RAJ SHIWACH, MD PA

941 YORK DRIVE SUITE 200 DESOTO, TEXAS
75115
P: (214) 884-5601 F: (214) 452-3060 AFTER HOUR
NUMBER (800) 200-8766

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

PATIENT INFORMATION:

_____
Name (Last, First, and Middle) D.O.B

_____
Street Address

_____
City State Zip code Phone Number

I authorize and request (PCP) _____ to be released and disclose protected health information identified below to:

Name: Raj Shiwach, MD PA **Address: 941 York Dr., Suite 200, Desoto, Texas 75115**
Phone: (214) 884-5601 Fax: (214) 452-3060 _____

TYPE OF INFORMATION TO BE DISCLOSED:

- ☐ PSYCHIATRIC EVALUATION
- ☐ DISCHARGE SUMMARY
- ☐ CONSULTATION
- ☐ HISTORY& PHYCICAL
- ☐ LAB/RADIOLOGY REPORTS
- ☐ CONSULTATION
- ☐ OTHER(specify) _____

PURPOSE OR REASON THIS INFORMATION IS NEEDED:

- ☐ ADMISSION/INTAKE/PLACEMENT/TRANSFER
- ☐ CONTINUITY OF CARE/ MONITOR MEDICAL STATUS
- ☐ OTHER (specify) _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired Immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), psychological or psychiatric treatment, behavioral or mental health service, and alcohol and drug abuse. I authorize the release or disclose of this information.

I understand I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. I understand the information released in response to this authorization may be re-disclosed to other parties. I understand my treatment, payment for my treatment and enrollment or eligibility for benefits cannot be conditioned on the signing of this authorization. I understand I may be charged a reasonable fee for copies of these medical records according to State and Federal Laws.

This document will expire in 90 days from the date signed below.

_____ _____
Signature of Patient or legally authorized representative Date

Revised 9/19/2025

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We will be using E-Script as of September 15, 2017; the following information will be needed.

Pharmacy Name: _____

Zip code of pharmacy: _____

Pharmacy Phone Number: _____

Patient's Name: _____

Patient's Phone Number: _____

Patient's DOB: _____

Any Known Allergies: _____

_____
Patient's Signature

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Patient Information

Patient Name:_____ Gender ☐ M ☐ F
DOB: (mm/dd/yy):_____ SSN:_____ Email: _____
Mailing Address:_____ City:_____ ST:_____ Zip Code:_____
Home Phone:_____ Work Phone:_____
Driver License #:_____ Marital Status:_____ Ethnicity:_____
Employer Name:_____ Position:_____
Emergency Contact:_____ Relationship:_____
Driver License #:_____

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: _____
Policy Number:_____ Group #: SSN:_____
Name of Insured:_____ DOB: _____
Employer Name: _____ Relationship to Patient:_____

SECONDARY INSURANCE

Insurance Name:_____ Phone: _____
Mailing Address: _____
Policy Number:_____ Group #: SSN:_____
Name of Insured:_____ DOB: _____
Employer Name: _____ Relationship to Patient:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Raj. Shiwach, MDPA to release 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 weather 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 Today's Date

Updated: 9/19/2025

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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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E. PSYCHIATRIC HISTORY

Do you have any psychiatric conditions that you know of? YES ☐ NO ☐

If yes, please check the box next to any diagnoses you have been given.

DEPRESSION	☐	ANXIETY DISORDER	☐	ALCOHOLISM	☐
BIPOLAR DISORDER	☐	ADD/ADHD	☐	BORDERLINE	☐
SCHIZOPHRENIA	☐	SUBSTANCE ABUSE	☐	OBSESSIVE COMPULSIVE	☐
other (please list)					

List any other psychiatrists or therapists you have seen_____

Have you ever attempted suicide or been hospitalized for psychiatric reasons? YES☐

NO☐ If yes, when and where were you hospitalized?_____

G. SUBSTANCE USE

I. ALCOHOL USE

When was the last time you drank anything containing alcohol? _____

How many days per month do you drink? _____

When you drink, how many drinks do you usually have? _____

What is your typical pattern of alcohol use? [check one or more]

Never	Socially	Daily	Most Days	Weekends	Binges
☐	☐	☐	☐	☐	☐

II. DRUG USE

Have you ever used any of the following?

