PSYCHIATRY, PSYCHOLOGY & PSYCHOTHERAPY
Mark Kosins, M.D. & Consulting Staff
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AFFILIATED PSYCHIATRIC MEDICAL GROUP, INC.
MARK S. KOSINS, MD & Consulting Staff
Psychiatry, Psychology & Counseling
Diplomat-American Board of Psychiatry and Neurology
Our charge for service includes the following:

1. Meeting with you, providing an initial evaluation and developing a treatment plan.
2. Discussing your care and providing for a positive experience.
3. Chart review and review of records.
4. Evaluation of laboratory testing and reviewing physical exam, if you have one.
5. Communicating with the treatment team that is working with you.
6. Any meetings or discussions with relatives.
7. Time spent regarding your insurance to help you get reimbursed.
8. Writing notes in your chart.
9. Writing of orders and review of medications.
10. Medication changes as appropriate.
11. Calls from the staff and others involved with your care and - with your permission.
12. Any letters that need to be sent to insurance companies.
13. Involvement in discharge planning and follow up.
14. Availability regarding your care and consultation with our staff.

As you can see, meeting with you is just a small part of what is needed to co-ordinate your care and treatment.

We are happy to be available to you and your relatives (with your consent) and anyone else involved with your care and treatment. There are other things that are involved in the treatment of a patient. There is an extra charge for extensive time on the phone, reviewing documents and records or writing detailed letters in your behalf.

The only extra charges are for triplicate prescriptions, detailed reports or review of records, scheduled phone consultations, phone calls over 10 minutes, medical legal reports, etc. In addition, we will charge for any emails that require more than a few minutes of time, or involve pulling a chart, reviewing records, etc. Our charge for e-mail is based on time spent and is usually $25, billed to your credit card or other arrangements that you have made in advance.

Thank you for letting us be of service to you.

Initial Evaluation 2

MARK S. KOSINS MD & Staff
DIPLOMAT-AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
302 N El Camino Real #112 *(949) 489-9898=Phone*
SAN CLEMENTE, CALIFORNIA 92673 (949) 489-2569=Fax

Informed Consent-General—We will give specific info as well, if we use any particular medication etc.

Informed Consent Regarding Nutritional and Herbal Supplements & Lab Testing

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements - Affiliated Psychiatric Medical Group, Inc.

You are under no obligation to purchase nutritional supplements at our clinic.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

Functional Medicine Laboratory Testing Informed Consent

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Initial Evaluation 3

To my patients: Regarding the use of off label medications. Please ask questions.

Medications are developed and approved by the food and drug administration (FDA). They are given specific indications for specific uses based upon very detailed and expensive testing. We want to make sure they are safe and work. Often times we have found that medications are effective when used in situations called off-label. This means they are not FDA approved but have been shown to be helpful and much literature exists to support the use of medicines off label. For example there is no medicine indicated for the treatment of Bipolar Disorder in very young Children or behavioral disruptive conditions or autistic spectrum disorders. Yet, we must treat these conditions.

In addition, I use caution to use combinations or supplements and or medications that are often helpful and result in increased effectiveness for a multitude of conditions such as unusual pain disorders, ADHD, ADD, Bi-Polar Disorder, Anxiety Disorder, Panic Attacks, oppositional defiant disorder, Bi-Polar Spectrum Disorder, Depression, Dysthymia, and others like behavioral loss of control, irritability, temper, rages, anger, impulsivity, lack of attention, low frustration tolerance, etc. Furthermore, combinations of medications are often better than a high dose of one medication. There are not always FDA studies for these combinations. I encourage you to ask questions and look up anything you wish on the internet or consult other sources of information.

Though side effects are common with all medications, it is important to distinguish between side effects that are inconvenient and those that are dangerous. Inconvenient would be a slight bit of nausea or transient trouble falling asleep. Dangerous side effects can cause irreversible damage. So I try to be as careful with you as I would with my own family even if the chances of a problem are 1 in 1000 or 100,000 or 1,000,000. Side effects can happen, I will and we must always weigh risks and benefits.

If a blood test is helpful, I will give you a prescription for one. If you have any unusual symptoms that are very mild, they will most likely go away. If you have any that concern you an e-mail is helpful for non urgent issues, but for urgent issues please CALL. I try to be very available and return my phone calls daily..…please don't call it an emergency unless it is one. If ever in doubt and you can't reach me or my associates, go directly to an emergency room.

The medications and supplements I use help a person's brain chemistry function more normally. I never have the goal of turning someone into a zombie or making them zoned out.

