

# Raj Shiwach, MD PA

941 York Drive Suite 205  
DeSoto, Texas 75115  
P: (972) 283-6286 F: (972)331-8748  
AFTER HOURS NUMBER 800-200-8766

## Patient Information

Patient Name: \_\_\_\_\_ Gender: M \_\_\_ F \_\_\_  
Date of Birth (mm/dd/yy): \_\_\_\_\_ SSN: \_\_\_\_\_ Email: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_ Zip code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Drivers License #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Ethnicity \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Position: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact Phone #: \_\_\_\_\_

### Primary Care Physician

Doctor's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_ Zip code: \_\_\_\_\_

### Referral Source

Title and Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_ Zip code: \_\_\_\_\_

### Primary Insurance

Insurance Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_ Zip code: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### Secondary Insurance

Insurance Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_ Zip code: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### Insurance Authorization and Assignment

I authorize Raj. Shiwach, MDPA to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Raj. Shiwach, MDPA. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

X \_\_\_\_\_  
Signature of Patient or Responsible Party Date

**PATIENT HISTORY**

OFFICE (972) 283-6286

AFTER HOUR NUMBER: (800) 200-8766

**A. DEMOGRAPHICS**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_ Medication Allergies: \_\_\_\_\_

**B. DESCRIPTION OF PRESENTING PROBLEMS:**

State in your own words the nature of your main problem(s)

Please explain your current symptoms

How long has this been a problem? \_\_\_\_\_

**C. PERSONAL MEDICAL HISTORY**

Do you have any medical conditions that you know of? YES  NO

If yes, please check the box next to your medical condition.

HIGH BLOOD PRESSURE	SEIZURES	ASTHMA
HIGH CHOLESTEROL	STROKE	HEAD INJURY
THYROID PROBLEMS	HEART ATTACK/ HEART TROUBLE	CHRONIC PAIN
DIABETES	COPD (LUNG DISEASE)	CANCER

other (please list)

Who is your primary care physician? \_\_\_\_\_

**D. MEDICATIONS**

Are you taking any medications? YES  NO

If yes, please list their names and doses, if known.



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## Prescription Refill Policy

When your healthcare provider supplies you with a prescription, he or she may decide to designate a certain number of refills for that medication. The number of refills is left up to the provider's discretion and may depend on what type of medicine you are taking, or how long you have been taking it. Your provider will provide you with enough medication to last until you are to come in to the office for your next appointment. This should ensure that you do not run out of medications before your next appointment, as long as you are taking them as they are prescribed.

The following outlines the current policy at the office of Raj Shiwach, MD PA regarding prescription refills:

1. In general, you should not need to contact the office for prescription refill requests. As stated above, your provider will supply you with enough medication until your next appointment. If your provider has specified that you need to follow up with a face-to-face appointment in a certain amount of time, it is important that you come to the office to be seen as directed.
2. Prescription refills will not be issued if you cannot keep your scheduled appointment, except in extenuating circumstances.
3. If you do encounter an extenuating circumstance (e.g., illness, death in the family, etc.) that prevents you from keeping your scheduled appointment, your provider may allow you a refill that will last until you can be seen in person. **However, any such requests must be made by calling the office. Refill requests called or faxed by your pharmacy will not be processed or filled.**
4. Even in the case of an extenuating circumstance, the office does not guarantee that you will receive a prescription refill. This decision will be left to the discretion of the provider. **If a refill request is authorized, please allow up to five (5) business days for processing.**
5. Raj Shiwach, MD PA and his providers will not refill medications originally prescribed to you by another doctor if the medication was given for a physical health condition (e.g., we cannot refill your diabetes medication if your primary care doctor is out of town).
6. It is possible that appointments may be cancelled by our office due to unforeseen circumstances. In the event of a cancellation, every effort will be made to reschedule your appointment as soon as possible and additional medication will be authorized, if necessary.
7. In most cases there should be no issues filling your prescription. However, if your medication requires pre-authorization, please allow up to five (5) business days for processing.

This policy is in place to promote patient safety and continuity of care. It is important that you see your provider at face-to-face appointments as directed to ensure that your symptoms and medications are regularly monitored.

If you have any questions about this prescription refill policy, please ask your healthcare provider or contact the office at (972) 283-6286. In the event of an emergency, please call (800) 200-8766.

I acknowledge the policies and procedures outlined above.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness

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## Email Release Agreement

Dr. Shiwach and his healthcare providers offer patients the convenience of communicating via electronic mail (email) for non-urgent matters. Both you, as the patient, and your provider have to agree to this arrangement. No personal health information is ever sent electronically without permission given by you or your legally authorized representative.

