In order to best serve your medical needs, we ask that you complete the following packet in full before your arrival to our office. Although we do appreciate any efforts to save our environment, we ask that you print out the packet as it is shown to you; single sided and in black ink. When filling out the packet, please use black or blue ink. If you are unable to comply with the fore-mentioned requests, please arrive 40-45 minutes prior to your appointment so that you can complete your paperwork in a timely manner. We appreciate your cooperation with us.

Thank you,
Dr. Hamilton

Please Complete All Forms

NOTE: If your child is here for an evaluation, have your child do the four Self-Assessment Forms while you complete the other paperwork. Look over your child's responses and put a check mark beside any differences in perspective that you may have.

Thank you,
Dr. Hamilton

REGARDING INSURANCE PLANS

You can be helpful in preserving our ability to provide services to you under your insurance plan by making certain that you track the timely payment of your claim**. If you do not receive an Explanation of Benefits (EOB) from your insurance company within 30 days from the date of your appointment, you should call them to check on the status of your claim**. If you receive an EOB, but it shows that no payment was made to us, you need to call your insurance company.

Unpaid balances beyond 45 days will, by necessity, be charged to your credit card. Hopefully, your efforts and ours will meet with success.

Thank you,

Dr. Hamilton

TEXAS BEHAVIORAL HEALTH SYSTEMS, P.A.
7707 San Jacinto Place #300
Plano, TX 75024
(214) 227-1300

PATIENT INFORMATION

DATE: _____

Patient's Name: _____
(First) (Middle) (Last)

How do you wish to be addressed? _____ Marital Status: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____ Work Phone: (_____) _____

Birthdate: _____ SS# _____

Employer: _____ Occupation: _____

Years Employed: _____

If Patient is a Minor (under age 18), name of parent or guardians _____

Referred By: _____
(Name) (Relationship)

RESPONSIBLE PARTY

Name: _____
(First) (Middle) (Last)

Marital Status: _____ Drivers License# _____

Address: _____
(Street) (City) (State) (Zip)

How long at this address? _____ Relationship to Patient: _____

Previous address(if less than 3 years): _____
(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____

Birthdate: _____ SS# _____

Employer: _____ Years Employed: _____

Occupation: _____

SPOUSE INFORMATION (if applicable)

Name: _____
(First) (Middle) (Last)

Birthdate: _____ SS# _____

Employer: _____ Years Employed: _____

Occupation: _____

INSURANCE INFORMATION

Primary Insured Policy Holder Name: _____
(First) (Middle) (Last)

Birthdate: _____ SS# _____

Employer: _____ Group #: _____

Insurance Company Name: _____ Member Services Phone #: _____

EMERGENCY INFORMATION

In case of emergency, call: _____

Home Phone: _____ Work Phone: _____

Relationship to patient: _____

OFFICE POLICIES

TEXAS BEHAVIORAL HEALTH SYSTEMS, PA
7707 SAN JACINTO PL, STE 300, PLANO, TX 75024

Office Hours and Missed Appointments

- Regular office hours are 8a-5p on Monday and 8a-4p Tuesday thru Friday.
- We require 24 hours notice if you need to cancel your appointment. There is a **$60.00** fee for follow up appointments not cancelled within 24 hours, as well as all missed follow up appointments.
- **We do reminder calls as a courtesy ONLY**. If you do not receive a reminder call, you are still responsible for keeping your appointment.

Initial

Emergencies

- In case of emergency during regular business hours, contact the office as soon as possible.
- In case of an emergency after hours please go to the nearest emergency room. For urgent, but non emergency issues, Dr. Hamilton's cell number is provided via the answering system. RX refills are neither urgent nor emergent. A fee is assessed for all urgent calls to Dr. Hamilton.

Initial

Fees and payment

- Payment of co-pay/deductible/co-insurance is expected at the time of your appointment, unless prior arrangements have been made with the office manager.
- If you have difficulty making your payment, we will try to negotiate a payment plan with you.
- We accept cash, personal checks, MasterCard, Visa, American Express and Discover.

Initial

Insurance

- Notification of any change in your insurance must be provide ***before*** your scheduled appointment.
- If we are not provided this information in a timely manner, you will be required to pay in full.
- We are not Medicare or Medicaid providers, but accept self pay for patients with that coverage.