Examples:

1. Mood Stabilizers…originally used for epilepsy. Many are approved for Bipolar disorder and migraine. Most of my patients never get any serious side effects and even the inconvenient ones are reduced because we start with a low dose and increase very slowly. Examples are:

a. Depakote…requires blood tests to check blood level, blood and liver function.
b. Tegretol…requires blood tests to check blood level, blood and liver function.
c. Gabitril…no tests required.
d. Neurontin and Lyrica…no tests required.
e. Topamax…no tests …rare kidney stones…rare increased eye pressure.
f. Lamictal……can rarely cause a rash…..notify me at once and stop the medicine.
g. Lithium….. Requires blood test for thyroid, kidney function and blood level of lithium…
h. Zonegran …no tests.
i. Trileptal … a rare rash, can lower effect of birth control pills.
j. . And others. Although it is very uncommon, if you get a rash while taking any of the above medicines…stop it at once and call me.

2. **Atypical Anti-psychotic Medications**: These are used for severe psychiatric disorders in high doses. They have been shown to be effective in low doses in combination or alone for many of the disorders I have noted above. These medications include:
    a. Risperdal…rarely increases prolactin…we can test for this
    b. Zyprexa….most likely to cause weight gain
    c. Seroquel…can be used at times in low doses for sleep
    d. Geodon...may require a electrocardiogram---uncommon
    e. Abilify…rarely can cause muscle stiffness or drooling
    f. Invega...similar to Risperdal…but less sedation and given in the am
    g. Clozapine…requires frequent blood monitoring
    Thorazine (chlorpromazine), Mellaril, Stelazine, Navane and others are "typical" anti-psychotic medications we sometimes use for off label use.
3. Medications usually used for blood pressure control:
    a. Clonidine (catapress) is often useful for impulse control, pain and tic disorders
    b. Tenex…often used for impulse control
    c. Beta Blockers such as inderol, propranolol, atenolol, viskin, zebeta and others for headaches and for impulse control and rapid heart beat or tremor.

4. We may also use medicines for sleep like Trazodone (desyrel), or muscle pain (soma, or robaxin), and various other medicine for a detox from various drugs or alcohol. Or we may use Xyrem (a medicine for narcolepsy) to help with the pain for Fibromyalgia. (off label)

5. We may also use medication for **Attention Deficit Disorder and Oppositional Defiant Disorder** that include a combination of medications such as a psycho stimulant, a mood stabilizer or an SSRI/SNRI like Prozac, Paxil, Effexor, Celexa, Zoloft and other medications that are appropriate. ALWAYS LET US KNOW WHAT HERBS OR OVER THE COUNTER MEDICATIONS OR VITAMINS YOU USE.
    a. The FDA notes that stimulants may have a slight increased incidence of cardiac (heart) side effects in patients that have a structural defect, heart irregularities, hypertension that is not controlled and frequent bouts of dizziness, fainting, chest pain, rapid heart beat or history of heart attack. Please let me know if you know of any issues related to this. Let us know if there is any history of heart problems in you or your first degree family relatives. In this instance an EKG or physical exam from your primary care doctor or pediatrician may be indicated.
    b. The FDA also notes that very rarely Psychosis, Aggression, and severe behavioral disorders can occur with stimulants. If any this should happen while you are first taking stimulants or any time, please let us know at once.
    c. Finally there is the issue of growth. In a 3 year study it was noted that on average children lost 5 pounds compared to children not on stimulants and grew about ¾ of an inch less. Studies are underway to see if this changes their total height as an adult.
6. As it relates to taking anti depressants in children and adolescents;
    Rarely there is an increase in suicidal thinking in children and adolescents who have been started on anti depressants. Of course, they did not feel well in the first place, and it is thought that the increase in this thinking is due to the activating effect of the medications (especially in the first weeks on the medication).
    With this in mind, it is important to monitor children more closely when first starting these medications. If there is any doubt please contact us at once.

There are other examples and I will explain if I/we…use any others. This list is not inclusive and I may use unusual combinations of medications to achieve goals which we will discuss. I will always be happy to explain what I am doing and why. Just ask.
INFORMED CONSENT I have been told that medications, supplements, testing, etc. as described above may be used off label. I have had an opportunity to ask questions and have been told about common side effects. Furthermore, I know how to reach the doctor in an emergency.

Date: _____ Patient Signature: _____Clinician_____

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TELEMEDICINE/EMAIL CONSENT FORM/MISSED APPOINTMENTS

I hereby authorize the staff of Affiliated Psychiatric Medical Group, Inc., a Medical Corporation, (APMG, Inc.) to perform and charge for telemedicine and/or email and missed appointments in the course of my diagnosis and treatment. I understand that telemedicine involves the communication of medical information, orally or by email between the medical staff and myself, other family members, and/or other healthcare providers (with my consent).

