EVANSVILLE PSYCHIATRIC ASSOCIATES REGISTRATION AND CONSENT

Patient Name: First: _____ Middle: _____ Last: _____

Preferred Name: _____ DOB: _____ Social Security #_____

Gender: ○Male ○Female ○Transgender Male/Trans man ○Transgender Female/Trans woman

Address: _____ City: _____ ZIP: _____

Home# _____ Cell# _____ Work# _____

Employer: _____ Emp Phone#_____

Patient's email address: _____

Preferred Local Pharmacy/Street address: (Choose one)_____

We ask to communicate with your Primary Care Provider to improve care/avoid drug interactions:

Doctor/NP/PA: _____ Phone: _____

Primary Insurance:
Subscriber Name: _____ Employer:_____
DOB: _____ SSN: _____ Email: _____
Address: _____ City: _____ Zip: _____
Insurance Company: _____ Ins Phone# _____
Subscriber ID # _____ Group #_____

Secondary Insurance:
Subscriber Name: _____ Employer:_____
DOB: _____ SSN: _____ Email: _____
Address: _____ City: _____ Zip: _____
Insurance Company: _____ Ins Phone# _____
Subscriber ID # _____ Group #_____

Emergency Contact(s): (If the patient is under 18, please complete this section with parent names)

Name: _____ Relationship: _____ Phone: _____
DOB :_____ SSN: _____ Email: _____
Address: _____ City: _____ Zip: _____

Name: _____ Relationship: _____ Phone: _____
DOB: _____ SSN: _____ Email: _____
Address: _____ City: _____ Zip: _____

CONSENT TO TREATMENT AND OFFICE POLICY REVIEW

EVANSVILLE PSYCHIATRIC ASSOCIATES, LLC is an independently owned clinic, providing outpatient mental health services through our professional staff of Board Certified Psychiatrists, Psychiatric Nurse Practitioners, Clinical Psychologists, and Professional Counselors, Licensed Clinical Social Workers, and Licensed Mental Health Counselors. All providers are Independent Contractors and each clinician is individually contracted with their specific insurance companies, EAP (Employee Assistance Programs), and treatment panels.

Important: Please initial where indicated.

_____**Check in/Arrive Early, PAYMENT EXPECTED AT TIME OF SERVICE:** Check in 15 minutes before scheduled in-office appointments, or 5 minutes before at-home telehealth appointments. Use the Patient Portal to verify your demographics, insurance, and pharmacy information. For in-office visits, please have your Driver's License/state ID and insurance card(s). Copays/deductibles are due at time of service *unless previously arranged with our billing department*. Payments may be made via the Patient Portal or by phone. We accept cash, check, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. Unpaid copays may incur an additional fee. Receipts are available through your Patient Portal.

_____**CREDIT CARD ON FILE:** In order to establish or continue care with us, and as a convenience, patients are asked to keep a credit card on file with our office. When you sign a credit card authorization, any unpaid copays or fees will be processed for you. Should you become delinquent on your account and/or be sent to collections, a new card must be placed on file before you can schedule further appointments. Paper statements are not mailed, regardless of account status. Statements are sent by email. If we do not have a current card on file, missed copay/coinsurance fees and statement fees will apply to all balances.

_____**BILLS:** Statements are exclusively emailed and may be paid online, by phone, by mail, or in office. Payment is required upon receipt of this statement. Charges that are unpaid after 90 days may be sent to collections without additional notice. Collection fees are set by state law and incur an additional 33% fee that is the patient's responsibility. Returned checks incur a non-sufficient fund (NSF) fee per Indiana allowance. If we are required to send a printed statement, a statement fee will be added (see front desk for current fee).

_____**NON-COVERED SERVICES:** Services not covered by insurance are the patient's responsibility. This includes insurance fees if we are out of network, whether primary or secondary insurance. Other examples include letters, forms, mailings and certain *types* of appointments. We do not traditionally allow appointments with two different providers on the same day, as such situations may not be covered by insurance and could cause the full cost of the appointment(s) to fall on the patient. It is your responsibility to know how your insurance covers your services. Your insurance policy is a contract between you and your insurance company. Likewise, our relationship is with you as a patient and *not* the insurance company. Costs for non-covered requests vary depending on the time and personnel involved. Estimated costs are posted at the front desk.

_____**COVID-19 CRISIS:** If you are experiencing symptoms or have been exposed to anyone with symptoms of COVID-19, message or call us to convert your appointment to telehealth or phone, or to reschedule as necessary. If your clinician has symptoms or is exposed, our office will contact you with the same courtesy.