Initial

Prescription Refills

- Medications will be handled during regular office hours.
- We do not do refills through pharmacies; you will have to contact us directly for refills.
- Please allow 48-72 hours for completion on all refill requests.
- **Controlled substance medications will NOT be refilled early regardless of whether they are lost, stolen, misused, etc**

Initial

Fee Disclosures

The following fees are incurred when you request services in addition to your regular office visit. These fees are not paid by your insurance plan. These fees include, but are not limited to:

1.	Medical records	$25.00
2.	Returned checks	$30.00
3.	Letters to employer, school, etc	$25.00 minimum
4.	Disability paperwork	$45.00 minimum
5.	Missed / cancelled follow ups without 24 hr notice	$60.00
6.	Written prescriptions between appointments	$30.00
7.	Prior authorizations required by your insurance	$25.00

Initial

Termination of the Provider – Patient Relationship

A good relationship between a provider and his or her patient is essential for quality medical care. There are times when this relationship is no longer effective and the provider finds it necessary to ask the patient to select another provider. The following are examples of situations that could make this necessary:

1. Repeated missed appointments
2. Non payment of account
3. Not following treatment recommendations
4. Misuse / abuse of prescribed medications
5. Obtaining duplicate prescriptions from multiple prescribers
6. Abusive behavior towards office staff

Initial

I have read and understand the Office Policies, and I agree to be bound by its terms.

_____ ____/____/____
PATIENT OR RESPONSIBLE PARTY (PLEASE PRINT) DATE

_____
SIGNATURE

Texas Behavioral Health Systems, PA

Consent to Treatment / Financial Responsibility / Authorization to Release Medical Information / Assignment of Benefits

I, _____ , consent to treatment to be rendered to
(Patient or Responsible Party- please print)
me, my dependent, or other person designated below, and, in so doing, agree to be responsible for the payment of professional fees**. Such fees or supplemental charges, may include, but are not limited to patient copays, deductibles, non-insured services (ie., prescription renewals outside your appointment time, pharmacy authorizations, telephone/email communications, document preparation, hospital admission coordination), or services deemed by my insurance company or its agents as medically unnecessary**. **In the event that my insurance coverage cannot be verified prior to service delivery, I agree that I will be responsible for payment in full. I further agree that I am responsible, as a supplemental charge, for payment of the full billed amount of charges not paid by my insurance company or its agent within 45 days from the date of their receipt of a claim. (In accordance with The Texas Insurance Code and Department Rules, Articles 3.70-3C, Section 3A and 20 A.18B and in the Texas Administrative Code Sections 21.2801 - 21.815. An interest rate of 6% per annum may be imposed on amounts commencing on the 60th day from the date of service. A fee of $60.00 is charged for missed appointments, unless canceled 24 hours in advance. The office does not file out of network claims, but will provide a statement for you to file. Full payment for those covered by a non-network plan is due at the time of service.**

I authorize Texas Behavioral Health Systems, PA, or those acting in its behalf, to provide information regarding my medical, psychiatric, or substance abuse treatment to my insurance company or its agents for the purpose of determining benefit eligibility, for certification of care, or for claims processing purposes. This authorization is valid until revoked in writing by me or by my legal guardian. By signing this document, I represent to Texas Behavioral Health Systems, PA and its employees that I have in force, and am entitled to, the benefits of any applicable health plan which I have presented. I hold Texas Behavioral Health Systems, PA and its employees harmless for any damages resultant from denial of payment, lack of certification, lack of payment for medically-recommended treatment, or failure on the part of my insurance company or its agents to maintain confidentiality in regard to my condition.

I assign any insurance benefits to Texas Behavioral Health Systems, PA.

_____ _____
Patient (Recipient of Care) (Please Print) Date

_____
Signature

_____ _____
Responsible Party (if other than patient) (Please Print) Date

Signature of Responsible Party_____

We require a credit or debit card for services not covered by insurance:

*Unpaid balances for services rendered **including those listed above**, may be charged to the following Credit or Debit Card* [ ] MC [ ] VISA [ ] AMEX [ ] DISC

Card No. _____Exp. Date _____

Cardholder Name_____
(Please Print)

Cardholder Signature_____

TEXAS BEHAVIORAL HEALTH SYSTEMS, PA

The "Off-Label" Use of Medication

There are times we prescribe medications, which are not labeled specifically for usage in a particular condition. This is because the U.S. Food and Drug Administration (FDA) indications for any given drug is based on their review and acceptance of studies which have been submitted to them for usage in specific diagnoses rather than symptoms. Medications treat symptoms, not diagnoses. There are times when a medication is found to be useful for one symptom or disorder, but clinical experience reveals that it is also useful in other areas. When this occurs, pharmaceutical companies occasionally conduct new medication trials and seek additional FDA approval. This pursuit of "indication for use" from the FDA is a business decision that many pharmaceutical companies decide **not** to make because of the extremely high cost of medication research and testing and the fact that the medication has already received approval for prescribing. Most pharmaceutical companies decide to rely upon doctors learning of these additional uses through articles published in medical journals, professional educational forums, and collegial networking. The usage of medications without FDA indication for a certain condition is referred to as "off-label" use.