I understand that I have all of the following rights with respect to telemedicine/email:

1. **Patient Choice of Care**- I have the right to withhold or withdraw my consent at any time without affecting my right to future care or treatment and risking the loss of my health coverage.
2. **Access to Information**- I have to right to inspect all medical information transmitted during the consultation, or to request or exchange information, and may receive copies of this information for a reasonable fee.
3. **Confidentiality**- I understand that the laws which protect the confidentiality of medical information and that no information from the interaction that identifies me will be disclosed to researchers or other entities without consent.
4. **Potential Risks**- I understand that there are risks, including the possibility, despite reasonable and appropriate efforts, that the transmission of medical information could be disrupted or distorted by technical failures in the

transmission. In addition, I understand that telemedicine or email does not negate or minimize the risks that may be inherent in a medical illness or condition. Finally, I understand that it is impossible to anticipate every possible risk, that my condition may not be cured or improved, and, in rare cases, may get worse.
5. **Consequences**- I understand that by consenting to telemedicine and/or email, my health care provider may communicate medical information concerning me to physicians and other health care practitioners, located in other parts of the state or outside the state.
6. **Benefits**- I understand that I can expect benefits from telemedicine and email, but that no results can be guaranteed or assured. (Where applicable: Telemedicine and Email provide me with access to medical care that otherwise might not have been available.) Additional benefits may include convenience and/or continuity of care with the staff of APMG, Inc.
7. **Options**- I understand that I may see a staff member of APMG, Inc. for a face to face appointment in lieu of a telephone appointment at my request. In the event of an emergency regarding a need for immediate access to care, I understand that I am to dial 911 and/or go to the nearest emergency room, local mental health clinic, or crisis unit or that I should contact my primary care physician for instructions.
8. **Charges for Telemedicine and/or Email or missed appointments**- I understand that charges for telemedicine and/or email or missed appointments apply at the regular rate that my treating clinician charges and will be charged to the following credit card:

Card Number: _____Exp. Date: _____

Card Type: Visa MC Disc Amex

Name as Shown on Card: _____

_____ _____
Signature of Patient/ Other's Signature (indicate relationship)

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Affiliated Psychiatric Medical Group
PATIENT INFORMATION
Patient's Name: _____
RESPONSIBLE PARTY and/or SPOUSE'S INFORMATION
Responsible Party: _____ SS# ____-____-____
Home Address: _____ _____
Home Phone: _____
Spouse's Name: _____ SS# ____-____-____

FEES CHARGED: *The fees charged by doctors/therapists are based on the amount of time scheduled for dealing with patient issues. The minimum about of time scheduled/charged by our physicians is for a half session (20-30 minutes in length). If additional time beyond the scheduled time is taken to assist patients, you will be charged for the amount of time used. In addition, patients are typically charged for time spent on the telephone and time taken to write triplicate prescriptions outside of scheduled appointments, time taken to write notations in patient's chart and time taken to write reports or correspondence on the patient's behalf.*

INSURANCE BILLING: *It is not our policy to bill insurance carriers for our patients. We will provide patients with receipts that may be submitted to your insurance carrier for reimbursement. Patients/Responsible Parties are responsible for all charges whether or not they are covered by your insurance.*

PAYMENT POLICY: Our office requires payments for in-office services at the time services have been rendered. *Payments may be made by cash, personal check or credit card (American Express, MasterCard, or Visa).*

Telephonic appointments must be prepaid by either personal check or credit card. *As our patients are expected to maintain a zero balance, our office does not send any billing or statements.*

APPOINTMENT CANCELLATION POLICY: *We require that cancellations for scheduled appointments be received 24 hours in advance AND during regular business hours (Monday through Friday 8:30-5:00 pm).* ***Missed or cancelled appointments that do not follow this policy will be charged a missed appointment fee at the discretion of your therapist or doctor.*** *This fee can equal but will not exceed the regular charge for the time scheduled. Insurance do not pay for missed appointment fees and the patient/responsible party is held fully accountable for this charge.*

I have read and understand the stated policies of Affiliated Psychiatric Medical Group
Signature of Responsible Party (required):

_____

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ADULT

Initial Outpatient Evaluation ***to be filled out by patients***
Fill out those items on all pages as completely as possible so that we can best evaluate your needs and develop a plan of action to be of assistance: ***NOTE THOSE AREAS TO BE FILLED OUT BY PSYCHIATRIST OR THERAPIST: If something is confidential please discuss personally.***

Evaluated By: _____ Date of Evaluation: _____

An independent consultant will be with you shortly

TO BE FILLED OUT BY PATIENT OR SIGNIFICANT OTHER:

