Changing Tides Psychiatry

2600 NE Hwy 101 Suite 200 Lincoln City, OR 97367
(541) 921-3584 Fax (541) 614-1291
contact-us@changingtidespsychiatry.org

PATIENT INFORMATION FORM

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (Cell) _____ (Home) _____ SSN: _____

Email: _____

Select one: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

Who referred you? _____

EMERGENCY CONTACT

Primary Contact: _____ Phone: _____

Relationship: _____ Email: _____

Secondary Contact: _____ Phone: _____

Relationship: _____ Email: _____

RESPONSIBLE PARTY

Name: _____ Relationship to patient: _____

Address: _____ Phone: _____

DOB: _____ SSN: _____

Is this person currently a patient in this office? ☐ Yes ☐ No

INSURANCE INFORMATION

Insurance Company: _____ ID: _____ Group: _____

Secondary: _____ ID: _____ Group: _____

X _____ Date: _____

Signature of patient (or guardian if minor)

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OFFICE POLICIES AND PROCEDURES

Practice Information

- Office Hours: Monday 9 – 2, Tuesday, Wednesday and Thursday 9-5 and Friday 9-2.
- Emergency Contact: (541) 921-3584
- After-hours Coverage: (541) 921-3584
- Website: https://sites.google.com/view/changingtidespsychiatry/

Appointment Policies

1. Scheduling and Cancellations

- Initial appointments are 60 to 90 minutes in length
- Follow-up appointments are 30 to 60 minutes in length
- 48-hour notice is required for cancellations
- Late cancelations or no-shows will incur a fee of $85.00, except if you carry Medicaid insurance.
- Repeated no-shows may result in termination of care

2. Payment and Insurance

- Self pay is due at the time of service
- Accepted payment methods: Cash, credit card, check
- We accept the following insurance plans: Most plans - please ask
- Patients are responsible for knowing their insurance coverage
- Co-pays and deductibles must be paid at the time of visit

3. Medication Management (not applicable for therapy)

- Prescription refills require 72-hour notice
- Controlled substances require an appointment for refills at a minimum every three months
- Lost prescriptions will not be replaced without an appointment
- Random drug screening may be required for certain medications

4. Communication Policies

- Emergency situations: Call 911, 988 or go to the nearest emergency room
- Non-urgent matters: Response within 48 business hours
- Portal communication is for refills, questions related to medications, or a request to change an appointment.
- Telehealth appointments are available

5. Confidentiality and Records

- All information is confidential except when:
  - Patient authorizes release of information
  - Patient presents immediate danger to self or others
  - Child/elder abuse is suspected
  - Court order requires information release
- Medical records requests require written authorization
- Processing time for records: seven business days

6. Treatment Agreement

I understand and agree to the following:

- Active participation in treatment is required
- Regular attendance at scheduled appointments
- Compliance with recommended treatment plan
- Honest communication
- Immediate notification of significant changes in condition
- Adherence to payment policies

PATIENT INFORMATION AND CONSENT

CONSENT FOR TREATMENT

I, _____ , have read and understand the above policies. I authorize Changing Tides Psychiatry to provide psychiatric evaluation and treatment. I understand that I have the right to revoke this consent in writing at any time except to the extent that action has been taken in reliance upon it.

Signature: _____

Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Changing Tides Psychiatry.

Signature: _____

Date: _____

CREDIT CARD AUTHORIZATION

I authorize Changing Tides Psychiatry to charge my credit card for services rendered, including missed appointment fees and late cancellation fees.

Card Type: _____

Card Number: _____ CCV: _____

Expiration Date: _____

By signing this form, I acknowledge that there is a no-show or late cancellation fee of $85.00.

Signature: _____

Date: _____

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PATIENT MEDICAL HISTORY

1. Current Health Status

Height: _____ Weight: _____ Last physical exam: _____

Primary Care Physician: _____ Phone: _____

2. Medical Conditions

Please select all that apply and provide year of diagnosis:

- ☐ High Blood Pressure (_____)
- ☐ Diabetes (_____)
- ☐ Heart Disease (_____)
- ☐ Cancer (_____)
- ☐ Asthma (_____)
- ☐ Thyroid Issues (_____)
- ☐ Mental Health: _____

3. Current Medications

Please list all medications, including over-the-counter drugs and supplements:

1. _____ Dosage: _____ Frequency: _____
2. _____ Dosage: _____ Frequency: _____
3. _____ Dosage: _____ Frequency: _____

4. Allergies

- ☐ Medications: _____
- ☐ Food: _____
- ☐ Others: _____

5. Surgical History

Procedure	Year
1. _____	_____
2. _____	_____

6. Family History

Please indicate any immediate family members (parents, siblings) with:

- ☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ High Blood Pressure
- ☐ Mental health conditions: _____

7. Social History

Tobacco Use:	☐ Never	☐ Current	☐ Former (Quit Date: _____)
Alcohol Use:	☐ Never	☐ Occasional	☐ Regular
Exercise Level:	☐ None	☐ Moderate	☐ Regular

8. Women Only

Last Menstrual Period: _____ / _____ / _____

Pregnant? ☐ Yes ☐ No

Number of Pregnancies: _____ Number of Live Births: _____

I certify that the above information is accurate to the best of my knowledge.

Signature: _____ Date: _____ / _____ / _____

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TELEHEALTH/TELEPHONE APPOINTMENT CONSENT FORM

Patient Name: _____

Date of Birth: _____

Reason for using telehealth service: _____

_____

_____

Select one: ☐ Synchronous audio-video ☐ Synchronous audio only
Telehealth visit performed through _____
Patient was located at _____

I hereby consent to receive psychiatric care through telehealth/telephone services. I understand that:

1. Telehealth/telephone services involve the delivery of healthcare services using electronic or telephone communications while the provider and patient are at different locations.