YES	NO	DRUG NAME	IF YES, WHEN DID YOU LAST USE AND HOW MUCH?
☐	☐	Marijuana	
☐	☐	Cocaine/Crack	
☐	☐	Methamphetamine	
☐	☐	Heroin	
☐	☐	Pain pills (not prescribed to you)	
☐	☐	LSD	
☐	☐	PCP	
☐	☐	Other	

Have you ever felt you had a problem with any of the above drugs? If so, explain _____

_____

What is your typical pattern of drug use? [check one or more]

Never	Socially	Daily	Most Days	Weekends	Binges
☐	☐	☐	☐	☐	☐

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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. There 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 in 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.

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.

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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. It is understood that failure to adhere to these policies may result in cessation of therapy.

15. Renewals are contingent on keeping scheduled appointments. In case of an emergency, please call (214)884-5601.

16. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit

17. The provider reserves the right to terminate services if agreement has been breached.

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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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 the medication. The number of refills is left 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 you until you are to come in to the office for your next appointment. This should ensure that you do not run out of medication 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 request. 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, ect.) that prevent you from keeping your scheduled appointment, your provider may allow you a refill that will 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. The 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 preauthorization, PLEASE ALLOW UP TO FIVE (5) BUSINESS DAYS for processing.

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

If you have any question about this prescription refill policy, please ask your healthcare provider or contact the office at (214) 844-5601. In the event of an emergency, please call (214) 844-5601.

I acknowledge the policies and procedures outlined above.

_____ _____
Patient Name Today's Date

_____ _____
Patient Signature Witness

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Email Release Agreement

Dr. Shiwach and his healthcare providers offer patients the convenience of communicating via electric mail (mail) for non-urgent matters. Both you, as a 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 representatives.

Appropriate uses for email

Email may be used to request information and ask non-urgent question. It should not be used in emergencies. If you are experiencing 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:

- Prescription/ 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 you 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 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 communication will be documented as (1) an electronic note maintained in a computer system and/or (2) a paper copy filed in y medical records.

Sending email

Please include your full name and DOB 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 you please call the provider's office and make sure you have the correct email address and that the computer system is functioning property. If we do not answer your email in 2to 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 ab 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 risk 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 associa technicians, and other healthcare providers.

_____ _____

Patient Signature Provider Signature

_____

Patient Representative (Relationship)

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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 charged $250.00 for the initial doctor's appointment. Continue therapy, including medication management follow-ups, will be a charge of $125.00. It is agreed that Client will provide Raj. Shiwach, MDPA with a permanent contact address and telephone number.

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.

Cancellation
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 no called within 24 hours. The charge is $50.00 billed to you, not the insurance. Continued missed appointments may cause 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 $40 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 $40.00. We do not complete forms until the 40.00 fee is paid. Please allow two weeks for this request to be processed.

Telephone Calls
Your calls are welcome and we will return them promptly during business hours. Telephones will be answered from 8A 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 24 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 medicine

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refill, please call during our business hours. 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 cash.

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 anytime. 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

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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 program's rules and regulations before you are admitted.
6. You have the right to be told before admission:

    - 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**

_____ _____

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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?	☐	☐
...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 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 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 into 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?	☐	☐

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? *Please circle one response only.*

☐ 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?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

_____ _____

Signature **Date**

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PATIENT HEALTH QUESTIONNAIRE-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
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
☐	☐	☐	☐

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Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____ .

Interpretation

A grand sum between **0 – 21** indicates very low anxiety. That is usually a good thing. However, it is possible that you might be unrealistic in either your assessment which would be denial or that you have learned to "mask" the symptoms commonly associated with anxiety. Too little "anxiety" could indicate that you are detached from yourself, others, or your environment.

A grand sum between **22 – 35** indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved. Clearly, it is not "panic" time but you want to find ways to manage the stress you feel.

A grand sum that **exceeds 36** is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a counselor if the feelings persist.