I. IDENTIFYING DATA: (Fill in information where appropriate and explain as appropriate)
Your Name: _____ Age: _____ Sex: M/F Marital Status: _____
Address: _____ City, State, Zip: _____
Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____
Social Security # _____-_____-_____ Date of Birth: _____/_____/_____

Please authorize me to send a copy of this report to your family MD or the person who referred you by filling in the following:
Name: _____ *Phone:* _____
Address: _____ *City/State/Zip:* _____

Patient gave consent: ____ Yes____No

What is your email address: _____@_____.com

II. PURPOSE OF EVALUATION: ____ Mental Status exam ____ Develop Treatment Plan ____ Establish Dx ____ Follow up

III. ***What brought you to our office****...what are the main things we should know about in order to best assist you? Please explain what your goals are in being here.*

_____
_____
_____
_____
_____
_____

A. CURRENT SYMPTOMS: (Check all that apply) **1 = Mild, 2 = Moderate, 3 = Severe**

___ Poor sleep	___ Personality changes	___ Physical complaints	___ Racing heart
___ Poor appetite	___ Constipation	___ Feelings of inferiority	___ Suicidal feelings
___ Increased appetite	___ Diarrhea	___ Hearing voices	___ Blurred vision
___ Weakness	___ Weight loss	___ Seeing things	___ Shaky inside
___ Decreased sex drive	___ Tiring easily	___ Paranoia	___ Avoiding people
___ Hyperventilation	___ Abdominal discomfort	___ Anger	___ Inability to have fun
___ Palpitations	___ Feelings of hopelessness	___ Fearfulness	___ Short-tempered
___ Depression	___ Lack of interest	___ Phobias	___ Worrying a lot
___ Nausea	___ Anxiety	___ Low self esteem	___ Inability to relax
___ Headaches	___Feelings of guilt	___ Socially withdrawn	___ Menstrual changes
___ Crying easily	___ Family problems	___ Dry mouth	___ Numbness
___ Indecisiveness	___ Poor attention span	___ Nightmares	___ Sexual problems
___ Work problems	___ Ringing in ears	___ Dizziness	___ Shaky hands
___ Irritability	___ Other: _____	___ Other: _____	___ Other: _____

B. (Check all problem areas that apply) **1 = Mild, 2 = Moderate, 3 = Severe, 0 = No Problem**…Symptoms may indicate ADD/ADHD

____ Hyperactivity	____ Attention span	____ Distractibility	____Emotional meltdown
____ Impulse control	____ Concentration	____ Frustration tolerance	____ Cooperativeness
____ Follows directions	____ Finishes tasks	____ Anger/aggressiveness	____ School performance
____Truancy	____ Defiant	____ Running away	

C. HISTORY OF THE PROBLEM: Date of Onset _____ How did your problems start and when was the last time you felt good?

_____
_____
_____
_____

D. CURRENT STRESSES (Check all that apply) describe those areas of your life that have been stressful.

___ Primary support group ___ Legal ___ Social ___ Economic ___Education ___Occupational
___ Marital ___ Family
___ Other: (Please Explain): _____

E. PAST MENTAL HEALTH CARE (Date, provider, type of payment, inpatient, or CD explain:

Please explain any past mental health care or counseling you have had: (include medications, doses, responses).

_____
_____
_____

IV. OTHER INFORMATION: _____

A. FAMILY HISTORY:

Family history of emotional problems, suicide attempts, or substance abuse:

Please describe any family history of the above types of problems. Indicate the type of problem and the relative involved:

_____
_____
_____

What is your mother's current state of health: _____ If deceased: Cause, age: _____
What is your father's current state of health: _____ If deceased: Cause, age: _____
Any comments: _____
Who were you raised by? Circle one: Parents Foster Parents Other: specify: _____
Name your siblings and their ages and anything special that we should know: _____
_____
_____
Who lives in your home at this time: List name and relationship: _____
_____
_____
Children: Names, ages, problems, strengths, and your relationship to them: _____
_____
_____
_____

B. DRUG AND ALCOHOL HISTORY:

Past or present use of drugs, alcohol, and tobacco: (include legal, family, occupational, physical problems due to substance abuse)
Check and explain all that apply: Do you drink? ___ Yes ___ No If yes, how much: ___ Rarely ___ Socially ___ Frequently
___ Daily ___ Weekends ___ During ___ At work Explain: _____
___ Cigarettes: ___ Yes ___ No How many a day: _____ _____ Illicit drugs (opiates, stimulates, cocaine, marijuana, hallucinogens, other or prescribed drugs) ____ None Explain: Check off the above boxes and explain any information that may help:
_____