There are special circumstances in regard to children. Most of all the medications that child psychiatrists, pediatric neurologists, and pediatricians use are used "off-label." Considering the complications of testing medication on children (a child cannot sign a waiver stating that he / she understands the risks of being involved in medication research), there are very few medications that are "approved" by the FDA for children. An example of an "off-label" use of medication with which you might be acquainted would be amoxicillin. Amoxicillin was widely used with adults and its success in treating infection led to its almost immediate embrace by pediatricians. Because it was already being used with children the manufacturer never sought an approved indication and, to this day, amoxicillin is not "approved" by the FDA for use in children although its use is nearly universal.

It is important for you to understand that the medications we recommend and prescribe have been shown to be helpful in the hands of many physicians. We want you to be informed of the possible benefits and side effects of these medications and encourage you to read all you can and ask any questions that you have. We are committed to pursuing a plan of action which leads to the lowest dosage of medication and the smallest number of medications used, consistent with optimal level of wellness. Our goal for the medication we prescribe is to treat and reverse as many symptoms as possible while pursuing additional non-medication strategies. Counseling and lifestyle changes can further add to the recovery from the presenting symptoms in the short-run. This will also enable the medication itself to work more effectively and may, in the long run, possibly negate the need for some or all of the medications originally prescribed.

Please feel free to express any concerns or questions you may have during your visit. We endeavor to provide you all the information we can in order to help you make informed decisions concerning you or your child’s care.

_____ _____

SIGNATURE OF PATIENT (If 16 or older) Date

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN Date

Texas Behavioral Health Systems, PA

CONSENT TO EVALUATE and/or TREAT MINOR

(Must be completed in regard to anyone under 21 years of age)

Note: Step parent may not grant permission to evaluate or treat.
In situations of divorce, a copy of your divorce decree section pertaining to custody and consent to medical care must be provided. If you are not the parent, but are legal guardian, you must provide court documents establishing guardianship.

I, _____ , as the

( ) Parent

( ) Custodial Parent (in situations of divorce)

( ) Legal Guardian

attest to have legal authority to grant consent and permission to Paul M. Hamilton, MD and associated clinicians (dba, Texas Behavioral Health Systems, PA) for psychiatric evaluation and treatment of:

_____ ____/____/_____
(Print Name of Minor) Date of Birth

My name is:

_____ _____
(Print) Signature

_____/_____/_____
Date

_____
Witness

TEXAS BEHAVIORAL HEALTH SYSTEMS, P.A.
7707 San Jacinto Place #300 Plano, TX 75024
Phone: 214-227-1300 Fax: 214-227-1333

Paul Hamilton, M.D.
Certified by The American Board of Psychiatry & Neurology

Karah Brashier RN, C-PMHNP
Dasha Joseph RN, C-PMHNP
Sophie Krchmar RN, C-PMHNP
Matthew Vickers RN, C-PMHNP
Linda Fortmeier DNP, FNP-BC

COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN

Communication of your treatment plan with your Primary Care Physician (PCP) is important to your overall health care. In addition, your insurance company monitors records to insure that there is evidence of communication to the Primary Care Physician. Please sign the necessary Authorization to Release this information to your primary care physician.

I, ____, authorize Texas Behavioral Health Systems, PA to release medical information, including that pertaining to (select one below)
( ) MY
( ) My MINOR CHILD'S ____mental health and substance
Print Full Name of Minor

abuse, to my Primary Care Physician. This authorization is effective until revoked by me in writing.

My Primary Care Physician is ____

Address of Primary Care Physician ____
____

Phone Number: _______________________________________ Fax ____

____ ______ / _____/ __________________
Signature Date
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
(Remainder to be completed by our Staff) [ ] Mailed or Faxed to PCP [ ] Logged into Database

To PCP : your patient ____was seen by

us on _________ / ______________/____________________ .