PATIENT PORTAL: Your Patient Portal is set up through the email address that you have provided to us and is accessed through our website. Your email address is your username, unless the patient is a minor; if the identified patient is a minor, the username for the child's account is your email with a "+childsname" modification inserted between the user name and the domain. For example: youremail+childsname@domain.com. Emails will come directly to your email address.

Your Patient Portal is HIPAA compliant and secure, and can be used to pay your bill, request refills, make/change/cancel appointments, and send messages to your provider. You can send a message 24/7 and we will respond on the next business day and when we hear back from your provider.

If you are having trouble with your password, contact the office to send you a password reset link. If you do not have online access and need to call, leave the nurses only *one* message. Leave all the information for your request, as our voicemail will not cut your message off. Additional messages will delay us in helping you.

NOTIFY US IMMEDIATELY OF INSURANCE CHANGES: Notify us immediately of insurance changes or Medicaid enrollment. New policies require a verification of benefits, and may need pre-authorization or a change of provider. We do not bill traditional Medicaid, and those fees could become your responsibility. If you add Medicaid as a secondary insurance, the nurses may be unable to complete medication prior authorizations for you if your prescriptions are billed through Medicaid.

COURTEOUS WAITING ROOM BEHAVIOR is expected. Do not bring additional children or extraneous family members or friends to your appointment. Guest Wi-Fi is available. Do not talk on your phone, play audio aloud, or use a camera in our waiting room. You may be asked to wait in your car if the waiting area does not allow for social distancing. If you cannot agree to these requests or are otherwise disruptive, you will be asked to leave and refunds will not be issued.

FOLLOW-UP APPOINTMENTS: At the end of your appointment, your provider will discuss a time frame for your follow-up appointment. Schedule your follow-up at check-out. If your appointment is by telehealth, please send a portal message after your appointment to request your follow-up and tell us the dates and times that would work best for you. If you are a therapy client and need a specific weekday and/or time for your appointments, you may schedule up to four future appointments with your therapist—then, after each appointment, you may schedule an additional appointment on your provider's schedule. If you no-show/late cancel, all future appointments are subject to cancellation.

If you are seeing a provider who prescribes medications for you, you must have a follow-up appointment scheduled in order for the nurses to be authorized to handle refills, prior authorizations, and any paperwork you need for FMLA, ESAs, life insurance forms, etc.

REFILLS: Check with your pharmacy *first* to make sure if you have refills or a prescription *on hold/ on file*. If you submit refill requests by entering prescription numbers, make sure you are using *your most current bottle*. If you still need a refill, send a Patient Portal message. Make sure to request all Schedule II and III prescriptions 7 days in advance to give the prescriber adequate time to submit your prescription. This also allows your pharmacy time to stock your medication.

Patient Portal requests are the preferred method for refills. If the prescription is a Schedule II medication that does not allow for refills, you may opt to enroll in the Prescription Monitoring Program (PMP). There is a fee for this service, per person, renewed annually, and non-refundable.

Current rates are posted at our desk and website. Due to federal law, you will still need to request that your pharmacy actually fills the prescription, but we ensure your prescription is at your pharmacy in time. You must schedule/attend all requested appointments.

If your pharmacy has had issues having your medication in stock, check with them that they have enough to fill your prescription. Re-prescribing adds more time to complete your request.

Patients who are prescribed Schedule II + medications are subject to random pill counts or Urine Drug Screens as part of the requirements of the Controlled Substances Act. If you are selected, then you must comply with the pill count on the same business day or submit a urine sample to a lab within 24 hours. You must keep your contact information current and make your voicemail works.

CANCELLATIONS: Use the Patient Portal to notify us of cancellations. If you need to cancel an appointment, please give us 48 hours' notice. Appointments that are missed or canceled in less than 24 hours are subject to a missed appointment fee. Fees are posted at the front desk and website. If you have 2 or more missed appointments within 6 months, you are subject to having your case closed without additional warning. Arriving late for an appointment may be considered a missed appointment. Telehealth appointments follow these same guidelines. If you are forced to miss an appointment or you arrive late due to a verified emergency, please write or speak to the office staff. Each provider has a specific policy in regards to missed appointments, rescheduling, and fees, and will require payment and review by management before rescheduling.

If there is an illness or a transportation problem, or you are in a quarantine situation, please notify us and we will do our best to arrange a telehealth appointment for you. If your provider has a mobility or quarantine issue, they may also request to complete your appointment by telehealth. Some insurance differs on reimbursing telehealth appointments, but your financial responsibility remains the same as it would with an in-office appointment.