Do you or anyone else feel you have a drug or alcohol problem? ____ Yes ____ No
If yes, please explain: _____
Are you currently over-using non-prescription drugs? ____ Yes ____ No
If yes, please explain: _____
Have you ever felt guilty about your drug or alcohol use? ____ Yes ____ No
If yes, please explain: _____
Have you ever had any withdrawal symptoms: _____
Please list age when you started and types of substances used throughout the years. Include: Marijuana, hashish, prescription tranquilizers, sleeping pills, cocaine or crack, amphetamines or crank or ice, opiates (heroin, codeine, morphine, Vicodin, Oxycontin, barbiturates, hallucinating drugs, ecstasy, P.C.P., and others:

_____
_____
_____
_____

C. WORK AND MILITARY HISTORY

Occupational History: Employment: ____ Full time ____ Part time ____ Not working/Retired ____ Homemaker ____ Student

Type of Work: What do you actually do in your job. Check off the boxes above that apply:

_____
_____

Have you been exposed to toxic chemicals in the past twelve (12) months or been injured or stressed at work: ___ Yes ___ No
If yes, please explain: _____
Disabled: ____Totally ____ Partially ____ Not Disabled ____ Other: _____
Salary: _____ Longest job ever held: _____ Shortest: _____ Reason for leaving Jobs:
____ Fired ____ Promoted ____ Resigned to find better job ____ Did not get along ____ Other: _____
Any work related problems: _____
Describe your military history: _____
_____

D. MEDICAL HISTORY ____ Healthy ____ Other: _____

_____
_____
_____

What is the name of any doctors you have visited in the past year and what is their phone #:
1. _____ 2. _____
When was your last physical exam? _____ and list any abnormal findings: _____
_____
Past medical history: List anything that would be important in treating you. Such things as high blood pressure, glaucoma, kidney disease, heart disorder or other: Circle any illnesses listed and explain those or any others that I should know about in understanding your physical health: _____

_____
_____

Any history of head trauma or seizures: _____
Any prior abnormal lab tests, X-Rays, EEG, etc.: _____
_____
Do you have any allergies? ___ Yes ___ No If yes, to what medicine or food and what happens? _____
_____

Please list any chiropractor, nutritional expert, or other type of healing person you have seen and what has been done and what is the result: _____

_____
_____
_____
_____

Female only: Last Menstrual Period _____

E. SEXUAL HISTORY

History of Physical/Sexual Abuse: **Physical:** **___Yes ___ No ___ Not Evaluated**
Sexual: **___ Yes ___ No ___ Not Evaluated**

Please check off the above and explain: _____
_____

Regarding sexual adjustment: A. Sexual Education ____ Yes ____ No By whom: (circle one) School Father Mother Books Friends Other: Please explain: _____

Is HIV an issue, please explain: _____

Do you have any sexual problems? ___ Yes ___No If yes, please explain: _____
_____

F. MARITAL HISTORY:

List your marriages: _____

1. Your age_____ Spouse's age _____ Duration: _____ Relationship: _____
2. Your age ____ Spouse's age _____ Duration: _____ Relationship: _____

List any children and their ages: 1._____ 2. _____ 3. _____ 4. _____

If marriage ended, reasons: _____

Current marital or relational satisfaction: _____

G. EDUCATION:

Highest grade completed: _____ Grades Repeated: _____ Type of student: __ Average __ Good __ Excellent __ Below Average

Favorite Classes: _____ Relationship with teachers: _____ With classmates: _____

Other information regarding your education: Please list any learning problems or school problems you may have had:
_____
_____
_____

Please bring any report cards and any state, national, or special testing that has been performed

HAVE YOU EVER HAD:

Suicidal Ideation: ____ None ____ Present (no plan) ____ Present (plan) ____ Past history

Explain any past attempts, any plans you now have and if you would act on these plans if you have any:
_____
_____

Homicidal Ideation: ____ None ____ Present (no plan) ____ Present (plan) ____ Past history

Explain if you have any plans to hurt anyone else and if so, who? _____
_____

Have you ever had any conflicts with the law: ____ Yes ____ No

Explain:
_____
_____
_____

I. Medications: ____ Prescribed by Psychiatrist ____ Prescribed by Primary Care M.D.

List any medications below that you take; the name, dosage and how taken, with any other information such as side effects.

Current Medications: (name and dosage)	**How much and how often:**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Other information about medications that would be helpful; for example, medicine you have tried and the result and how long it was taken and any side effects, etc. (Include herbal supplements, vitamins, etc.)

