Changing Tides Psychiatry

Informed Consent and Rights and Responsibilities for Medical Provider (PMHNP/MD) Services

This notice outlines Changing Tides policy and procedures for receiving psychiatric medication evaluation and management services with Medical Providers. Medical providers include psychiatric nurse practitioner (PMHNP) and psychiatrist (MD or DO). This notice is in addition to the Changing Tides Informed Consent Rights and responsibilities and Notice of Privacy Practices. These notices also apply to your service with our medical providers.

Treatment Process

Your medical provider at Changing Tides will conduct an assessment. Your medical provider will talk with you about recommended treatments and medications. This includes a discussion of the risks and benefits of particular medications. Please ask any questions you might have. Information may be shared with your therapist. If further medication management is necessary, your provider will recommend that you schedule a follow-up appointment.

Therapy

Changing Tides believes that most conditions are best treated with a combination of therapy and psychiatric medications. Your medical provider may suggest treatment with a therapist along with medications.

Primary Care Provider (PCP)

Coordination of care with your PCP is very important for your health. Federal and state privacy laws encourage healthcare providers to coordinate with one another. As a result, your medical provider will provide information to other providers as is necessary for coordinating care. You may restrict this disclosure. Shared information includes prescribed medications, plans for care, and other medical information.

Medication Refills

If you need a prescribed medication refill prior to an appointment, please call your pharmacy. They will contact us, and the order can be filled more quickly than if you call our office. Be sure to contact your pharmacy 1 to 2 days before you run out of your medications so that there is enough time to process the request. If you do not attend appointments, your provider may not be willing to authorize refills. It is often very important to complete an exam prior to continuing a prescribed medication.

Minors and Custody

Changing Tides role is to help people and families with mental health issues to make lasting life improvements. It is not our role to conduct a custody evaluation, determine whether a parent is "fit", or recommend one parent over another. We do not provide forensic services such as custody evaluations.

For children with divorced parents we expect the parents to communicate with each other about services, decide who will schedule appointments, who will bring the child to treatment, etc. The medical provider and the child cannot be messengers between parents.

It is important to note that both parents have access to a child's record, regardless of custody. The only exception is if parental rights have been revoked.

We will notify parents of any risks of harm. We include parents in treatment for the benefit of the child.

Minor Consent

Changing Tides may provide treatment to a child who is 14 (fourteen) years or older in Oregon without the consent of a parent. Oregon law requires that parents are involved in treatment before the end of treatment unless there are very clear clinical reasons as to why they should not be involved. It is our policy to notify the parents on or before the third session, unless there is a clear clinical reason not to.

It is also important to know that parents have a right to access a minor's record, unless parental rights have been revoked, up until the son/daughter turns 18 (eighteen) years of age.

Crisis and Emergencies

Call 9-1-1 if you are experiencing a medical emergency. Your medical provider is involved only with crises that involve prescribing medications. During office hours, please call Changing Tides Psychiatry. Your therapist is the primary person to address a mental health crisis.

Changing Tides Psychiatry

Acknowledgement of Informed Consent and Rights and Responsibilities for Medical Provider (PMHNP/MD) Services

I have read the Informed Consent and Rights and Responsibilities for these services. This includes:

- Care is coordinated with primary, care, unless I restrict this disclosure.
- Medication refills start from an appointment with a medical provider or by contacting my pharmacy.

Print Client name_____ Client date of birth_____

If Parent/Guardian, print name_____

Parent_____ Guardian_____ Other_____

Signature of Client or Parent/Guardian_____ Date_____

Patient Information Form

Name: _____ Date: _____
First Middle Last

Address: _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Work _____

E-mail address: _____

Birthdate _____ Social Security # _____ Male ____ Female ____ Other ____

Drivers License #: _____ State: _____

Employer: _____ Phone: _____

Address: _____ City _____ State _____ Zip _____

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Whom can we thank for referring you: _____

Is the patient a minor: ☐ Yes ☐ No Full-time student: ☐ Yes ☐ No Name of school: _____

Name of person responsible: _____
First Last

Phone number: _____ Address: _____

Emergency Contact

Emergency Contact: _____ Relationship to patient: _____

Home phone: _____ Cell phone: _____

Insurance Information

Name of Insurance: _____

Phone number: _____ Address: _____

Policy #: _____ Group #: _____

Name of responsible party: _____
First Last

Phone number: _____ Address: _____

Birthdate _____ Social Security # _____ Relationship to Patient: _____

Name of secondary Insurance: _____

Phone number: _____ Address: _____

Policy #: _____ Group #: _____

Name of responsible party: _____
First Last

Phone number: _____ Address: _____

Birthdate _____ Social Security # _____ Relationship to Patient: _____

Date: _____ _____
Patient Signature or parent (if patient is a minor)

Medical History Form

Directions: Please answer the following questions to the best of your knowledge.