Office closings due to inclement weather, electrical outage, or natural disaster will be posted to our website and Facebook page www.facebook.com/evansvillepsychiatric, or on Twitter @EvvPsychiatric. If we are able to arrange telehealth visits on those days, you will be contacted through the Patient Portal. Keep your contact information current with the office so we can reach you for emergencies.

PRIVACY: Our office complies with all HIPAA privacy regulations. If you wish to have a copy of these regulations, it is located on our website. Your providers at Evansville Psychiatric Associates may communicate with each other for coordination of care. Your health information remains confidential to our office with only a few exceptions: (1) Your insurance company may request records for payment, to approve a medication, or as part of an audit (2) Court subpoenas (3) Child or elder abuse as mandated by state law.

Outside of these very specific situations, information and records are released only with your authorization. Authorizations may be signed for a single release, a specific time period, or for the duration of your active patient status in our clinic. If you wish to allow someone to be able to speak on your behalf, request appointments, or handle billing, make sure we have a completed release that includes their name, their contact information, and the timeframe for the release.

TELEHEALTH APPOINTMENTS: We use a HIPAA compliant platform for telehealth.. We need your accurate email address and current cell number. Invitations for your visit are sent early on the day of

your appointment.. Please call us immediately if you do not see your email. Make sure to check all email folders and spam. Your telehealth room name changes with each appointment.

If you are using a laptop/desktop, open your email and scroll to the bottom of your message. The room link is in a grey box at the end of your email. The grey box is a hyperlink that will open your telehealth room. If you are using a smartphone or tablet, make sure you have the GOOGLE MEET APP downloaded on your device. If you join early, or if your provider is running behind, your request to join may time out. If this happens, simply request to join again.

You must have a good internet connection and private space for your telehealth appointment. When you open your link, your device may ask for permission to access your camera and microphone for the appointment. Do not take calls or open other programs on your device during this time, as you may miss when your provider connects. If you are having trouble connecting, our office may call you. If you live out of state, you may be required to come across state lines or to the office even for a telehealth appointment. *This is dependent on your state's laws*. If you are required to come to the office, we will provide a space and tablet for your appointment.

RECORD REQUESTS: Records can be faxed to a new provider at no charge. Requests for printed records must be approved by your provider and will incur fees per state standards (labor fee plus print page fees by number of pages and additional fees for urgent requests for printing within 48 hours or less, and certification). Attorney, disability and life insurance requests may incur fees.

AFTER HOURS EMERGENCIES: If you have an emergency after hours, you may reach a provider through the answering service. Please follow the prompts on our phone tree, 812-422-7974. If it is a non-urgent request, please use the portal or leave a phone message at the office.

PARENTS AND PARENTAL SEPARATION: The person who brings the child in for treatment is responsible for payment of any copay or balance due at time of service. IF THERE IS A DIVORCE SITUATION, THE PARENT OR RESPONSIBLE ADULT WHO BRINGS THE CHILD TO THE APPOINTMENT IS THE PERSON RESPONSIBLE FOR THE CHARGES, unless a prior authorization has been signed with the billing department.

WE WILL NOT BECOME INVOLVED WITH THE PARTICULARS OF YOUR DIVORCE. We will provide a receipt so that the responsible party can be reimbursed. We will not bill third parties for payments of balance due.

We do require a copy of any court orders in instances where there is a custody issue or restraining order that we need documented.

The appointment that your child has with their health care provider is the child's appointment and should be a safe space for them. We do not engage in releasing records to a parent seeking litigation involving their child's custody, etc. If records are subpoenaed by the court, we will follow procedure and fax them directly to the judge or officer of the court as ordered.

Per HHS.Gov:
"HIPAA also allows a healthcare provider to determine, based on professional judgment, that treating someone as a patient's personal representative for HIPAA purposes would endanger the patient, and to refuse to treat the person as a personal representative under those circumstances. This applies whether the patient is an adult or a minor child."

COURT APPEARANCES: We do not traditionally perform court-ordered services. If you wish to subpoena your clinician to be a witness for a court case, be advised: these requests will require prepayment in full for the clinician's time to include preparation, travel, and testimony and cancellation of a day or more of appointments. You may request your clinician's fees so you are fully informed. Each provider has a separate agreement for court fees. If your clinician is treating your child: be aware that court involvement with your child's therapist is not therapeutic for your child, and may influence the therapeutic relationship the child has with the provider.