2. The same confidentiality protections that apply to in-person visits apply to telehealth/telephone services.

3. There are potential risks to telehealth/telephone technology, including:
   - Internet or phone service interruptions
   - Technical difficulties
   - Unauthorized access to confidential information
   - Limited ability to perform physical examinations

4. I have the right to withhold or withdraw this consent at any time.

5. All applicable federal and state laws regarding privacy, security, and access to my medical information apply to telehealth/telephone services.

6. Verbal/informed consent obtained from the patient.

Patient Signature: _____ Date: _____

Provider Name: _____ Date: _____

Patient Acknowledgment

- I agree to inform my provider of my location at the start of each session.
- I understand that telehealth services may not be appropriate for all medical conditions.
- I agree to ensure privacy at my location during sessions.

By signing below, I acknowledge that I have read, understand, and **agree to the Telehealth/Telephone Consent** terms above:

Patient Signature: _____

Date: _____

Guardian Signature (if applicable): _____

Date: _____

Patient Name: _____

Date: _____

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How We May Use and Disclose Health Information About You

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar processes.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this. Notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical records; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Secretary of the Department of Health and Human Services: 200 Independence Avenue S.W., Washington D.C. 20201.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the user or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- **Right to a copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at: Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

_____ _____

Signature of Patient *Date*

_____

Printed Name

The effective date of this Notice is January 8, 2025

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RANDOM DRUG TESTING CONSENT FORM

Patient Name: _____ DOB: _____

- ☐ I hereby agree to submit to a random drug test by furnishing a sample of my: urine for analysis to Changing Tides Psychiatry when requested.
- ☐ I have been fully informed of the reason for this test and I understand what I am being tested for and the procedure involved.
- ☐ I am fully aware that the results of this test may be included in my patient chart and become part of my health care record.
- ☐ I understand that if at any time I refuse to submit to a drug test or if I otherwise fail to cooperate with the testing procedures, my continued care/treatment at Changing Tides Psychiatry may be immediately withdrawn from consideration or I may be subject to immediate termination of treatment/counseling.

Reason for consent: Prescribed a controlled substance as part of my ongoing treatment/counseling at Changing Tides Psychiatry.

X _____ Date: _____
Patient/Guardian Signature

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Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date:_____ Patient Name:_____ Date of Birth:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please select your answers.

PHQ-9	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 hurting yourself in some way.	☐ 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**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please select your answers.

GAD-7	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'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**

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

Patient Name		**Date**				
Instructions *Please answer the questions below, rating yourself on a scale of 1 through 5 on each of the criteria as shown to the right. As you answer each question in a way that best describes how you have felt and conducted yourself in the past 6 months. Please give this complete checklist to your healthcare professional to discuss during your appointment.*		1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
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 must 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 must 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?	◯	◯	◯	◯	◯
7.	How often do you make careless mistakes when you must 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 are 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?	◯	◯	◯	◯	◯
Total Score: Inattention, Subscale A						
Total Score: Hyperactivity, Subscale B						

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

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?	☐	☐

How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

International Trauma Questionnaire

Instructions: Please identify the experience that troubles you most and answer the questions in relation to this experience.

Brief description of the experience _____

_____

When did the experience occur? (Select one)

- ☐ Less than 6 months ago
- ☐ 6 to 12 months ago
- ☐ 1 to 5 years ago
- ☐ 5 to 10 years ago
- ☐ 10 to 20 years ago
- ☐ More than 20 years ago

Below are several problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then check one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
P5. Being “super-alert”, watchful, or on guard?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
P6. Feeling jumpy or easily startled?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

In the past month have the above problems:

P7. Affected your relationships or social life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
P8. Affected your work or ability to work?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you.

How true is this of you?	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
C1. When I am upset, it takes me a long time to calm down.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
C2. I feel numb or emotionally shut down.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
C3. I feel like a failure.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
C4. I feel worthless.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
C5. I feel distant or cut off from people.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
C6. I find it hard to stay emotionally close to people.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

In the past month, have the above problems in emotions, in beliefs about yourself and in relationships:

C7. Created concern or distress about your relationships or social life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
C8. Affected your work or ability to work?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
C9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

DOB: _____ MRN: _____ Provider: _____

Please select 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
☐ Auvelity	
☐ Paxil	Paroxetine
MAOI	
☐ Nardil	Phenelzine
☐ Parnate	Tranylcypromine
☐ Marplan	Isocarboxazid
Mood stabilizer/Atypical antipsychotic	
☐ Conasen	Blonanserin
☐ Rexulti	Brexiprazole
☐ Risperdal	Risperidone
☐ Seroquel	Quetiapine
☐ Geodon	Ziprasidone
☐ Abilify	Aripiprazole
☐ Zyprexa	Olanzapine
☐ Clozaril	Clozapine
☐ Latuda	Lurasidone
☐ Invega	Paliperidone
☐ Saphris	Asenapine
☐ Caplyta	
☐ Vraylar	Cariprazine
ADHD	
☐ Ritalin	Methylphenidate
☐ Adderall	Dextroamphetamine
☐ Strattera	Atomoxetine
☐ Concerta	Methylphenidate ER
☐ Vyvanse	Lisdexamphetamine
☐ Provigil	Modafinil
☐ Kapray	Clonidine
☐ Dexedrine	Amphetamine
☐ Zenzedi	Amphetamine

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
☐ Gabapentin	Neurontin
Others	
☐ Cogentin	Benztropine
☐ Thorazine	Chlorpromazine
☐ Deplin	L Methylfolate