_____
_____
_____
_____
_____
_____
_____

V: MENTAL STATUS EVALUATION: Check the boxes and describe the questions below: (1 to 9 only)

1. Describe your body type: ____ Slight ____ Medium ____ Overweight ____ Heavy ____ Obese
2. Do you appear to be your: ____ Stated age ____ Older ____ Younger ____ Other
3. Your hygiene and dress could be described as ____ Well dressed ____ Neatly groomed/casually dressed
   ____ Sloppily dressed ____ Poor hygiene ____ Unusual appearance:

_____

Please describe what you are wearing today:

_____
_____
_____

4. How would you describe your attitude today? __ Cooperative __ Uncooperative __ Guarded __ Suspicious __ Angry
   __ Hostile __ Agitated Other: _____
5. Describe yourself: __ Calm __ Hyperactive __ Tremors/tics __ Retarded (Slow) __ Restless __ Lethargic
   __ Other: _____
6. Describe your speech: __ Clear __Pressured __ Soft __ Monotone __ Not organized __ Rapid __ Slowed __ Loud
7. Orientation: Please list the:
   Date: _____ Day: _____ Year: _____ Month: _____
8. Memory: (check if intact) __ Recent, what did you have for breakfast? _____
   __ Remote, Where were you born?_____
   __ Immediate, what is my name? _____
   __ Is your memory decreased relative to normal: Is your memory less good than normal?

_____
_____

9. Concentration: Are you having problems with your concentration compared to normal for you? Your concentration is:
   __ Normal __ Mild Impairment __ Moderate impairment (Somewhat decreased) __ Marked impairment (Very decreased)
   Please explain: _____
   _____

~~VI: CHECK THE TYPES OF TREATMENT YOU WANT HELP WITH and add any that have not been listed:~~

(MED=MEDICATION) Type of treatment:	__ Individual	__ Family	___ Med Management
__Psychological Testing	__ Med Evaluation	__ Lab Tests	__Group	___Sexual Problems
__Utilize Meds and Stabilize	__ Stabilize Marriage	__ Parent/child Relationship		___ADD/ADHD
__ Help with Work Problems	__ Decrease Anxiety	__ Decrease Depression		___OCD
__ Help with Suicidal Ideation	__ Somatic Symptoms	__ Aggressive Behavior		___Hallucination/Delusions

HEALTH QUESTIONAIRE

• General
- ❑ Being overweight
- ❑ Recent weight gain or weight loss
- ❑ Poor appetite
- ❑ Increased appetite
- ❑ Abnormal sensitivity to cold
- ❑ Cold sweats during the day
- ❑ Tired or worn out
- ❑ Hot or cold spells
- ❑ Abnormal sensitivity to heat
- ❑ Excessive sleeping
- ❑ Difficulty sleeping
- ❑ Lowered resistance to infection
- ❑ Flu-like or vague sick feeling
- ❑ Sweating excessively at night
- ❑ Urinating excessively
- ❑ Excessive daytime sweating
- ❑ Excessive thirst
- ❑ Other_____

• Neurological
- ❑ Pacing due to muscle restlessness
- ❑ Forgotten periods of time
- ❑ Dizziness
- ❑ Drowsiness
- ❑ Muscle spasms or tremors
- ❑ Impaired ability to remember
- ❑ "Tics"
- ❑ Numbness
- ❑ Convulsions / fits
- ❑ Slurred speech
- ❑ Speech problem (other)
- ❑ Weakness in muscles
- ❑ Other_____

• Respiratory
- ❑ Asthma, wheezing
- ❑ Cough
- ❑ Coughing up blood or sputum
- ❑ Shortness of breath
- ❑ Rapid breathing
- ❑ Repeated nose or chest colds
- ❑ Other_____

▪ Chest and Cardiovascular
- ❑ Ankle swelling
- ❑ Rapid / irregular pulse
- ❑ Breast tenderness
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Other_____

○ Head, Eye, Ear, Nose, & Throat
- ❑ Facial pain
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain or stiffness
- ❑ Frequent sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Overly sensitive to light
- ❑ See spots or shadows
- ❑ Hearing loss in both ears
- ❑ Ear ringing
- ❑ Disturbances in smell
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Sore tongue
- ❑ Other_____

▪ Gastrointestinal and Hepatic
- ❑ Trouble swallowing
- ❑ Nausea or vomiting (throwing up)
- ❑ Abdominal (stomach / belly) pain
- ❑ Anal itching
- ❑ Painful bowel movements
- ❑ Infrequent bowel movements
- ❑ Liquid bowel movements
- ❑ Loss of bowel control
- ❑ Frequent belching or gas
- ❑ Vomiting blood
- ❑ Rectal bleeding (red or black blood)
- ❑ Jaundice (yellowing of skin)
- ❑ Other_____