PATIENT INFORMATION				
Last Name	**First Name**	**Middle**	**Primary Language**	**Social Security No.**
Street Address	**City**	**State** **Zip**	**OK to Send Letter?** ☐ Yes ☐ No	**Sex:** ☐ Male ☐ Female
Home Phone	**OK to Call?** ☐ Yes ☐ No	**Work Phone**	**OK to Call?** ☐ Yes ☐ No	**If No, How can you be reached?**
Date of Birth	**Marital Status:** ☐ Single without partner ☐ Single with partner Length of Time: _____ ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Sexual Orientation ☐ Heterosexual ☐ Homosexual ☐ Bisexual				
Children: ☐ Yes ☐ No How Many?		**Number of Persons Living in Your Home?**		**Race/ Ethnicity**
Emergency Contact Person		**Phone Number**	**Relationship**	

PRIMARY PHYSICIAN(S)		
Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

Medication Allergies? Yes No
If yes, what medication(s) _____

Substance or Food Allergies? Yes No
If yes, what substance(s) _____

FAMILY HISTORY: Please check the box if your family has a history of:

Diabetes High Blood Pressure Heart Attack, Heart Disease Blood Clots or Stroke Tuberculosis
Cancer Alzheimer's Family History Unknown Mental Illness Epilepsy/Seizure

Any other major conditions?_____

If you answered Yes to any of the above, please explain: _____

Are you currently being treated for medical conditions? Yes No If yes, please list: _____

MEDICATIONS **(List more on separate page if necessary)**

Current Medications	For what condition?	Dosage	Frequency	Date started	Comments / Problems / Concerns

Past Medications / For what condition? (List sedatives, pain medications, sleeping pills, antidepressants, etc)			

Social/Sexual Risk History		
Yes	No	Do you smoke? If yes, how many cigarettes per day?
Yes	No	Do you use alcohol? If yes, how often, how much?
Yes	No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
Yes	No	Have you ever had or would you like help now with an alcohol or drug problem?
Yes	No	Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?
Yes	No	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

Patient Name: _____

REVIEW OF SYSTEMS:	Please check the box if you currently have or have ever had the following					
1. General						
Productive cough (3 weeks or more)	Current	Past		Unusual discharge (vaginal or from penis)	Current	Past
Dry, unproductive cough (3 wks or more)	Current	Past		Bloody or painful urination	Current	Past
Shortness of breath	Current	Past		Dark, bloody or painful bowel movements	Current	Past
Chest pain	Current	Past		Hepatitis A	Current	Past
Recurrent night sweats, chills, fevers	Current	Past		Hepatitis B	Current	Past
Swollen glands (neck, armpits or groin)	Current	Past		Hepatitis C	Current	Past
Persistent weight loss without dieting	Current	Past		Chronic Fatigue	Current	Past
Weight problem/eating disorder	Current	Past		Cancer	Current	Past

Tuberculosis: Ever Tested? Yes No Date and result of last test: _____ If Positive, did you have a chest x-ray? _____

Ever Treated? Yes No Date(s) and type(s) of treatment: _____

HIV: Ever Tested? Yes No Would you like information regarding HIV/AIDS or testing sites? Yes No

