☐ 12. If I don't think about a problem, I don't have to do anything about it.
- ☐ 13. Any signs of tension in a relationship indicates the relationship has gone bad; Therefore, I should cut it off.
- ☐ 14 If I ignore a problem, it will go away.
- ☐ 1. I am needy and weak.
- ☐ 2. I need somebody around available at all times to help me carry out what I need to do or in case something bad happens.
- ☐ 3 My helper can be nurturant, supportive, and confident- if he or she wants to be.
- ☐ 4. I am helpless when I'm left on my own.
- ☐ 5. I am basically alone- unless I can attach myself to a stronger person.
- ☐ 6. The worst possible thing would be to be abandoned.
- ☐ 7. If I am not loved, I will always be unhappy.

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- [ ] 8. I must do nothing to offend my supporter or helper.
- [ ] 9. I must be subservient in order to maintain his or her good will.
- [ ] 10. I must maintain access to him or her at all times
- [ ] 11. I should cultivate as intimate a relationship as possible.
- [ ] 12. I can't make decisions on my own.
- [ ] 13. I can't cope as other people can
- [ ] 14. I need others to help me make decisions or tell me what to do.
- [ ] 1. I am self-sufficient, but I do need others to help me reach my goals.
- [ ] 2. The only way I can preserve my self-respect is by asserting myself indirectly- for example, by not carrying out instructions exactly.
- [ ] 3. I like to be attached to people but I am willing to pay the price of being dominated.
- [ ] 4. Authority figures tend to be intrusive, demanding, interfering, and controlling.
- [ ] 5. I have to resist the domination of authorities but at the same time maintain their approval and acceptance.
- [ ] 6. Being controlled or dominated by others is intolerable.
- [ ] 7. I have to do things my own way.
- [ ] 8. Making deadlines, complying with demands, and conforming are direct blows to my pride and self-sufficiency.
- [ ] 9. If I follow the rules the way people expect, it will inhibit my freedom of action.
- [ ] 10. It is best not to express my anger directly but to show my displeasure by not conforming.
- [ ] 11. I know what's best for me and other people shouldn't tell me what to do
- [ ] 12. Rules are arbitrary and stifle me
- [ ] 13. Other people are often too demanding.
- [ ] 14 If I regard people as too bossy, I have a right to disregard their demands.
- [ ] 1. I am fully responsible for myself and others.
- [ ] 2. I have to depend on myself to see things get done.
- [ ] 3 Others tend to be too casual, often irresponsible, self-indulgent, or incompetent.
- [ ] 4. It is important to do a perfect job on everything
- [ ] 5. I need order, systems, and rules in order to get the job done properly

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- [ ] 6 If I don't have systems, everything will fall apart.
- [ ] 7. Any flaw or defect of performance may lead to a catastrophe
- [ ] 8. It is necessary to stick to the highest standards at all times, or things will fall apart.
- [ ] 9. I need to be in complete control of my emotions.
- [ ] 10. People should do things my way.
- [ ] 11. If I don't perform at the highest level, I will fail.
- [ ] 12. Flaws, defects, or mistakes are intolerable.
- [ ] 13. Details are extremely important.
- [ ] 14. My way of doing things is generally the best way.

- [ ] 1. I have to look out for myself
- [ ] 2. Force or cunning is the best way to get things done.
- [ ] 3. We live in a jungle and the strong person is the one who survives.
- [ ] 4. People will get at me if I don't get them first.
- [ ] 5. It is not important to keep promises or honor debts.
- [ ] 6. Lying and cheating are OK as long as you don't get caught.
- [ ] 7. I have been unfairly treated and am entitled to get my fair share by whatever means I can
- [ ] 8. Other people are weak and deserve to be taken.
- [ ] 9. If I don't push other people, I will get pushed around.
- [ ] 10. I should do whatever I can get away with.
- [ ] 11. What others think of me doesn't really matter
- [ ] 12. If I want something, I should do whatever is necessary to get it.
- [ ] 13. I can get away with things so I don't need to worry about bad consequences.
- [ ] 14. If people can't take care of themselves, that's their problem.

- [ ] 1. I am a very special person.
- [ ] 2. Since I am so superior, I am entitled to special treatment and privileges
- [ ] 3. I don't have to be bound by the rules that apply to other people
- [ ] 4. It is very important to get recognition, praise, and admiration.

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- [ ] 5. If others don't respect my status, they should be punished.
- [ ] 6. Other people should satisfy my needs.
- [ ] 7. Other people should recognize how special I am.
- [ ] 8. It's intolerable if I'm not accorded my due respect or don't get what I am entitled to.
- [ ] 9. Other people don't deserve the admiration or riches they get.
- [ ] 10. People have no right to criticize me.
- [ ] 11. No one's needs should interfere with my own.
- [ ] 12. Since I am so talented, people should go out of their way to promote my career.
- [ ] 13. Only people as brilliant as I am understand me.
- [ ] 14. I have every reason to expect grand things.

- [ ] 1. I am an interesting, exciting person.
- [ ] 2. In order to be happy, I need other people to pay attention to me.
- [ ] 3. Unless I entertain or impress people, I am nothing.
- [ ] 4. If I don't keep others engaged with me, they won't like me.
- [ ] 5. They way to get what I want is to dazzle or amuse people.
- [ ] 6. If people don't respond very positively to me, they are rotten.
- [ ] 7. Is is awful if people ignore me.
- [ ] 8. I should be the center of attention
- [ ] 9. I don't have to bother to think things through- I can go by my "gut" feeling
- [ ] 10. If I entertain people, they will not notice my weaknesses.
- [ ] 11. I cannot tolerate boredom.
- [ ] 12. If I feel like doing something, I should go ahead and do it.
- [ ] 13. People will pay attention only if I act in extreme ways.
- [ ] 14. Feelings and intuition are much more important that rational thinking and planning.

- [ ] 1. It doesn't matter what other people think of me
- [ ] 2. It is important for me to be free and independent of others.
- [ ] 3. I enjoy doing things more by myself that with other people.

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- [ ] 4. In many situations, I am better off to be left alone
- [ ] 5. I am not influenced by others in what I decide to do.
- [ ] 6 Intimate relations with other people are not important to me.
- [ ] 7 I set my own standards and goals for myself.
- [ ] 8. My privacy is much more important to me than closeness to people
- [ ] 9. What other people thinks doesn't matter to me
- [ ] 10. I can manage things on my own without anybody's help
- [ ] 11 It's better to be alone than to feel "stuck" with other people.
- [ ] 12 I shouldn't confide in others.
- [ ] 13. I can use other people for my own purposes as long as I don't get involved.
- [ ] 14. Relationships are messy and interfere with freedom

- [ ] 1. I cannot trust other people
- [ ] 2. Other people have hidden motives.
- [ ] 3 Others will try to use me or manipulate me if I don't watch out.
- [ ] 4. I have to be on guard at all times
- [ ] 5 It isn't safe to confide in people.
- [ ] 6. If people act friendly they may be trying to use or exploit me
- [ ] 7. People will take advantage of me if I give them the chance.
- [ ] 8. For the most part, other people are unfriendly
- [ ] 9. Other people will deliberately try to demean me.
- [ ] 10 Often people deliberately want to annoy me.
- [ ] 11. I will be in serious trouble if I let other people think they can get away with mistreating me
- [ ] 12. If other people find out things about me, they will use them against me.
- [ ] 13. People often say one thing and mean something else.
- [ ] 14. A person whom I am close to could be disloyal or unfaithful.

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