### Appropriate uses for email

Email may be used to request information and ask non-urgent questions. It should not be used in emergencies. If you are experiencing a sudden or severe change in your health or otherwise need an immediate response, please contact your healthcare provider's office by telephone, call 911, or go to an emergency room.

Email may be appropriately used to send protected personal health information for:

- Prescriptions/refills
- General medical advice after a face-to-face office visit
- Patient educational material

If you have an email address and would like to take advantage of this service, please discuss your wishes with our office.

Dr. Shiwach and his office will not forward emails to anyone without your prior written consent, except as authorized or required by law.

**Email is not to be used in the place of a face-to-face office visit if you cannot keep your scheduled appointment. It is also NOT to be used for emergencies, or urgent matters requiring a response in less than 24 hours.** Furthermore, your healthcare provider has the right to request that you schedule an appointment in person if he or she feels that your concerns cannot be adequately managed via email.

### Keeping records of email communications

Email communications will be documented as (1) an electronic note maintained in a computer system and/or (2) a paper copy filed in your medical record.

### Sending email

Please include your full name and date of birth in every email message that you send to your healthcare provider. The subject line should include the purpose of the email, for example: "Prescription Refill Request".

When you receive a message from your provider containing medical advice, please acknowledge the message by sending a brief reply to the provider.

If a message is ever returned because of a "bad address", please make sure that you entered the complete address as it was given to you. If you are sure that you entered the address the provider gave to you, please call the provider's office and make sure you have the correct email address and that the

computer system is functioning properly. If we do not answer your email in 2 to 3 business days, contact our office by telephone.

Dr. Shiwach's office may choose to discontinue email communication at any time.

### Privacy and security of email

Do not use email to send or request sensitive information. This includes personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use email provided by your employer, any email sent on your employer's system may be viewed by your employer.

Dr. Shiwach and his office cannot and do not guarantee the privacy or security of any messages being sent over the internet. There is the potential that email sent over the internet can be intercepted and read by others. If this is of concern to you, you should not communicate with your healthcare provider through email.

This document, along with the notice of privacy practices included in your intake paperwork constitutes a notice of privacy practices for email use as required by the Texas State Board of Medical Examiners.

### Authorization to use email

I have been informed of and understand the risks and procedures involved with using email. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of email as one form of communication with my physician, his/her associates, technicians, and other healthcare providers.

You will be given a copy of this signed form to keep for your records.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Representative (Relationship)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

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### CONTROLLED SUBSTANCES AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, stimulants and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is pro-longed. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the provider whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your condition.

1. All controlled substances must come from the provider whose signature appears below or, during his or her absence, by the covering provider, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is: \_\_\_\_\_ Phone: \_\_\_\_\_
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that this office prescribed.
4. The prescribing provider has permission to discuss all treatment details with dispensing pharmacist or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to the medications.
6. These drugs should not be stopped abruptly, as a withdrawal abstinence syndrome will likely develop.
7. Routine urine or serum toxicology screens may be requested and your cooperation is required. Presence of unauthorized substances may prompt referral for addictive disorder therapy or termination from the practice.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

Revised date: April 14, 2016

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9. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
10. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made once.
11. Early refills will generally not be given, unless there is a need for the provider to either increase or decrease dosage.
12. Prescriptions may be issued early if the provider or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they may not be filled until the appropriate date.
13. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these regulatory authorities may be given full access to our records of controlled substances administration.
14. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends. In case of an emergency, please call 800-200-8766.
15. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
16. The provider reserves the right to terminate services if agreement has been breached.
17. It is understood that failure to adhere to these policies may result in cessation of therapy.
18. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

\_\_\_\_\_  
Provider/Admin Staff

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Printed)

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## Contact and Consent for Evaluation/Treatment

I, \_\_\_\_\_, ("Client/Guardian") request treatment for myself at Raj. Shiwach, MDPA. may include diagnosis, evaluation, and treatment for any medical, emotional and behavioral problem, which may be found to exist.

### Liability

In consideration of services rendered, Client agrees to hold Raj. Shiwach, MDPA blameless for any liability due to an accident, illness, injury, or incident, which may occur to Client while receiving outpatient services. Client also agrees to hold Raj. Shiwach, MDPA free from all liability for any losses through fire or theft. Client agrees, if hospitalization or extensive medical care Raj. Shiwach, MDPA to assist the client in obtaining appropriate medical attention. Further, the family, guardian, or Client is needed; that permission is hereby given to any agent of will assume all liability for any medical expenses, hospital care, or other expenditures without liability to Raj. Shiwach, MDPA

### Financial Responsibility

Client and/or financially responsible party have been informed that she/he is financially responsible for services received at Raj. Shiwach, MDPA, unless payment is otherwise assured. The Client and/or financially responsible party have been further informed of all applicable co-pay fees. If, for any reason, your insurance company fails to pay any portion of the amounts we billed, you will be responsible for the balance and will be billed accordingly. All co-pays and deductible are due at the time of service. We charge \$200-\$350 for the initial doctor's appointment. Continue therapy, including medication management follow-ups, will be a charge of \$90-\$175.00. It is agreed that Client will provide Raj. Shiwach, MDPA with a permanent contact address and telephone number. If you are unable to pay your co-pay or deductibles, services will not be rendered.

