Welcome back to Mid Cities Psychiatry!

Our scheduled appointment form takes approximately 5-10 minutes to complete. Completing this form is essential for us to provide the care you need and to schedule your appointment. If the form is not completed, we may be unable to assist you. Please note, in case of an emergency, immediately visit your nearest emergency room or call 911.

Demographics

Appointment Date: _____ Appointment Time: _____

Full Name: _____ Date of Birth: _____

Height _____Weight_____

Please only fill the information on the following line if you are able to:

Temperature (Fahrenheit)_____ BP_____ Pulse_____

Reason for visit: _____

Please only fill the following information if you have had a change in any of your information since your last visit:

Email:_____ Home Phone Number: _____

Cell Phone Number:_____ Work Phone Number:_____

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

Please provide a copy of your ID to the front desk if you have a new one for them to scan into your chart when you hand them this form.

Insurance Information

Please only fill the following information if you have had a change in any of your information since your last visit:

Will you pay for services as a self-pay patient? ☐ Yes ☐ No ***If Yes, there is no need to fill out the rest of this section.***

Primary Insurance Name: _____

Secondary Insurance Name: _____

Tertiary Insurance Name: _____

Please provide all copies of your insurance cards to the front desk for them to scan into your chart when you hand them this form.

Are you a Medicare Patient? ☐ Yes☐ No ***If Yes, then you must fill out the ABN form below, if no then please skip it.***

Please provide a copy of your insurance ID to the front desk if you have a new one for them to scan into your chart when you hand them this form.

Please Choose Your Provider

☐ Bailey Hofer, MSC, PA-C ☐ Haylee Hughes, MPAS, PA-C ☐ Heather Spengler, MSC.PMHNP-BC

☐ Jackquelyn D. Williams, DNP, APRN, FNP-C, PMHNP-BC ☐ Jenny Bui, MMS, PA-C

☐ Phillip Lafontaine, MPAS, PA-C ☐ Dr. Ramya Seeni, MD ☐ Rebecca Perthel, MMSC, PA-C

☐ Dr. Seema Kazi, MD ☐ Dr. Triet M. La, DO, MS ☐ Wing Kei Chiu, MPAS, PA-C

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Use the following scale to choose the most appropriate number for each situation:

#s	Questions	frequency			
		Not At All	Several Days	More Than Half of 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
	Columns Totals				
	Total Score				

If you checked off any of the 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	

If you scored a 10 or above on your PHQ9, Mid Cities Psychiatry provides various treatment alternatives besides medicine for Depression, Anxiety and more symptoms. These include:

1. TMS (Transcranial Magnetic Stimulation) is a non-invasive therapy alternative for treatment-resistant depression.
2. SPRAVATO™ (Esketamine) Nasal Spray used in conjunction with oral antidepressants for treatment-resistant depression.
3. Ketamine is an innovative approach showing promising results quickly alleviating symptoms of depression and anxiety.

Are you interested in learning more about any of these treatment options? Please indicate your preference:

☐ TMS Therapy ☐ SPRAVATO™ ☐ Ketamine ☐ I Would Like To Know Best Treatment Option ☐ None

Name of Patient:_____ Date of Birth: _____ Signature of Patient: _____
Signature of Responsible Party (if the Patient is a minor or requires a Representative): _____ Date: _____

CSSRS Screening

If you marked 1, 2, or 3 on question #9 of the PHQ-9, please complete the CSSRS screening. Otherwise, skip this section please.

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***	**YES**	**NO**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
If YES, ask: ***Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

Homicidal Ideations

Are you having Homicidal Ideations? ☐ Yes ☐ Yes and I am afraid I may act on them ☐ No

If you answered Yes or Yes and I am afraid I may act on them: Do You Have a Plan? ☐ Yes ☐ No

If you answered Yes: What is your plan? _____

Possession of Gun

Do you own a gun? ☐ Yes ☐ No

Generalized Anxiety Disorder Questionnaire (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

#	Questions	Frequency			
		Not At All	Several Days	More Than Half of the Days	Nearly Every Day
1	Feeling nervous, anxious or on edge?	0	1	2	3
2	Not being able to stop or control worrying?	0	1	2	3
3	Worrying too much about different things?	0	1	2	3
4	Trouble relaxing?	0	1	2	3
5	Being so restless that it is hard to sit still?	0	1	2	3
6	Becoming easily annoyed or irritable?	0	1	2	3
7	Feeling afraid as if something awful might happen?	0	1	2	3
	Columns Totals				
	Total Score				