TRUST: Good mental health care requires mutual trust. We expect patients to be honest with their providers. We also ask that administrative staff be treated with respect.

If you have a complaint or suggestion for improvement, please allow us the opportunity to hear it first. We take pride in providing excellent service, and we would love to have your feedback. We appreciate the opportunity to address any issues when possible.

By signing this form you acknowledge that you have read and understand the above information, rights, and responsibilities.

By signing this form, I authorize my insurance company to make payment directly to Evansville Psychiatric Associates unless I choose to pay for all services in full at time of service. I understand that medical records may need to be released to my insurance company in order to substantiate claims.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(Required if patient is under 18)

Relationship of Parent/Guardian to patient: _____

Provide a copy of any custody agreement, court judgments, or POA papers necessary.

Witness: _____ Date:_____
Office use only

Credit Card Authorization

As a convenience to you Evansville Psychiatric Associates will keep a credit card authorization on file to fulfill your financial requirements. This will ensure timely posting for your financial responsibility due at the time of service.

We will charge and post the amount due at the time of service for the patient due balances. Receipts will be provided upon request.

○ MasterCard	○ Visa	○ American Express	○ Discover

Is this an HSA or FSA Card? **O** Yes **O** No

Card Number:	CVV:
Card Holder Name: _____ Address: ZipCode: _____ Signature:	Expiration Date:

By signing this agreement I understand the terms and conditions listed above. I also understand that any charges incurred for treatment and are not included with this date's payments will be due at the next billing cycle. A receipt will be provided at the time of services upon my request.
This Credit Card Authorization is to be used for the following patient accounts:

_____ _____

_____ _____

_____ _____

_____ Today's Date

Scan/attach to each patient record as indicated; Billing/Payment:CCAuth

Initial Assessment - Child(4-16 years old)

Date: _____ Parent/Guardian: _____

Child Name: _____ Cell Phone: _____

Child Age: _____ Email: _____

Please list everyone who lives in the home and his/her relationship to child: _____

_____

What are your child's strengths, interests, and/or hobbies? _____

_____

_____

What are the concerns/issues that bring you to therapy today? _____

_____

_____

_____

When did these behaviors begin?_____

How frequently do these behavior occur? _____

On a scale from 1-10 how much do these behaviors impact the child's daily routine/functioning?

1 2 3 4 5 6 7 8 9 10

What strategies have you tried to address these behaviors? _____

_____

_____

What changes are you hoping to see in therapy? _____

_____

How hopeful are you about seeing improvement in your child?

1 - Not at all hopeful 2 - a little hopeful 3 - somewhat hopeful 4 - very hopeful

If you are not hopeful, why not? _____

_____

Medical History

Is your child currently under the care of a physician? yes no

Name of Physician _____

Date of last visit _____

Are your child's immunizations up to date? yes no

Has your child ever undergone surgery? yes no

If yes please explain: _____

Does your child have any allergies? yes no

If yes please explain: _____

Please list current medical conditions your child is being treated for and date of diagnosis: _____

Current medications being prescribed:	Dosage	Frequency	Improvement Noticed

Does your child have any trouble falling asleep? yes no

Does your child have any trouble staying asleep? yes no

Is your child easy to wake up in the morning? yes no

Usual bedtime: _____

Usual Wake Time: _____

Does your child experience nightmares/terrors? yes no

Comments/Explanation of Positive Responses:

Have you noticed any changes in your child's appetite/eating habits? yes no

If yes, please explain: _____

What form of discipline is used in the home:

_____

_____

Does your child respond to discipline? yes no

Birth History & Development

Mother's Age at time of Pregnancy	_____	
Father's Age at time of Pregnancy	_____	
Planned Pregnancy	yes	no
Known use of drugs/alcohol during pregnancy	yes	no
Medical Problems/Complications during pregnancy	yes	no
Prenantal Care	yes	no
Full Term Pregnancy	yes	no
Birth Weight	_____	
Complications at delivery for child	yes	no
Complications at Delivery for Mother	yes	no
Did baby stay more than 5 days in Hospital	yes	no
Follow up Child Care	yes	no
Post-Partum Depression for Mother	yes	no
Follow up care for Mother	yes	no
COMMENTS/Explanation of Positive Responses:		

Early Development of Child

Was growth and weight gain normal	yes	no
Was there any Failure to Thrive	yes	no
Was child colicky	yes	no
Age when child:		
sat up independantly	_____	
crawled	_____	
walked	_____	
spoke words	_____	
spoke sentences	_____	
Age when fully toilet trained	_____	
Any concerns about Global Development Delay	yes	no
Any current enuresis or encopresis	yes	no
COMMENTS/Explanation of Positive Responses:		

