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:_____

BSDS

Patient Name: _____
Today's Date: _____

1. Please read through the entire passage and put a check after each sentence that definitely describes you.

Some individuals notice that their mood and/or energy levels shift drastically from time to time___. These individuals notice that, at times, their mood and/or energy level is very low, and at other times, very high___. During their "low" phases, these individuals often feel a lack of energy; a need to stay in bed or get extra sleep; and little or no motivation to do things they need to do___. They often put on weight during these periods___. During their low phases, these individuals often feel "blue", sad all the time, or depressed___. Sometimes, during these low phases, they feel hopeless or even suicidal___. Their ability to function at work or socially is impaired___. Typically, these low phases last for a few weeks, but sometimes they last only a few days___. Individuals with this type of pattern may experience a period of "normal" mood in between mood swings, during which their mood and energy level feels "right" and their ability to function is not disturbed___. They may then notice a marked shift or "switch" in the way they feel___. Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do___. Sometimes, during these "high" periods, these individuals feel as if they have too much energy or feel "hyper"___. Some individuals, during these high periods, may feel irritable, "on edge", or aggressive___. Some individuals, during these high periods, take on too many activities at once___. During these high periods, some individuals may spend money in ways that cause them trouble___. They may be more talkative, outgoing, or sexual during these periods___. Sometimes, their behavior during these high periods seems strange or annoying to others___. Sometimes, these individuals get into difficulty with co-workers or the police, during these high periods___. Sometimes, they increase their alcohol or non-prescription drug use during these high periods___.

2. Now that you have read this passage, please check one of the following four boxes:

( ) This story fits me very well, or almost perfectly
( ) This story fits me fairly well
( ) This story fits me to some degree, but not in most respects
( ) This story does not really describe me at all

Jasper / Goldberg Screening Examination - Version 5.0

The items below refer to how you have behaved and felt DURING MOST OF YOUR ADULT LIFE. Circle one of the numbers that follows each item using the following scale:

0 = Not at all 1 = Just a little 2 = Somewhat 3 = Moderately 4 = Quite a lot 5 = Very much

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1. At home, work, or school, I find my mind wandering from tasks that are uninteresting or difficult. 0 1 2 3 4 5
2. I find it difficult to read written material unless it is very interesting or very easy. 0 1 2 3 4 5
3. Especially in groups, I find it hard to stay focused on what is being said in conversations. 0 1 2 3 4 5
4. I have a quick temper...a short fuse. 0 1 2 3 4 5
5. I am irritable, and get upset by minor annoyances. 0 1 2 3 4 5
6. I say things without thinking, and later regret having said them. 0 1 2 3 4 5
7. I make quick decisions without thinking enough about their possible bad results. 0 1 2 3 4 5
8. My relationships with people are made difficult by my tendency to talk first and think later. 0 1 2 3 4 5
9. My moods have highs and lows. 0 1 2 3 4 5
10. I have trouble planning in what order to do a series of tasks or activities. 0 1 2 3 4 5
11. I easily become upset. 0 1 2 3 4 5
12. I seem to be thin skinned and many things upset me. 0 1 2 3 4 5
13. I almost always am on the go. 0 1 2 3 4 5
14. I am more comfortable when moving than when sitting still. 0 1 2 3 4 5
15. In conversations, I start to answer questions before the questions have been fully asked. 0 1 2 3 4 5
16. I usually work on more than one project at a time, and fail to finish many of them. 0 1 2 3 4 5
17. There is a lot of "static" or "chatter" in my head. 0 1 2 3 4 5
18. Even when sitting quietly, I am usually moving my hands or feet. 0 1 2 3 4 5
19. In group activities it is hard for me to wait my turn. 0 1 2 3 4 5
20. My mind gets so cluttered that it is hard for it to function. 0 1 2 3 4 5
21. My thoughts bounce around as if my mind is a pinball machine. 0 1 2 3 4 5
22. My brain feels as if it is a television set with all the channels going at once. 0 1 2 3 4 5
23. I am unable to stop daydreaming. 0 1 2 3 4 5
24. I am distressed by disorganization. 0 1 2 3 4 5

TOTAL SCORE:_____

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	

<u>Analyze Your Score Interpretation</u>:

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.

THIS FORM IS OPTIONAL YOU ARE NOT REQUIRED TO RELEASE

Confidential: Not to be Re-released without express written consent.

Bearden Behavioral Health

Primary Care Communication Form

Physician's Name _____Phone #_____ Fax#_____

Dear Dr. _____:

Your patient, _____, DOB _____, was seen by

_____, APN in our office. Date of initial assessment: _____

Most recent appointment: _____. Follow up in: _____

Diagnosis and/or presenting problem: _____

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_____

_____

Treatment Recommendations: _____

_____

Medication (if applicable): _____

Please call if further information would be helpful. Sincerely,

_____ (865) 212 6600

Signature Phone

Authorization to Disclose Information

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations 42 CFR Part 2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

This consent shall expire one (1) year from the date of signature. I understand I may revoke my consent in writing at any time except to the extent that action has already been taken in reliance on it.

Patient, please check one:

_____ I agree to release this information to my physician listed above.

_____ I do not agree to release this information to my physician listed above.

_____ I do not have a physician.

Patient Signature _____Date _____

Parent/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

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:_____

_____

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.

8. **For Females**: Because certain medications could be harmful to a developing fetus, I will notify my NP immediately if I suspect pregnancy or have plans to attempt pregnancy

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 _____