REVIEW OF SYSTEMS:	Please check the box if you currently have or have ever had the following:					
2. Skin				**7. Gastrointestinal**		
Allergies/Rash/Itching	Current	Past		Recurrent nausea/vomiting/diarrhea	Current	Past
Psoriasis / Eczema	Current	Past		Stomach/bowel problems	Current	Past
				Gall bladder disease	Current	Past
3. Eyes				Pancreatitis	Current	Past
Vision problems	Current	Past		Diabetes / hyperglycemia / hypoglycemia	Current	Past
Eye infections	Current	Past		Encopresis (incontinent of feces)	Current	Past
4. Ears, Nose, Throat, Lungs				**8. Genitourinary**		
Hearing problems	Current	Past		Bladder/kidney problems or infection	Current	Past
Teeth/gum problems or disease	Current	Past		Incontinence (unable to control bladder)	Current	Past
Frequent nosebleeds	Current	Past		Enuresis (bedwetting)	Current	Past
Recurrent sinusitis	Current	Past		Sexually transmitted diseases:		
Frequent sore throats	Current	Past		___Gonorrhea ___Syphilis ___Herpes		
Recurrent Pneumonia	Current	Past		___Chlamydia ___Trichomonas		
Asthma	Current	Past		___HPV or genital warts		
5. Cardiac				**Females:**		
Palpitations/arrhythmia	Current	Past		Menstrual Difficulties	Current	Past
Heart disease/murmur	Current	Past		Cycle: Regular ___ Irregular ___		
High blood pressure / Low blood pressure	Current	Past		Pre-Menopause ___ Menopause ___		
High cholesterol	Current	Past		Problems/infection of tubes/ovaries/uterus	Current	Past
Thrombophlebitis/blood clots	Current	Past		Abnormal Pap Smear(s)	Current	Past
				Number of pregnancies _____		
6. Neurological				Number of births _____		
Stroke	Current	Past		Problems with pregnancies/births (explain)		
Frequent Headaches or Migraines	Current	Past				
Seizures/Epilepsy	Current	Past		Breast disease / tumor / surgery (explain)		
Weakness/paralysis/unsteady walking	Current	Past				
Dizziness/confusion/wandering	Current	Past		**Miscellaneous:**		
Forgetfulness/memory lapse/memory loss	Current	Past		Anemia / blood disorder	Current	Past
				Arthritis	Current	Past
Other conditions / problems not listed:				Sleep disturbance	Current	Past

I certify that I have answered these questions to the best of my knowledge

Patient Signature: _____ Date: _____

CLINICIANS NOTES (CLARIFICATIONS / FOLLOW UP / ETC)

Reviewed by (Clinician): Date:

Patient Name: _____

HIPPA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- that this facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this facility is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness: _____

Printed Name of Patient or Legal Representative Witness: _____

Date: _____

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I acknowledge that I have been provided with and understand this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's ***Notice of Privacy Practices*** prior to signing this acknowledgment;
- this facility reserves the right to change their ***Notice of Privacy Practices*** and prior to implementation of this will mail a copy of any revised notice to the address I've provided, if requested.

Signature of Individual or Legal Representative Witness: _____

Printed Name of Individual or Legal Representative Witness: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our ***Notice of Privacy Practices***, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

Privacy Official: _____

Date: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Authorization for Use or Disclosure of Protected Health Information

CHANGING TIDES PSYCHIATRY, LLC
116 N. Highway 101, Unit B
Depoe Bay, OR 97341
Phone: 541-921-3584 Fax: 541-514-1291

I authorize my physician and/or administrative and clinical staff to use or disclose the following protected health information:

NAME OF ENTITY/CLASSOF PERSONS TO RECEIVE/SEND INFORMATION:

ANY Lab

DESCRIPTION OF PROTECTED INFORMATION TO BE USED OR DISCLOSED:

	Initial Assessment		Radiology Report
	Discharge Summary	X	Consultation Reports
	Progress Notes	X	Lab Reports
	Date of Service _____		
X	Other (Specify) Labs, insurance info, Demographics, Diagnosis		
X	Exchange of information/release of clinical information for coordination of care between above-named individuals (telephone and/or written communications).		

Reason for Use or Disclosure:

X	At the Request of the Individual		Specific Purpose _____
X	Continued Treatment		

I understand the contents to be released, the need for the information and that there are statutes and regulations protecting confidentiality of authorized information. I also understand that the contents may be subject to facsimile transmission. I acknowledge that the information may contain sensitive material, such as, but not limited to, my condition relating to HIV status, drug, or alcohol abuse, or psychiatric or psychological information.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's privacy officer. I understand that this authorization will expire one year from the date of its being signed by me. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand the information used or disclosed-pursuant to this authorization may be disclosed by the recipient and may no longer be covered by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization may result in direct or indirect remuneration to my physician from a third party (if applicable).