Family History of Mental Illness

Please identify any family members with a mental health diagnosis and/or substance abuse issues:

_____

_____

_____

_____

Psychiatric Social History

Was child adopted?	yes	no		
Relationship status of biological parents	married	divorced	separated	never married
Loss of parent by death prior to age 18	yes	no		
Would you descibe childhood as	happy	average	unhappy	
How would you describe socio-economic status	lower	middle	upper economic class	
Has this child experienced any of the following:				
Emotional abuse	yes	no		
Physical abuse	yes	no		
Sexual abuse	yes	no		
Has child ever witnessed violence or been involved in violent episode?	yes	no		
Comments/Explanation of Positive Responses:				

Education

Current School: _____

Grade: _____ Teacher: _____

Does your child enjoy school? Yes No

Academic performance: failing poor average above average

Has child ever repeated a grade? Yes No

Has child been suspended/expelled? Yes No

If yes, please explain: _____

Does your child have an IEP/receive Special Education Services? (including Speech) Yes No

If yes, what accomodations are being provided? _____

Does your child have problems with teachers/authorities? Yes No

If yes, please explain: _____

Social

Does your child make friends easily? Yes No

How woud you describe the nature of his/her friendships? Good Average Poor

Is the child involved in community activities/after school activities? Yes No

Does your family participate in community activities? Yes No

Does the child usually attend religious services with the family? Yes No

COMMENTS/Explanation of Positive Responses:

Legal History

Is custody of child with biological family	yes	no
Past DCS involvement or services	yes	no
Any past Foster Care placement	yes	no
Has the child ever been arrested	yes	no
Any past placement in Detention	yes	no
Any past placement in a YDC	yes	no
COMMENTS/Explanation of Positive Responses		

Past Psychiatric History

Prior out patient psychiatric treatment in the past?	yes	no
Prior out patient alcohol/substance abuse treatment?	yes	no
Prior outpatient treatment was helpful?	yes	no
Number of prior psychiatric hospitalizations: _____		
Date of last psychiatric hospitalization: _____		
Involuntary hospitalizations in past?	yes	no
Other levels of Care	yes	no
History of non-suicidal injury (scratching, cutting, burning)?	yes	no
Method of self harm: _____		
Prior History of suicide attempt?	yes	no
Number of attempts _____		
Last attempt was: _____		
Attempt resulting in medical hospitalization:	yes	no
Prior History of Aggression or Violence?	yes	no
Aggression towards: _____		
Legal charges stemming from aggression:	yes	no
Incarceration stemming from aggression:	yes	no

Please identify any current stressors in the home that may be impacting your child: _____

_____

_____

Please provide any current or past use of substances (parent)			**If yes, how much how often?**
Alcohol: (beer, wine, liquor)	yes	no	
Cannabinoids: (marijuana, hashish)	yes	no	
Opioids and Morphine Derivatives: (codeine, morphine, Heroin, opium)	yes	no	
Stimulants: (cocaine, amphetamines, methamphetamines)	yes	no	
Club Drugs: (MDMA, GHB, Flunitrazepam)	yes	no	
Dissociative Drugs: (Ketamine, PCP, Dextromethorphan Salvia)	yes	no	
Depressants: (barbiturates, benzodiazepines)	yes	no	
Hallucinogens: (LSD, Psilocybin, Mescaline)	yes	no	
Anabolic steroids: (depo-testosterone, anadrol)	yes	no	
Inhalants: (huffing, glue, solvents etc)	yes	no	
Intravenous drug use	yes	no	
Have you had any difficulties with any of the following issues related to substance use?	yes	no	
TOLERENCE (increased amount of substance required to obtain initial effect of the drug)	yes	no	
WITHDRAWAL (symptoms of physiologic or psychological distress upon stopping or reducing the amount of drug used)	yes	no	
consumption exceeds intented amount	yes	no	
efforts to reduce/control consumption	yes	no	
excessive time spent related to substance use and leading to disruption of daily functioning	yes	no	

Domestic Violence Screening (parent)

Have you been emotionally or physically abused by your partner or someone close/important to you	yes	no
Have you ever been hit, kicked, punched or otherwise hurt by someone close/important to you within the past year	yes	no
Do you feel safe in your current relationship	yes	no
Is there a partner from a previous relationship who is making you feel unsafe now	yes	no
Was Victim Services information provided to client/family	yes	no
COMMENTS/Explanation of Positive Responses		