Treatment prescribed: Medication(s) ____

____

Purpose: ____

Referral to Therapy: ____

Other: ____

Recommended Lab Monitoring:____

____

Texas Behavioral Health System's Provider

☐ Paul M. Hamilton, MD
☐ Karah Brashier, RN, MSN
☐ Matthew Vickers, RN, MSN
☐ Linda Fortmeier, DNP
☐ Dasha Joseph, RN, MSN
☐ Sophie Krchmar, RN, MSN

Notice to Recipient: This information is protected by Federal (42CFR, Part 2) and State laws regarding confidentiality. These statutes prohibit you from disclosing this information to anyone else. A general authorization is not sufficient in regards to mental health and / or substance abuse information.

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and Acupuncturists, may be reported for investigation at the following address:

Texas State Board of Medical Examiners
Attention: Investigations
333 Guadalupe , Tower 3, Suite 610
P.O. Box 2018,MC-2018
Austin, TX 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

AVISO SOBRE QUEJAS

Se pueden presentar quejas acerca de medicos, asi tambien como de otras Personas authorizadas y registered por la Junta de Examinadores Medicos del Estado de Texas (Texas State Board of Medical Examiners), incluyendo a ayudantes medicos y Acupunturistas, para su investigacion, en la sanguine direccion:

Texas State Board of Medical Examiners
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Tx 78768-2018

Se puede obtener ayuda para presentar una queja llamando al sanguine numero Telephonic:

1-800-201-9353

_____

PATIENT SIGNATURE

TEXAS BEHAVIORAL HEALTH SYSTEMS, P.A.

HEALTH INFORMATION PRACTICES

Effective 04/14/2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

UNDERSTAND YOUR HEALTH RECORD INFORMATION

This notice describes the practice of Texas Behavioral Health Systems, P.A. (hereinafter "TBHS") and that of its physician with respect to your protected health information created while you are a patient at TBHS. TBHS physician and personnel authorized to have access to your medical chart are subject to this notice. In addition, we create a record of the care and services you receive at TBHS. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at TBHS. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of TBHS, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, healthcare operations and as to disclosures permitted to persons, including family members involved with your care as provided by law. However, we are not required by law to agree to a requested restriction.
- Obtain a paper copy of this notice of information practices.
- Inspect and request a copy of your health record as provided by law.
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record.
- Obtain an accounting of disclosures of your health information as provided by law.
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests.
- Revoke your authorization disclose health information except to the extent that action has already be taken.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of this notice to the Practice Administrator at TBHS.

Our Responsibilities:

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures.
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change, we are not required to notify you, but we will have the revised notice available at your request.
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law

The following categories describe different ways that we use and disclose medication information. For each category, we will explain what we mean & give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment. For example: We may disclose medical information about you to your primary care physician or subsequent health care providers with copies of various reports to assist in treating you once you are discharged from TBHS.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that may identify you, as well as your diagnosis.

Business Associates: There are some services provided in our organization through agreements with business associates. Examples including: copying services, accounting services, computer services, etc. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communications for treatment and health care operations: 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. We may leave appointment reminders on your answering machine or voicemail at home or work, or with a person answering the telephone.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law. For example: You may apply for Disability Insurance Benefits or Life Insurance. Your insurance carrier may request medical information to review your application.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and/or law enforcement purposes. We will disclose medical information about you when required or allowed to do so by federal, state, or local law.

I acknowledge that I have reviewed and accept the TBHS policy regarding Health Information Practices.

_____ _____

Patient/Guardian Signature Date

Authorization for Disclosure of Protected Health Information

I , _____ , authorize Paul M. Hamilton, MD
(Print name)
and / or his designated authorized staff to disclose and provide information including copies of the following
protected health information regarding (Check One)

( ) Myself

( ) My minor child over whom I am parent or guardian _____
Name of minor child

( ) My minor child of whom I am the Managing Conservator _____
Name of minor child

( ) Other party of whom I have legal guardianship. (Copy of Court Documents Required).
_____
Name of other party

to the following party:

☐ Therapist or Counselor: _____

☐ Other: _____

Protected medical information I am authorizing for disclosure is: (CHECK ALL THAT APPLY).

