Stonebriar Psychiatric Services, PA
Medical and Social History

Name: _____ Age: _____ M ____ F ____ Date: _____ DOB_____

Address: _____ City:_____ Zip:_____

SS # _____ Home Phone: _____ Work phone: _____

Cell phone: _____ E-mail Address: _____

Emergency contact Name/Relationship/Number _____

How did you hear about our office: _____

Primary Care Physician/Address:_____

_____

Date of Last Physical: _____

HISTORY OF PAST ILLNESS: Have you had

Childhood

☐ Measles ☐ Rheumatic fever or heart disease
☐ Congenital Abnormalities ☐ Mumps ☐ Chicken Pox

Adult:

☐ Asthma ☐ High Blood Pressure ☐ Cancer (Site _____)
☐ Diabetes ☐ Ulcer or Gastritis ☐ Thyroid Problems
☐ Tuberculosis ☐ Kidney Problem ☐ Liver Problem
☐ Blood Problem ☐ Venereal Disease ☐ Heart Failure
☐ Heart Attack ☐ Abnormal Heart Rhythm
☐ Osteopenia/osteoporosis

OPERATIONS:

Have you ever had any surgery? ☐ yes ☐ no
If yes, what type and when:

_____
_____
_____

ALLERGIES:

_____
_____

CURRENT MEDICATIONS:

_____
_____
_____
_____
_____
_____

INJURIES:

Have you ever been in a serious motor vehicle accident? ☐yes ☐no
Have you had any head concussions or injuries? ☐ yes ☐ no
Have you ever been knocked unconscious? ☐ yes ☐ no

PAST PSYCHIATRIC HISTORY:

List all therapists, counselors and hospitalizations (with dates)

_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY:

Circle One: Single Married Separated
Divorced Widowed Significant Other

With whom do you live? _____

History of Drug Usage? ☐ yes ☐ no
Do you have concerns regarding sexual function? ☐ yes ☐ no
Foreign Travel within the past year_____

Coffee _____ Tea _____ Colas _____ per day

Alcohol ☐ Never ☐ < 1 per week ☐ 1-5 per week ☐ Other

Tobacco: ☐ Never smoked ☐ Quit _____ years ago
☐ Packs per day ☐ Years smoked _____

SOCIAL HISTORY: (continued)

Are you employed? ☐ Full Time ☐ Part Time

What is your job? _____

_____

Are you a student? ☐ yes ☐ no If so, where_____
How much time have you lost from work or school because of your health during the past: Six months _____ One year _____
5 Years _____
Education: (Years)
Grade School _____ College _____ Postgraduate _____
Do you wear seatbelts? ☐ Always ☐ Sometimes ☐ Never

FAMILY HISTORY	**AGE**	**HEALTH**	If Deceased, Age @ Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or grandparent ever had psychiatric problems, substance abuse, or treatment? If so, what type of illness and treatment _____

_____

_____

Has any blood relative had diabetes ☐ Yes ☐ No
Has any blood relative ever attempted or completed suicide?
☐ Yes ☐ No

SYSTEMIC REVIEW:
WEIGHT: Current _____ Max. _____ Min _____
Recent weight change? ☐ Yes ☐ No

Height _____ Neck Circumference: _____ inches

Stonebriar Psychiatric Services, PA
Medical and Social History

Have you recently had: ☐ Weakness ☐ Fever ☐ Chills
☐ Fainting ☐ Problems Sleeping ☐ Night Sweats

CIRCLE if you have had the following:

SKIN
Skin Disease ……....Yes No
Jaundice …… .Yes No
Hives, eczema, rash……...……Yes No

Head-Eyes-Ears-Nose-Throat

Dry eyes or mouth …….. Yes No
Bleeding gums – frequent or consistent ……..… Yes No
Blurred vision…...……..... Yes No
Date of last eye exam _____
Nosebleeds – frequent …….. Yes No
Chronic sinus trouble …… Yes No
Ear disease …… Yes No
Impaired hearing …….. Yes No
Dizziness or sensation of room spinning ……. Yes No
Frequent or severe headaches …….. Yes No

Respiratory
Asthma or Wheezing …… Yes No
Difficulty breathing …….. Yes No
Pleurisy or Pneumonia …… Yes No
Cough up Blood (ever) …… Yes No

Cardiovascular
Chest pain, pressure or tightness ……..… Yes No
Shortness of breath with walking or lying down ……. Yes No
Palpitations …… Yes No
Swelling of hands, feet or ankles …… Yes No
Awakening in the nights feeling smothered …….. Yes No
Heart murmur …….. Yes No