X _____ X _____

PATIENT NAME – PRINT DATE OF BIRTH

X _____ X _____

SIGNATURE-PATIENT OR PERSONAL REPRESENTATIVE-RELATIONSHIP DATE

Changing Tides Psychiatry
116 N Highway 101, Unit B
Depoe Bay, OR 94341
Phone: 541-921-3584 Fax: 541-614-1291

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Changing Tides Psychiatry by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, _____, authorize Changing Tides Psychiatry to: (please initial)

_____ release to

_____ obtain from

_____ exchange with

_____

_____

_____

The following information pertaining to myself: (please initial)

_____ treatment summary

_____ history/intake

_____ diagnosis

_____ psychological test results

_____ psychiatric evaluation/medication history

_____ dates of treatment attendance

_____ other (specify): _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event: _____.

I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Signature of client _____ Date: _____

SSN or Date of Birth _____

DOB:_____ MRN:_____ Provider:_____

Please circle any of the following medications that you have used or tried:

Brand name	Generic name
Antidepressant/Anti-Anxiety	
Trintellix	Vortioxetine
Prozac	Fluoxetine
Zoloft	Sertraline
Celexa	Citalopram
Lexapro	Escitalopram
Effexor	Venlafaxine
Pristiq	Desvenlafaxine
Luvox	Fluvoxamine
Serzone	Nefazadone
Remeron	Mirtazapine
Wellbutrin	Bupropion
Cymbalta	Duloxetine
Elavil	Amitriptyline
Pamelor	Nortriptyline
Tofranil	Imipramine
Norpramin	Desipramine
Anafranil	Clomipramine
Sinequan	Doxepin
Viibryd	Vilazodone
Fetzima	Levomilnacipran
Savella	Milnacipran
Paxil	Paroxetine
MAOI	
Nardil	Phenelzine
Parnate	Tranylcypromine
Marplan	Isocarboxazid
Mood stabilizer/Atypical antipsychotic	
Conasen	Blonanserin
Rexulti	Brexpiprazole
Risperdal	Risperidone
Seroquel	Quetiapine
Geodon	Ziprasidone
Abilify	Aripiprazole
Zyprexa	Olanzapine
Clozaril	Clozapine
Latuda	Lurasidone
Invega	Paliperidone
Saphris	Asenapine
Vraylar	Cariprazine
ADHD	
Ritalin	Methylphenidate
Adderall	Dextroamphetamine
Strattera	Atomoxetine
Concerta	Methylphenidate ER
Vyvanse	Lisdexamphetamine
Provigil	Modafinil
Kapray	Clonidine
Dexedrine	Amphetamine
Zenzedi	Amphetamine
Nuvigil	Armodafinil
Evereo	Armodafinil

Brand name	Generic name
ADHD (continued)	
Pro Centra	Amphetamine (D)
Intuniv/Tenex	Guanfacine
Focalin	Methylphenidate
Mood stabilizer	
Eskalith	Lithium
Depakote	Divalproex
Trileptal	Oxcarbazepine
Lamictal	Lamotrigine
Keppra	Leviteracetam
Topamax	Topiramate
Neurontin	Gabapentin
Lyrica	Pregabalin
Zonegran	Zonisamide
Equetro	Carbamazepine XR
Tegetrol	Carbamazepine
Sleep aids	
Ambien	Zolpidem
Belsomra	Suvorexant
Sonata	Zaleplon
Lunesta	Eszopiclone
Rozerem	Ramelteon
Vistaril	Hydroxyzine
Desyrel	Trazodone
Restoril	Temazepam
Dalmane	Flurazepam
Silenor	Doxepin
Minipress	Prazosin
Tranzuilizer/Anti-anxiety	
Gabitril	Tiagabine
Xanax	Alprazolam
Klonopin	Clonazepam
Valium	Diazepam
Ativan	Lorazepam
Serax	Oxazepam
Tranxene	Chlorazepate
Librium	Chlordiazepoxide
Buspar	Buspirone
Kapvay	Clonidine
Inderal	Propranolol
Others	
Cogentin	Benztropine
Thorazine	Chlorpromazine
Deplin	L Methylfolate

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (☑) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...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 you didn't really miss it?	◯	◯
...you were much more talkative or spoke 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 much 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? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

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

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, 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?					

Part B