If you checked off any of the 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	

Anxiety level based on score is	No Anxiety (0-4)	Mild (5-9)	Moderate (10-14)	Severe (15-21)

Current Providers

Primary Care Provider

Have you already told us about your Primary Care Physician? ☐ Yes ☐ No ***If Yes, then please fill questions 3 and 4, if No then please proceed to question 1.***

1. Do you have a Primary Care Physician? ☐ Yes ☐ No ***If yes, then please questions 2-4 , if No then please skip to question 5 of this section.***
2. Who is your Primary Care Provider? _____
3. When was your last visit to your Primary Care Provider? _____
4. When was your last Health & Physical? _____
5. Do you need help finding a Primary Care Provider? ☐ Yes ☐ No

Psychotherapist

Have you already told us about your Psychotherapist? ☐ Yes ☐ No ***If Yes, then please fill questions 3, if No then please proceed to question 1.***

1. Do you have a Psychotherapist? ☐ Yes ☐ No ***If yes, then please fill questions 2 and 3 , if No then please skip to question 4 of this section.***
2. Who is your Psychotherapist? _____
3. When was your last visit to your Psychotherapist? _____
4. Would you be interested in exploring Psychotherapy services at Mid Cities Psychiatry? ☐ Yes ☐ No

Psychologist

Have you already told us about your Psychologist? ☐ Yes ☐ No ***If yes, then please fill questions 3, if No then please proceed to question 1.***

1. Do you have a Psychologist? ☐ Yes ☐ No ***If yes, then please fill questions 2 and 3, if No then please skip to question 4 of this section.***
2. Who is your Psychologist? _____
3. When was your last visit to your Psychologist? _____
4. Would you be interested in exploring Psychology services at Mid Cities Psychiatry? ☐ Yes ☐ No

Current Medical State

Stressors

Do you have Current Stressors? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Symptoms

Do you have Current Symptoms? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Physical Pain

Have you had physical pain in the last week? ☐ Yes ☐ No ***If yes, then please fill question 1, if No then please skip this section.***

1. On a scale of 0 to 10, how bad was your pain (0 = no pain, 10 = severe pain)? _____

Do you have physical pain now? ☐ Yes ☐ No ***If yes, then please fill out the next question, if No then please skip the next question.***

1. On a scale of 0 to 10, how bad is your pain (0 = no pain, 10 = severe pain)? _____

Nutritional Status

Do you have food allergies? ☐ Yes ☐ No

Have you had weight loss or gain of 10 pounds or more in the last 3 months? ☐ Yes ☐ No

Have you had a decrease in food intake and/or appetite? ☐ Yes ☐ No

Do you have dental problems? ☐ Yes ☐ No

Do you have eating habits or behaviors that may be indicators of an eating disorder, such as binging or inducing vomiting? ☐ Yes ☐ No

Current Psychiatric Health

Progress

How have you felt since your previous visit? ☐ Worse ☐ The Same ☐ Better

Please Explain: _____

_____

_____

Trauma, Abuse, Neglect, and Exploitation

Have you experienced any trauma, abuse, neglect, or exploitation? ☐ Yes ☐ No ***If yes, then please fill out all questions, if No then please skip this section.***

What have you experienced**?** ☐ Trauma ☐ Abuse ☐ Neglect ☐ Exploitation

Please Explain: _____

_____

_____

Medication History

Psychiatric Medications

Have you had changes in your Psychiatric Medications? ☐ Yes ☐ No ***If yes, then please fill question 1-5, if No then please skip this section.***

1. What were the names of the medication(s)? _____

   _____

   _____

2. What were the doses of the medication(s)? _____

   _____

   _____

3. When did you start taking the medication(s)? _____

   _____

   _____

4. When did you stop taking the medication(s)? _____

   _____

   _____

5. What side effects did you experience from the medication(s)? _____

   _____

   _____

Non-Psychiatric Medications

Have you had changes in your Non-Psychiatric Medications? ☐ Yes ☐ No ***If yes, then please fill question 1-5, if No then please skip this section.***

1. What were the names of the medication(s)? _____
   _____
   _____
2. What were the doses of the medication(s)? _____
   _____
   _____
3. When did you start taking the medication(s)? _____
   _____
   _____
4. When did you stop taking the medication(s)? _____
   _____
   _____
5. What side effects did you experience from the medication(s)? _____
   _____
   _____

Mid Cities Psychiatry