• Musculoskeletal
- ❑ Back pain or stiffness
- ❑ Bone pain
- ❑ Joint pain or stiffness
- ❑ Leg pain
- ❑ Muscle cramps or pain
- ❑ Other_____

▪ Skin, Hair
- ❑ Dry hair or skin
- ❑ Itchy skin or scalp
- ❑ Easy bruising
- ❑ Hair loss
- ❑ Increased perspiration
- ❑ Sun sensitivity
- ❑ Other_____

• Genitourinary
- ❑ Itchy privates or genitals
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Difficulty in starting urine
- ❑ Accidental wetting of self
- ❑ Pus or blood in urine
- ❑ Decreased sexual desire
- ❑ Other_____

○ *Females*
- ❑ No menses
- ❑ Menstrual irregularity
- ❑ Painful or heavy periods
- ❑ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- ❑ Painful menstrual periods
- ❑ Painful intercourse or sex
- ❑ Sterility infertility
- ❑ Abnormal vaginal discharge

Other_____

○ *Males*
- ❑ Impotence (weak male erection)
- ❑ Inability to ejaculate or orgasm
- ❑ Scrotal pain
- ❑ Abnormal penis discharge

Other_____

Explanation

_____
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Brief Nutritional Evaluation:

Your total health counts: If you need more room, use the bottom of the second page.

Do you take nutritional supplements or vitamins? Yes □ No □

_____

_____

_____Do you over eat? Yes _____NO _____ If so, which foods and how often?

_____

_____What type of proteins do you usually consume?

_____

Do you eat primarily organic foods? Yes ___ NO ___ _____

Do you have food allergies, restrictions, or sensitivities? _____

Do you crave any of the following?

□ Alcohol □ Bread □ Chocolate □ Dessert

□ Fish □ Fried Foods □ Salt □ Sugar

□ Meat fat □ Milk □ other _____

Which oils do you use/consume?

□ Almond oil □ Butter □ Canola □ Coconut oil
□ Cod Liver oil □ Corn oil □ Crisco □ Flaxseed oil
□ Macadamia Nut oil □ Margarine □ Mayonnaise □ Olive oil
□ Peanut oil □ Sesame oil □ Soybean oil □ Sun/Safflower
□ Vegetable oil □ Walnut oil □ other _____

Do you get noticeably irritable, light headed, or weak if you haven't eaten in a while? Yes □ No □
Do you have food allergies, restrictions, or sensitivities? Yes □ No □
If so, list KNOWN triggers:

_____

_____

_____

How many bowel movements do you have a day? _____

_____

Do you smoke: Yes □ No □ Drink alcohol: Yes □ No □
How much/when: _____
Do you drink caffeine? Yes □ No □ every morning? Yes____ NO ____
How much and when (include cola and energy drinks and tea):

_____

Activity:

Do you exercise? Yes ❑ No ❑
If so, what kind? _____

_____

_____

How often: _____
How Long? _____

Please rate the following:

Daily energy level: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Energy level after exercise: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Describe your daily energy levels: _____-
_____

_____

Daily stress level: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

General enjoyment of life: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Sleep:
Do you sleep soundly: _____
How many hours do you sleep? _____
Do you wake up w/o alarm? Yes ❑ No ❑
Do you fall asleep easily? Yes ❑ No ❑

How many times do you wake up during the night?

What else is important for us to know ABOUT YOUR NUTRITION AND WEIGHT??

PRIOR PSYCHIATRIC MEDICATIONS/SUPPLEMENTS **(Please list all medications/supplements taken alone and all medications taken in combination; including dosages, effectiveness and any side-effects.)** ***If you need more room, please attach another sheet.***

Date Taken	**Medication** ***Individual or Combinations Dosage(s) and time(s) taken per day***	**Effectiveness**	**Side-Effects/Problems**
Ex: 3/2000-12/2005	**Example** • *Ritalin 5 mg BID* • *Prozac 10mg QAM*	**Example** *Improved concentration in morning, still moody*	**Example** *Felt very unfocused in evening; hyperactive in evenings; dry mouth*

Medication History

Your medication history is a very important part of the evaluation. Before your history appointment please answer the following questions about all of the medications you have tried. We include a detailed list below of most psychiatric medication. **You can also write this information on a separate piece of paper and attach it to your paperwork prior to meeting with the Historian.** The information the doctor needs to know in order to do a through evaluation is:

1. The name of the medication
2. The mg, dose
3. The amount of tablets or mg you took in one day
4. The approximate dates taken – preferably in sequential order
5. Whether the medicine worked well, worked partially, or didn't work at all.
6. If you took any medications in combination with other medications
7. Any side effects or adverse effects from the medication
8. If any 1st degree relatives have had positive or negative responses from any of the medications below.