Returned checks are assessed a \$35.00 fee. You agree to pay your bill within 10 days of receipt. If payment is not received within 90 days, your account will be turned over to collections. We have the option to pursue all lawful collection procedures available and the patient/parent will be responsible for all the reasonable costs of collection, including attorney's fees incurred, if any. The minimum collection fee will be 50% of the total account balance. Unwillingness to pay may result in termination of services.

### Cancellations

We see all patients on an appointment basis. If you are unable to keep your scheduled appointment, please cancel as soon as possible so your allotted time may be given to another patient. We reserve the right to charge for missed appointments cancelled within 24 hours. The charge is \$50.00 billed to you, not the insurance. Continued missed appointments may result in patient termination.

### Records

Requests for records are received from various sources. Attention to these requests will only occur when we have received a signed (by patient or parent) release of information form. Records are copied at \$25.00 plus postage and billed directly to you. Please allow two weeks for this request to be processed.

### Letters

Letters and forms are often requested by patients (or their parents) to be sent to schools, employers, etc. You will be charged a letter writing fee for this service, minimum of \$35.00. We do not complete forms until the \$35.00 fee is paid. Please allow two weeks for this request to be processed. This also applies to all disability paperwork.

### Telephone Calls

Your calls are welcome and we will return them promptly during business hours. Telephones will be answered from 9A to 12P and from 1P to 5:00P. If the operator is unable to answer your call, please leave a message on the voicemail box. The voicemail is checked 3 times a day and your call will be returned within 48 to 72 hours. When leaving a message, please leave your full name, a good call back number and a brief message. If you need to make an appointment or need a



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medication refill, please call during our business hours. Should you need to reach someone other than a provider, please listen to the options and dial that extension. If you have an emergency, please call 911 or go to the nearest emergency room.

## Prescriptions

To prevent error and to maintain insurance and healthcare standards most prescriptions cannot be called in to the pharmacy. A charge of \$10.00 for prescriptions that are misplaced lost or not filled in the 21 day time frame for controlled substances. You must return the expired prescription and pay the fee by check or cash.

## Identification

You must present, at time of service, a valid photo ID or State driver's license along with your most current insurance card. Failure to present proper identification may result in you not being seen for your appointment.

## Termination

Clinic policy states that the third appointment that is not kept and/or follow up with in four months will be regarded as termination of treatment on the part of the patient/client, unless we as a team have decided otherwise. If you fail to comply with treatment recommendations termination is non-negotiable.

## Confidentiality

I have further been assured that any information, knowledge, or records associated with said Client are subject to release only by my informed and written consent or by a court order, except in instances of medical emergency or suspected child or elder abuse or neglect. Your confidentiality and privacy are protected by the following Federal guidelines: Code of Federal Regulations (CFR 42 Part2) and the Health Insurance Portability and Accountability Act (HIPAA).

## Discrimination Policy

No person will be discriminated against on the basis of gender, race, religion, age, national origin, disability (mental of physical), sexual orientation, medical condition, including HIV diagnosis or because an individual is perceived as being HIV infected. A person's economic condition and financial resources may be considered in admission criteria, but economic condition will not affect the services once an individual is admitted.

By signing this document, Client acknowledges that she/he understands the policy contained herein, and that if at any time there are questions, Client may return to a Raj. Shiwach, MDPA staff member for an explanation.

\_\_\_\_\_ (please initial). Consent for treatment is made with informed consent, and as such, consent may be revoked and services discontinued at any time. By signing below, Client acknowledges she/he has read the above information and fully understands its contents.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Financially Responsible Party Signature/Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