____Psychiatric Evaluation ____ Progress Notes ____ Medication Records ____ Billing Records

____Treatment Plans or Summaries ____Hospital Records Created by Dr. Hamilton ____Mental Health Records

____Substance Abuse Records ___ Lab Tests / Study Results ___ Other (Specify)_____

Purpose of Disclosure: ( ) Request of authorized individual patient
( ) Continuation of care by another clinician
( ) In support of application for insurance
( ) Security Investigation for employment.
( ) Insurance review of my claim for services
( ) For review in a legal matter
( ) To assist in educational and / or employment accommodations

This authorization will be in force and effect until revoked in writing by me via Certified Mail to Paul M. Hamilton, MD, PO Box 2396, Frisco, Texas 75034.
I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient who may not be bound to the same confidentiality standards as my physician, and, therefore, such disclosed information may no longer be protected by federal or state law. I hold Dr. Hamilton harmless for any adverse consequence derived
directly or indirectly from his authorized release of protected health information.

_____ _____
Signature of Patient or Authorized Individual Date

_____ (Print Name)

Depression Scale for Children (CES-DC)

INSTRUCTIONS: Below is a list of the ways you might have felt or acted. Check how *much* you have done so in the past few weeks.

Over the past few weeks	Not at All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	_____	_____	_____	_____
2. I did not feel like eating, I wasn't hungry.	_____	_____	_____	_____
3. I wasn't able to feel happy.	_____	_____	_____	_____
4. I felt like I was just as good as other kids. *	_____	_____	_____	_____
5. I felt like I couldn't pay attention to what I was doing.	_____	_____	_____	_____
Over the past few weeks				
6. I felt down and unhappy.	_____	_____	_____	_____
7. I felt like I was too tired to do things.	_____	_____	_____	_____
8. I felt like something good was going to happen. *	_____	_____	_____	_____
9. I felt like things I did before didn't work out right.	_____	_____	_____	_____
10. I felt scared.	_____	_____	_____	_____
Over the past few weeks				
11. I didn't sleep as well as I usually sleep.	_____	_____	_____	_____
12. I was happy.	_____	_____	_____	_____
13. I was more quiet than usual.	_____	_____	_____	_____
14. I felt lonely, like I didn't have friends.	_____	_____	_____	_____
15. I felt like kids I know were not friendly or that they did not want to be with me.	_____	_____	_____	_____
Over the past few weeks				
16. I had a good time.	_____	_____	_____	_____
17. I felt like crying.	_____	_____	_____	_____
18. I felt sad.	_____	_____	_____	_____
19. I felt people don't like me.	_____	_____	_____	_____
20. It was hard to get started doing things.	_____	_____	_____	_____

0 = Not at All
1= A little
2=Some
3= A Lot

(For 4, 8, 12, 16)
3=Not at All
2=A Little
1= Some
0= A Lot

Score: _____ 15 or > _____

PATIENT NAME: _____

DATE: _____

Self-Report Scale (ASRS) Symptom Checklist

Patient Name		Today's Date	

	Never	Rarely	Sometimes	Often	Very Often	Score
1. How often do you make careless mistakes when you have to work on a boring or difficult project?	0	1	2	3	4	
2. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	0	1	2	3	4	
3. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	0	1	2	3	4	
4. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	0	1	2	3	4	
5. How often do you have difficulty getting things in order when you have to do a task that requires organization?	0	1	2	3	4	
6. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	0	1	2	3	4	
7. How often do you misplace or have difficulty finding things at home or at work?	0	1	2	3	4	
8. How often are you distracted by activity or noise around you?	0	1	2	3	4	
9. How often do you have problems remembering appointments or obligations?	0	1	2	3	4	
					Part A – Total	
10. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	0	1	2	3	4	
11. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	0	1	2	3	4	
12. How often do you feel restless or fidgety?	0	1	2	3	4	
13. How often do you have difficulty unwinding and relaxing when you have time to yourself?	0	1	2	3	4	
14. How often do you feel overly active and compelled to do things, like you were driven by a motor?	0	1	2	3	4	
15. How often do you find yourself talking too much when you are in social situations?	0	1	2	3	4	
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	0	1	2	3	4	
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	0	1	2	3	4	
18. How often do you interrupt others when they are busy?	0	1	2	3	4	
					Part B – Total	

Beck Anxiety Self Rating Scale

Your name: _____

Date: _____

For each item, 1 through 21, check the severity, 0, 1, 2, or 3, which best describes your experience today or in recent weeks