ADD Medications

Ritalin *methylphenidate*	Concerta *Methylphenidate*	Dexedrine Spansules *dextroamphetamine*	Desoxyn *methamphetamine HCL*
Ritalin LA *methylphenidate*	Metadate *Methylphenidate*	Dextrostat *dextroamphetamine*	Adderall / Adderall XR *4 amphetamine salts*
Ritalin SR *methylphenidate*	Focalin *Dexmethylphenidate*	Strattera *atomoxetine*	Provigil *modafinil*
Methylin *methylphenidate*	Dexedrine *Dextroamphetamine*	Cylert *pemoline*	Adipex/ Fastin Ionamin *phentermine* Vyvanse

Antidepressants

Lexapro *escitalopram*	Serzone *Nefazodone*	Norpramin *desipramine*	Surmontil *trimipramine*
Celexa *citalopram*	Effexor / Effexor XR *Venlafaxine*	Tofranil *imipramine*	Vivactil *protrityline*
Prozac *fluoxetine*	Cymbalta *duloxetine HCL*	Elavil *amitriptyline*	Ludiomil *maprotiline*
Zoloft *sertraline*	Wellbutrin / Wellbutrin SR and XL *bupropion*	Pamelor *nortriptyline*	Nardil *Phenelzine or*
Paxil / Paxil CR *paroxetine*	Remeron *Mirtazapine*	Sinequan *doxepin*	Marplan *isocarboxazid*
Luvox *fluvoxamine*	Desyrel *Trazodone*	Ascendin *amoxapine*	Parnate *tranylcypromine*
Anafranil *Clomipramine hcl*			

Anti-Anxiety Medications

Buspar *buspirone*	Ativan *Lorazepam*	Xanax *alprazolam*	Tranxene *clorazepate*
Valium *diazepam*	Klonopin *Clonazepam*	Serax *oxazepam*	Librium *chlordiazepoxide*

Mood Stabilizers

Lithium/ Eskalith *lithium carbonate*	Tegretol/ Carbatrol Tegretol XR *carbamazepeine*	Lamictal *lamotrigine*	Keppra *levetiracetam*
Depakene *valproic acid*	Neurontin *Gabapentin*	Topamax *topiramate*	Zonegran *zonisamide*
Depakote *divalproex*	Gabitril *Tigabine*	Trileptal *oxcarbazepine*	Dilantin *phenytoin*

Donnatal *phenobarbital*			

Anti-Psychotic Medications

Risperdal *risperidone*	Seroquel *Quetiapine*	Prolixin *fluphenazine*	Mellaril *molindone*
Geodon *ziprasidone HCL*	Abilify *aripiprazole*	Haldol *haloperidol*	Loxitane *loxapine*
Clozaril *clozapine*	Orap *pimozide*	Navane *thiothixene*	Moban *molindone*
Zyprexa *olanzapine*	Thorazine *chlorpromazine*	Stelazine *trifluoperazine*	Zydis *Olanzapine*
Symbyax *Olanzapine/fluoxetine hcl*			

Anti-Tic Hypertensive Medications

Cataprex *clonidine*	Tenex *guanfacine*	Inderal *propranolol*	

Movement Disorders

Cogentin *benztropine*	Benadryl *diphenhydramine*	Symmetrel *amantadine*	

Memory / Alzheimer's Medications

Aricept *donepezil HCL*	Exelon *revastigmine tartrate*	Reminyl - now Razadyne ER *galantamine HBR*	Namenda *memantine*

Sleep Aid

Ambien *zolpidem tartrate*	Lunesta *Zopiclone*	Sonata *zaleplon*	Desyrel *trazodone*
Rozerem *ramelteon*			

Weight Loss

Meridia *sibutramine hydrochloride monohydrate*	Phentermine *phenethylamine*	Fenfluramine *fenfluramine hydrochloride*	

Sexual Dysfunction

Viagra *sildenafil citrate*	Levitra *Cardenafil hcl*	Cialis *tadalafil*	

Migraine Medications

Esgic plus *butalbital / acetaminophen*	Imitrex *sumatriptan succinate*	Frova *frovatriptan succinate*	Axert *almotriptan malate*
Fiorinal	Fioricet *butalbital / acetaminophen*		

Pain Medications

Vicodin *hydrocodone*	Oxycontin *oxycodone*	Percocet *oxycodone HCI/APAP CII*	Darvon *propoxyphene*
Darvocet *propoxyphene*	Percodan *aspirin / hydrocodone*	Roxanol *(morphine sulfate)*	Avinza (*morphine sulfate – extended release*)
Fentanyl (*fentanyl citrate*)			

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

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

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are requires to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The notice is effective as of April, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services,
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accounting Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____