# RAJ SHIWACH, MD PA

## CLIENT BILL OF RIGHTS

OFFICE: 972-283-6286

AFTER HOUR NUMBER: (800) 200-8766

1. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
2. You have the right to be free from abuse, neglect, and exploitation.
3. You have the right to be treated with dignity and respect.
4. You have the right to appropriate services in the least restrictive setting available that meets your needs.
5. You have the right to be told about the MD PA rules and regulations before services are rendered.
6. You have the right to be told before services:
  - the condition to be treated
  - the proposed treatment
  - the risks, benefits, and side effects of all proposed treatment and medication
  - the probable health and mental health consequences of refusing treatment
  - other available treatments and which ones, if any, might be appropriate for you
  - the expected length of treatment
7. You have the right to accept or refuse treatment after receiving this explanation.
8. If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law).
9. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
10. You have the right to meet with staff to review and update the plan on a regular basis.
11. You have the right to refuse to take part in research without affecting your regular care.
12. You have the right not to receive unnecessary or excessive medication.
13. You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
14. You have the right to be told in advance of all estimated charges and any limitations on the length of services that the facility is aware of.
15. You have the right to receive an explanation of your treatment or your rights if you have questions while you are receiving services.
16. You have the right to make a complaint and receive a fair response from the staff within a reasonable amount of time.
17. You have a right to complain directly to the Texas Commission on Alcohol and Drug Abuse at any reasonable time.

**Department of Investigations  
Texas Department of State Health Services  
Substance Abuse Services  
P.O. Box 149347  
Austin, Texas 78714  
1-800-832-9623**

18. You have a right to get a copy of these rights before you receive services, including the Commission's address and phone number.
19. You have the right to have your rights explained to you in simple terms before receiving services.

I (we) have received from Raj. Shiwach, MDPA's staff a clear explanation of my (our) rights in simplest terms. I (we) have received a written copy of these rights. I (we) acknowledge a clear understanding of my (our) rights.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

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NAME OF PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

## LEAVING MESSAGES

Yes  No

Initial \_\_\_\_\_

By checking "Yes" and initialing in the space provided, I authorize providers and personnel of Raj Shiwach, MD PA to leave messages for me either with an individual answering the phone or on the voicemail associated with the telephone number(s) I provide. I authorize the caller to identify him/herself as being affiliated with Dr. Shiwach's office, but understand that no specific medical information will be transmitted by telephone message.

## CONTACTING YOUR PROVIDER

Yes  No

Initial \_\_\_\_\_

By checking "Yes" and initialing in the space provided, I acknowledge that I have received and understand the information about how to contact my provider.

## PRESCRIPTION REFILL POLICY

Yes  No

Initial \_\_\_\_\_

By checking "Yes" and initialing in the space provided, I acknowledge that I have received and understand the office policy about how to refill my prescriptions.

## EMAIL RELEASE

Yes  No

Initial \_\_\_\_\_

By checking "Yes" and initialing in the space provided, I acknowledge that I have received the email release form. I agree that I will abide by the policies contained in this release.

## CONTROLLED SUBSTANCES AGREEMENT

Yes  No

Initial \_\_\_\_\_

By checking "Yes" and initialing in the space provided, I acknowledge that I have received the controlled substances agreement. I understand and will abide by the policies as explained in this agreement. *Please be aware that if you do not consent to the Controlled Substances Agreement, your provider will not be able to provide you with any controlled substances.*

## RELEASE OF INFORMATION TO FAMILY MEMBERS

I authorize medical providers and personnel of Raj Shiwach, MD PA to discuss my protected health information with:

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

\_\_\_\_ Information regarding the patient's diagnosis and treatment for HIV/AIDS (initial)

\_\_\_\_ Psychotherapy notes from a psychiatry provider or therapist/counselor (initial)

\_\_\_\_ Treatment for alcohol or drug abuse reports (initial)

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that the office has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization.

Signature of Patient or Patient Representative \_\_\_\_\_

Date \_\_\_\_\_

# THE MOOD DISORDER QUESTIONNAIRE

**Instructions:** Please answer each question to the best of your ability.

	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?	<input type="radio"/>	<input type="radio"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="radio"/>	<input type="radio"/>
...you felt much more self-confident than usual?	<input type="radio"/>	<input type="radio"/>
...you got much less sleep than usual and found you didn't really miss it?	<input type="radio"/>	<input type="radio"/>
...you were much more talkative or spoke much faster than usual?	<input type="radio"/>	<input type="radio"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="radio"/>	<input type="radio"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="radio"/>	<input type="radio"/>
...you had much more energy than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more active or did many more things than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="radio"/>	<input type="radio"/>
...you were much more interested in sex than usual?	<input type="radio"/>	<input type="radio"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="radio"/>	<input type="radio"/>
...spending money got you or your family into trouble?	<input type="radio"/>	<input type="radio"/>
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	<input type="radio"/>	<input type="radio"/>
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? <i>Please circle one response only.</i>		
No Problem      Minor Problem      Moderate Problem      Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	<input type="radio"/>	<input type="radio"/>
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	<input type="radio"/>	<input type="radio"/>

Sugn

Date