Legal Issues (parents/guardians)

Prior difficulties with the legal system ever?	yes	no
Prior incarcerated	yes	no
Current legal issues?	yes	no
Currently on Disability?	yes	no
Currently seeking Disability?	yes	no
COMMENTS/Explanation of Positive Responses		

Education & Employment

Mother's Highest Grade Completed: _____

Father's Highest Grade Completed: _____

Please explain any difficulty parents had in school? _____

_____

Do parents work outside the home? Yes No

Please provide name of employer and hours worked/schedule:

_____

_____

Please check all that apply

- ☐ Excessive/unrealistic worry
- ☐ Motor tension (restlessness, shakiness)
- ☐ Hypervigilance
- ☐ Social anxiety
- ☐ Separation anxiety
- ☐ Panic attacks
- ☐ Sleep disturbances

- ☐ Verbal aggression
- ☐ Physical aggression
- ☐ Mood swings
- ☐ Impulsive
- ☐ Low frustration tolerance
- ☐ Lying/Cheating/Stealing
- ☐ Defiance
- ☐ Argues with authority
- ☐ Sibling conflict
- ☐ Peer conflict
- ☐ Cussing/Inappropriate Language

- ☐ Difficulty paying attention to details
- ☐ Has difficulty sustaining attention
- ☐ Often does not seem to listen when spoken to directly
- ☐ Often unable to follow through on tasks
- ☐ Trouble with organization
- ☐ Avoids tasks requiring sustained mental effort
- ☐ Often loses things necessary for completing tasks
- ☐ Easily distracted
- ☐ Forgetful in daily activities

- ☐ Depressed mood
- ☐ Irritable
- ☐ Withdraws/isolates
- ☐ Suicidal thoughts or actions
- ☐ Disinterest in previously enjoyed activities
- ☐ Low energy, easily tired
- ☐ Significant weight loss or gain
- ☐ Low self-esteem
- ☐ Feelings of hopelessness
- ☐ Inappropriate guilt
- ☐ Unresolved grief issues
- ☐ Hallucination or delusions

- ☐ Fidgets/squirms
- ☐ Has trouble staying seated
- ☐ Excessive running/climbing or restlessness
- ☐ Trouble with quiet activities
- ☐ Needs to be “on the go”
- ☐ Often talks too much
- ☐ Blurts out answers
- ☐ Difficulty awaiting turn
- ☐ Interrupts conversations or intrudes on others

ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

	Never	Rarely	Sometimes	Often	Very Often
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
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?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half 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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Child's Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Grade: _____

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never 1 = Occasionally 2 = Often 3 = Very Often

1. Does not pay attention to details or makes careless mistakes, for example homework 0 1 2 3
2. Has difficulty sustaining attention to tasks or activities 0 1 2 3
3. Does not seem to listen when spoken to directly 0 1 2 3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand) 0 1 2 3
5. Has difficulty organizing tasks and activities 0 1 2 3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort 0 1 2 3
7. Loses things necessary for tasks or activities (school assignments, pencils or books) 0 1 2 3
8. Is easily distracted by extraneous stimuli 0 1 2 3
9. Is forgetful in daily activities 0 1 2 3
10. Fidgets with hands or feet or squirms in seat 0 1 2 3
11. Leaves seat when remaining seated is expected 0 1 2 3
12. Runs about or climbs excessively in situations when remaining seated is expected 0 1 2 3
13. Has difficulty playing or engaging in leisure/play activities quietly 0 1 2 3
14. Is "on the go" or often acts as if "drive by a motor" 0 1 2 3
15. Talks too much 0 1 2 3
16. Blurts out answers before questions have been completed 0 1 2 3
17. Has difficulty waiting his/her turn 0 1 2 3
18. Interrupts or intrudes on others (e.g., butts into conversations or games) 0 1 2 3
19. Argues with adults 0 1 2 3
20. Loses temper 0 1 2 3
21. Actively defies or refuses to comply with adults' requests or rules 0 1 2 3
22. Deliberately annoys people 0 1 2 3
23. Blames others for his or her mistakes or misbehaviors 0 1 2 3
24. Is touchy or easily annoyed by others 0 1 2 3

