

# GAD-7

## Anxiety

Patient Name: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

Over the <u>last 2 weeks</u> , 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Not being able to sleep or control worry	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Being so restless that it is hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Becoming easily annoyed or irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Feeling afraid as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved.  
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### 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 <u>last 2 weeks</u> , 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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: \_\_\_\_\_

<b>1. Has there ever been a period of time when you were not your usual self and...</b>	<b>YES</b>	<b>NO</b>
...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?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
...you felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you got much less sleep than usual and found that you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
...you were more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
...you had more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="checkbox"/>	<input type="checkbox"/>
...spending money got you or your family in trouble?	<input type="checkbox"/>	<input type="checkbox"/>

<b>2. If you checked 'YES' to more than one of the above, have several of these ever happened during the same period of time?</b>	<input type="checkbox"/>	<input type="checkbox"/>
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<b>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?</b>			
No Problems <input type="checkbox"/>	Minor Problem <input type="checkbox"/>	Moderate Problem <input type="checkbox"/>	Serious Problem <input type="checkbox"/>

**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.

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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:

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Patient Signature

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Date

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Witness Signature