1. Numbness and tingling
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

2. Feeling hot
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

3. Wobbliness in legs
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

4. Unable to relax
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

5. Fear of the worst happening
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

6. Dizzy or lightheaded
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

7. Heart pounding or racing
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

8. Unsteady
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

9. Terrified
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it

10. Nervous
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it

11. Feelings of choking
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it

12. Hands Trembling
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it

13. Shaky
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it

14. Fear of losing control
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

15. Difficulty breathing
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

16. Fear of dying
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

17. Scared
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

18. Indigestion or discomfort in abdomen
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

19. Faint
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

20. Face flushed
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

21. Sweating (not due to heat)
- ☐0 Not at all
- ☐1 Mildly – It did not bother me much
- ☐2 Moderately – It was very unpleasant but I could stand it
- ☐3 Severely – I could barely stand it

Scoring Instructions:

0 – 7	MINIMAL level of anxiety symptoms reported
0 – 15	MILD level of anxiety symptoms reported
16 – 25	MODERATE level of anxiety symptoms reported
26 – 63	SEVERE level of anxiety symptoms reported

A high score does not necessarily indicate that a person has an anxiety disorder, but indicates that a more detailed and individualized evaluation should be performed.

THE MOOD DISORDER QUESTIONNAIRE

Patient name:_____ Date:_____

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

	YES	NO
1. Since your last visit, was there a 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?	○	○

Texas Behavioral Health Systems, PA

Initial Psychiatric Assessment

THIS SECTION TO BE COMPLETE BY PATIENT OR PARENT (IF PATIENT IS A MINOR)

_____ _____ _____/_____/_____

PATIENT NAME (PRINT) **AGE** **TODAY'S DATE**

_____ _____

PERSON COMPLETING THIS FORM (PRINT) **RELATIONSHIP TO PATIENT**

_____

THERAPIST OR COUNSELOR'S NAME, ADDRESS, PHONE NUMBER

_____

PRIMARY CARE PHYSICIAN'S NAME, ADDRESS, PHONE NUMBER

REASON FOR EVALUATION: (IF PRESENT, RATE 0-10. 0 IS ABSENT, 10 IS EXTREME)

____ANXIETY____PANIC____DEPRESSION____MOOD SWINGS____SUICIDAL THOUGHTS
____SUICIDE ATTEMPT____AGITATION____AGGRESSION/VIOLENCE
____BEHAVIORAL PROBLEM____IMPULSIVITY____SCHOOL PROBLEMS
____RELATIONSHIP PROBLEMS____BIZZARE THOUGHTS____CONCENTRATION/FOCUS
____TASK COMPLETION____UNUSUAL OR STRANGE BEHAVIOR
____SLEEP PROBLEM____DRUG/ALCOHOL

BRIEFLY DESCRIBE PROBLEM:_____

_____

_____

_____

_____

PREVIOUS TREATMENT? ____THERAPY? WITH WHOM?_____

EVER HOSPITALIZED? ____ HOW MANY TIMES? ____ WHEN? _____

WHERE? _____

ON MEDICATION NOW? (NAME, DOSAGE, HOW LONG TAKEN, RESPONSE?)

_____

_____

_____

HERBALS OR SUPPLEMENTS? _____

MEDICATIONS USED IN THE PAST? ____Y ____N
NAME OF MEDICATION(S), DOSAGE(S), RESPONSE TO EACH_____

_____

MEDICATION ALLERGIES? _____

ANY MEDICAL PROBLEMS? _____

_____

HEIGHT _____ FT. _____ IN. WEIGHT _____ LBS.
DO YOU HAVE EXCESSIVE THIRST?____EXCESSIVE URINATION? ____

SUBSTANCE USE? (LIST ANY SUBSTANCES USED, PAST OR PRESENT, LAST USE)

_____

_____

_____

FAMILY HISTORY: (ANY BLOOD RELATIVES YOU BELIEVE HAVE HAD SYMPTOMS OF A PSYCHIATRIC OR SUBSTANCE ABUSE PROBLEM)

_____

_____

_____

_____

_____

LIVING SITUATION: (WHO LIVES AT HOME?) _____

_____

_____

EDUCATION LEVEL:
CURRENT GRADE LEVEL (MINORS) _____

ACADEMIC PERFORMANCE ____ BELOW AVERAGE ____ AVERAGE ____ ABOVE AVERAGE

EDUCATION COMPLETED (ADULTS):

____ HIGH SCHOOL ____ GED ____ HOURS COLLEGE
____ COLLEGE GRADUATE ____ POST GRADUATE DEGREE

EMPLOYMENT _____