PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Patient Name: _____

Today's Date: _____

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

Not difficult at all Somewhat difficult Very difficult Extremely difficult

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VITAL SIGNS (to be filled out by Office Staff)

Height	
Weight	
Blood Pressure	
Pulse	

Today's Date: _____

CSMD: _____

Completed by: _____

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	**YES**	**NO**
...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 that you didn't really miss it?	☐	☐
...you were 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 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 in 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?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Informed Consent for Psychiatric Medications

Patient Name:
Patient Date of Birth:
Today's Date:
Practitioner Name:_____, APN
State License #:
Practice Location: Bearden Behavioral Health

My nurse practitioner (NP) and I discussed:

1. The nature of my mental condition.
2. My NP's reasons for prescribing the medication, including the likelihood of my condition improving or not improving without the medicine.
3. I can refuse to take any medication at any time, but it is recommended that I discuss my decision with my NP before I stop taking any medication.
4. Reasonable alternative treatments available for my condition.
5. The type of medication that I will be receiving, the frequency and range of dosages, the method by which I will take the medication, and the duration of such treatment.
6. The common side effects of this medication, and any particular side effects likely to affect me.
7. That certain antipsychotic medications may cause additional side effects for some persons, including tardive dyskinesia. Tardive dyskinesia is defined as persistent involuntary movements of the face, mouth, torso, hands, or feet. These symptoms are potentially irreversible, and may continue after the antipsychotic medication has been stopped.

I was given information about the recommended medication. I understand that the information does not cover everything, but it includes items of clinical significance to me. I should discuss all my medical problems and any medication that I take with my NP/physician(s). For more information I may refer to a pharmacist or to a standard text such as the Physician's Desk Reference (PDR).

I have received the information about the psychotropic medication by means of: (Check those that apply)

☒ Oral Explanation ☒ Printed Material ☐ Video Presentation ☐ Other

Name of Medication (Generic name is acceptable. Include anticipated dosage range.):

_____

_____

I understand I have the right to refuse this medication, and that it cannot be given to me until I have spoken with my physician and given consent to it, except in an emergency. I understand and give consent to the medication listed above, which is an FDA approved medication, although its use in my condition(s) may not always appear as part of its approved labeling.

Client/Parent/Guardian signature _____Date _____

APN Signature_____Date _____

Nurse Practitioner Service Agreement

As a part of your holistic treatment plan, when working with a nurse practitioner, you may engage with 2 types of billable services. The 2 main services that a Nurse Practitioner (NP) can provide and bill for are:

1.) **Medication Management**

Service Expectations for Medication Management include:

- ☐ Medical evaluation
- ☐ Medication monitoring routinely and as needed
- ☐ Client education pertaining to the medication to support the individual in making an informed decision for its use.
- ☐ The service provider must make a good faith attempt to coordinate care with the individual's primary medical provider

2.) **Time Based Psychotherapy Services**

Service Expectations for Time Based Psychotherapy include:

- ☐ Interactive therapy involving any current symptom complaints or psychosocial stressors.
- ☐ Examples of time based psychotherapy: patients working collaboratively with their NP to improve organizational skills to cope with ADHD, patients working on sleep hygiene measures to reduce anxiety & improve sleep quality, processing of feelings surrounding a recent or past traumatic experience, working on strategies to ground when stressed or triggered, discussing family dynamics, working on ways to communicate effectively with one's partner, friends, or family, non-medicinal strategies for coping with nightmares, mindfulness work, creative imagery or safe place visualization.
- ☐ Examples of patients who do not need time based therapy services: patients who are stable, have no active psychiatric complaints, no active stressors, and are just coming in for medication maintenance refills.

When you come to see an NP at BBH you will always be billed for a Medication Management code as that is a crucial part of an NP's clinical training and expertise. Depending on the situation, your NP may or may not bill for a time based psychotherapy service. It depends on what is discussed in the session and for how long. Some NPs have more expertise and continuing education to provide therapy services than others. Those that do, will spend time on this service in most any session unless it is deemed that there is no need for therapy (such as in the example listed above). Other NPs may spend more time doing med management only. It depends on their areas of training/specialty.

Please be advised that unless you tell us in advance that you want no therapy from your NP, you may be billed for medication management and psychotherapy if an NP sees both services as medically necessary and they possess the expertise to offer both services to you.

If you ask for no therapy services to be provided, you will need to put this in writing and bring it to your NP for further discussion. All services rendered are ultimately up to the NP, not billing or front scheduling staff so we ask that you reserve these conversations for your scheduled session.

I acknowledge receipt and understanding of all information listed above and consent to receive the above services with my Nurse Practitioner, should they be assessed to be medically beneficial to me during the course of my treatment:

_____
Patient Signature

_____
Date

_____

Epworth Sleepiness Scale

Name: _____ Today's date: _____
Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze, 1 = slight chance of dozing,
2 = moderate chance of dozing, 3 = high chance of dozing

It is important that you answer each question as best you can

Situation	Chance of Dozing (0 - 3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL SCORE	

Analyze Your Score Interpretation:

0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

Bearden Behavioral Health
Medication Flow Sheet

Patient Name: _____

Date of Birth: _____

Pharmacy Address: _____

Phone: _____

Fax: _____

Psych Medications:

Start Date	Stop Date	Drug Name (brand + generic)	Dosage	Frequency

Drug Allergies & Reactions: _____

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