25. Is angry or resentful 0 1 2 3

26. Is spiteful and vindictive 0 1 2 3

27. Bullies, threatens, or intimidates others 0 1 2 3

28. Initiates physical fights 0 1 2 3

29. Lies to obtain goods for favors or to avoid obligations (i.e., "cons" others) 0 1 2 3

30. Is truant from school (skips school) without permission 0 1 2 3

31. Is physically cruel to people 0 1 2 3

32. Has stolen items of nontrivial value 0 1 2 3

33. Deliberately destroys others' property 0 1 2 3

34. Has used a weapon that can cause serious harm (bat, knife, brick, gun) 0 1 2 3

35. Is physically cruel to animals 0 1 2 3

36. Has deliberately set fires to cause damage 0 1 2 3

37. Has broken into someone else's home, business, or car 0 1 2 3

38. Has stayed out at night without permission 0 1 2 3

39. Has run away from home overnight 0 1 2 3

40. Has forced someone into sexual activity 0 1 2 3

41. Is fearful, anxious, or worried 0 1 2 3

42. Is afraid to try new things for fear of making mistakes 0 1 2 3

43. Feels worthless or inferior 0 1 2 3

44. Blames self for problems, feels guilty 0 1 2 3

45. Feels lonely, unwanted, or unloved: complains that "no one loves him/her" 0 1 2 3

46. Is sad, unhappy, or depressed 0 1 2 3

47. Is self-conscious or easily embarrassed 0 1 2 3

PERFORMANCE

	Problematic		Average	Above Average	
1. Overall Academic Performance	1	2	3	4	5
a. Reading	1	2	3	4	5
b. Mathematics	1	2	3	4	5
c. Written Expression	1	2	3	4	5

PERFORMANCE

	Problematic		Average	Above Average	
2. Overall Classroom Behavior	1	2	3	4	5
a. Relationship with peers	1	2	3	4	5
b. Following Directions/Rules	1	2	3	4	5
c. Disrupting Class	1	2	3	4	5
d. Assignment Completion	1	2	3	4	5
e. Organizational Skills	1	2	3	4	5

Scoring Instructions for the ADTRS

***Predominately inattentive subtype** requires 6 or 9 behaviors, (scores of 2 or 3 are positive) on items 1 through 9, and a performance problem (scores of 1 or 2) in any of the items on the performance section.

***Predominately hyperactive/Impulsive subtype** requires 6 or 9 behaviors (scores of 2 or 3 are positive) on items 10 through 18 and a problem (scores of 1 or 2) in any of the items on the performance section.

***The Combined Subtype** requires the above criteria on both inattention and hyperactivity/impulsivity.

***Oppositional-defiant disorder** is screened by 4 of 8 behaviors, (scores of 2 or 3 are positive) (19 through 26).

***Conduct disorder** is screened by 3 of 15 behaviors, (scores of 2 or 3 are positive) (27 through 40).

***Anxiety or depression** are screened by behaviors 41 through 47, scores of 3 of 7 are required, (scores of 2 or 3 are positive).

Parent Intake Form for _____ DOB _____

Please check each item that is true for your child. If you are unsure of what a question means, you may wait and ask the therapist.

1) ADHD SYMPTOMS:

A) INATTENTION

❍ 1) Often does not give close attention to details or makes careless mistakes in schoolwork, work or other activities.

❍ 2) Often has difficulty sustaining attention in tasks or play activities.

❍ 3) Often does not seem to listen when spoken to directly.

❍ 4) Often does not follow through on instruction and fails to finish schoolwork, chores, or duties (not due to oppositional behavior or failure to understand instructions.)

❍ 5) Often has difficulty organizing tasks and activities.

❍ 6) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework.)

❍ 7) Often loses things necessary for tasks or activities, such as toys, assignments, books or tools.

❍ 8) Is often easily distracted by extraneous stimuli.

❍ 9) Is often forgetful in daily activities.

B) HYPERACTIVITY / IMPULSIVITY

❍ 1) Often fidgets with hands or feet or squirms in seat.

❍ 2) Often leaves seat in classroom or in other situations in which remaining seated is expected.

❍ 3) Often runs about or climbs excessively in situation in which it is inappropriate (adolescents or adults may have feelings of restlessness.)

❍ 4) Often has difficulty playing or engaging in leisure activities quietly.

❍ 5) Is often "on the go" or often acts as if "driven by a motor."

❍ 6) Often talks excessively.

❍ 7) Often blurts out answer before questions are completed.

❍ 8) Often has difficulty waiting turn.

❍ 9) Often interrupts or intrudes on others, such as butting into conversations or games.

Parent Intake Form for _____

Please check each item that is true for your child. If you are unsure of what a question means, you may wait and ask the therapist.

