GAD-7

Anxiety

Patient Name: _____ Date of Visit: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
1. Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to sleep or control worry	☐ 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

Column Totals _____ + _____ + _____ + _____ =

Total Score: _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.” GAD-7 total score for the seven items ranges from 0 to 21.

0-4: minimal anxiety

5-9: mild anxiety

10-14: moderate anxiety

15-21: severe anxiety

PATIENT HEALTH QUESTIONNAIRE - 9

(PHQ - 9)

Patient Name: _____ Date of Visit: _____

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

Column Totals _____ + _____ + _____ + _____ =

Total Score: _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

MOOD DISORDER QUESTIONNAIRE

Patient Name: _____ Date of Visit: _____

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 ☐

CLIENT ACKNOWLEDGEMENT OF PARTICIPATION IN TREATMENT PLAN

(Signature Page)

Client Name: _____ DOB: _____

Clinician Name: _____

I, the undersigned, have participated in planning the treatment for myself/my child (those children under 16 years of age)

Electronic copies of this Client Acknowledgement of Participation in Treatment Plan or any amendments hereto shall be binding upon the parties, and electronic reproduction of signatures appearing herein or on any reproduction shall be deemed to be original signatures.

_____ _____

(Client Signature) Date

_____ _____

(Parent/Legal Guardian Signature) Date

☐ Unwilling ☐ Unable to participate in planning treatment due to:

_____ _____

Date

☐ Participated but unwilling to sign due to:

_____ _____

Date

☐ **Verbal Consent** participated by phone, but not physically present to sign:

Print name of BBH Witness who received the verbal consent

_____ _____

Date

CONSENT/REFUSAL FOR MEDICATION(S)

CLIENT NAME: _____ DOB: _____

By signing below, I acknowledge that the possible benefits and side effects or risks of taking:

_____
(Brand Name/Generic)

_____
(Brand Name/Generic)

_____
(Brand Name/Generic)

_____
(Brand Name/Generic)

have been explained to me by: _____

These risks include any black box warning or major side effects including:

- Antipsychotic (Elevation of prolactin, EPS, TD, NMS, metabolic and cardiac effects, and suicidal ideations)
- Mood Stabilizers (Stevens-Johnson Syndrome, seizures, adverse effects on liver/blood/kidney/ pancreatic function)
- Antidepressants SSRIs & TCAs (suicidal ideations, GI side effects, seizures)
- Sedatives or Benzodiazepines (addiction potential, drowsiness, driving precautions, memory loss)
- Stimulants (cardiac arrhythmias, GI side effects, headaches, seizures. Serotonin Syndrome)
- Risk of Priapism
- Potential for a severe interaction with illegal drug use or alcohol
- I understand the importance of avoiding pregnancy while taking the medication(s) and agree to contact the psychiatrist/nurse practitioner immediately should I become pregnant (applies to female patients only.)

I understand the reason (diagnosis) for my child/ward taking this medication and I understand what may happen if my child/ward does not take this medication, i have discussed possible alternative treatments. I have received educational information about this medication. I understand these explanations and agree to have my child/ward take the medication as directed.

_____	_____	_____
Client or Legal Guardian Signature	Relationship to Client	Date

_____	_____
Prescriber's Signature and Credentials	Date

_____	_____	_____
Telephone Consent/Refusal by: Client or Legal Guardian's name	Relationship to Client	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 ones 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 totally 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

_____

Witness Signature