II) DEPRESSION

- ❍ 1) Is your child frequently sad or irritable?
- ❍ 2) Is your child frequently bored?
- ❍ 3) Does your child have poor self esteem?
- ❍ 4) Do they have sleeping and/or energy problems?
- ❍ 5) Does your child ever speak of death or suicide?

III) ANXIETY

- ❍ 1) Is your child overly fearful of things or situations?
- ❍ 2) Does your child express excessive worries?
- ❍ 3) Does your child fidget or have a lot of nervous energy?
- ❍ 4) Is your child afraid of being away from his or her parents?
- ❍ 5) Does your child have repetitive behaviors or thoughts?

IV) MOOD

- ❍ 1) Does your child have explosive behavior or mood swings?
- ❍ 2) Does your child get overly happy, elated, euphoric or hyper-sexual?
- ❍ 3) Does your child ever destroy property or are they aggressive with others?
- ❍ 4) Does your child ever have distinct episodes of excess energy?
- ❍ 5) Does your child ever complain or speak of seeing or hearing things that aren't there?

V) SLEEP

- ❍ 1) Does your child have trouble initiating or staying asleep?
- ❍ 2) Does your child have trouble sleeping alone?
- ❍ 3) Does your child sleep too much?
- ❍ 4) Does your child have "Night Terrors" or frequent nightmares?
- ❍ 5) Does your child sleep-walk or sleep-talk?

VI) EATING

- ❍ 1) Is your child over or under weight?
- ❍ 2) Is your child a "picky eater"?
- ❍ 3) Does child binge on food?
- ❍ 4) Is your child overly concerned about being overweight?
- ❍ 5) Does your child vomit frequently or abuse laxatives?

Parent Intake Form for _____

Please check each item that is true for your child. If you are unsure of what a question means, you may wait and ask the therapist.

VII) TEMPERAMENT

- ❍ 1) Is your child overly sensitive to touch, temperature or textures?
- ❍ 2) Is your child fearful of new situations or loud activities?
- ❍ 3) Is your child picky about the tightness and/or texture of clothing?
- ❍ 4) Is your child persistent or strong-willed?
- ❍ 5) Was this child colicky as a baby?

VIII) PDD

- ❍ 1) Does your child have poor eye contact with others?
- ❍ 2) Does child have a restricted range of things that they are interested in?
- ❍ 3) Was/is this child's language delayed?
- ❍ 4) Does this child seek out comfort from parents?
- ❍ 5) Does your child get very upset if their routine is changed?

IX) SOMATIC

- ❍ 1) Does your child have a lot of physical complaints?
- ❍ 2) Does your child have any history of seizures or head trauma?
- ❍ 3) Does your child have any allergies?
- ❍ 4) Does your child have any vision or hearing problems?
- ❍ 5) Does your child have trouble with bed-wetting or having bathroom accidents?

Is there any other information you would like to add?

Signature of Parent/Guardian completing form _____ Date_____

Evansville Psychiatric Associates
Complete Outpatient Mental Health Care

2015 Maxwell Avenue, Evansville, IN 47711
Phone: 812-422-7974 Fax: 1-812-671-0627
Email: faxes+2038119@waitingroomsolutions.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Address:_____

Any Previous Name(s): _____ SSN:_____

The undersigned, Patient or Personal Representative of Patient, does hereby request and authorize Evansville Psychiatric Associates to:
(Please check all that apply)

☐ Receive records from ☐ Schedule and cancel appointments with

☐ Release records to ☐ Manage billing matters with

The following office or individual:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX:_____
(Note: This release is void unless this section is filled out with the relevant party's information)

For the following purpose: **O** Patient request, **O** Coordination of Care, **O** Legal Purpose, **O** Billing
(Please check all that apply)

•Offices or individuals that do not share a physical address will each need a separate signed release.
•Medical records may include but are not limited to the following information: described and disclosed demographics, symptoms, history and physical, diagnosis, functional status, treatment plan, medication, psychological test results, recent lab results, prognosis, attendance, progress, which may include mental health and drug/alcohol information.
•Information shared through this release may be subject to redisclosure.
•This release may be revoked early at any time, by providing a written request to Evansville Psychiatric Associates.
•Refusal to sign this release does not affect ability to obtain treatment, payment for services, or eligibility for benefits, with the exception of treatment dependent upon information from the above party.
•This release will expire 1 year after the signed date, unless specified otherwise below.

This authorization will expire in: **O** 1 year from last appointment, **O** 1 year, **O** other: _____

Signature of Patient / Parent / Guardian: _____

Date: _____