Gastrointestinal
Vomiting blood or food …….. Yes No
Gallbladder disease …… Yes No
Change in appetite …….. Yes No
Hepatitis / Jaundice …… Yes No
Painful bowel movements …… Yes No
Bleeding with bowel movements …… Yes No
Black stools …….. Yes No
Recent change in bowel habits …… Yes No
Frequent diarrhea …….. Yes No
Heartburn or indigestion …….. Yes No
Cramping or pain in the abdomen …… Yes No
Does food stick in throat …….. Yes No

Endocrine
Hormone therapy …….. Yes No
Any change in hat or glove size …… Yes No
Any change in hair growth …… Yes No
Have you become colder than before or skin dryer ……....Yes No

Neck
Stiffness ……...…… Yes No
Enlarged glands …… Yes No

Genitourinary:

Loss of urine ……. Yes No
Blood in urine ……Yes No
Frequent urination ……. Yes No
Burning or painful urination ……. Yes No
Bedwetting ……. …….. Yes No
Kidney trouble …….. Yes No
Testicular mass ……..Yes No
Prostate problem ……Yes No
Sexual dysfunction …… Yes No
STD / AIDS risk …… Yes No

Gynecological:

First day of last period _____
Age periods started _____
How long do periods last _____
Frequency of periods every _____
Pain with periods …….. Yes No
Number of pregnancies _____
Number of miscarriages _____
Date of last cancer smear and results _____
Breast lump or discharge……Yes No
Abnormal vaginal discharge ……..Yes No
Pain with intercourse ……Yes No

Locomotor-musculoskeletal

Stiffness or pain in joints……Yes No
Weakness of muscles or joints …….. Yes No
Any difficulty walking …….. Yes No
Any pain in calves/buttocks with walking relieved w/rest …Yes No

Neuro-Psychiatric

☐ Transient blindness ☐ Tremor ☐ Weakness ☐ Fingers numb
Have you ever had counseling for mental health …….. Yes No
Have you ever been advised to see a psychiatrist ……. Yes No
Have you or do you ever have fainting spells ……Yes No
Convulsions……Yes No
Paralysis ……Yes No
Problems with coordination ……Yes No
History of being physically or sexually abused ……..Yes No
Depression symptoms (difficulty sleeping, loss of appetite,
loss of interest in activities, feeling hopeless …… Yes No
History of ADHD …… Yes No
History of mood swings or bipolar illness …… Yes No
History of bingeing or purging ……..Yes No

Hematologic

Are you slow to heal after cuts …… Yes No
Anemia …….. Yes No
Phlebitis or blood clots in veins …… Yes No
Have you had difficulty with bleeding excessively
after tooth extraction or surgery? ……. Yes No
Have you had abnormal bruising or bleeding …….. Yes No

Other

Do you snore loud enough to be heard through a closed door? Yes No
Do you often feel tired, fatigued during the day? …… Yes No
Has anyone observed you stop breathing during sleep?..... Yes No
Do you have/are you being treated for high blood pressure? Yes No

The information provided herein is accurate to the best of my knowledge. I understand it is my responsibility to inform my doctor of any changes in this information.

Patient signature: _____ Date: _____ Provider: _____

Signature of person providing this information: _____

Stonebriar Psychiatric Services, P.A.

Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

May we leave messages at home? ❑ Yes ❑ No

May we leave messages at work? ❑ Yes ❑ No

May we send mail to you at this address? ❑ Yes ❑ No

Marital Status: ❑ S ❑ M ❑ D ❑ W Date of Current Marriage/Separation: _____

Number of Marriages: _____

Spouse's Name: _____ Date of Birth: _____

Child(ren)'s Name(s): _____ Date of Birth: _____ ❑ M ❑ F

_____ Date of Birth: _____ ❑ M ❑ F

_____ Date of Birth: _____ ❑ M ❑ F

Previously Married? ❑ Yes ❑ No If yes, when? _____ How long? _____

Occupation: _____ Highest Level of Education: _____

COUNSELING AND PSYCHIATRIC HISTORY

Have you had previous counseling? ❑ Yes ❑ No If yes, when? _____

Name and location of counselor: _____

If yes, for what reason? _____

For how long? _____ Was it helpful? _____

Have you ever been diagnosed with or treated for any type of mental illness? ❑ Yes ❑ No If yes, which type? _____

_____

Has anyone in your family ever been diagnosed with or treated for any type of mental illness? ❑ Yes ❑ No

If yes, who and which type? _____

_____

REASONS FOR SEEKING HELP

What concerns have brought you to counseling today? _____

_____

_____

_____

Which of the following are causing the most concern for you? Please check all that apply:

❑ Home ❑ Work ❑ Marriage ❑ Other Relationships ❑ God

When did your present concerns begin to be a problem for you? _____

What concerns about you have been identified by others? _____

_____

Please rate the severity of your present concerns on the following scale. Check one:

❑ Mild ❑ Moderate ❑ Severe ❑ Totally Incapacitating

Please indicate which of the following areas are currently problematic for you. Check all that apply:

- ❑ Blackouts or temporary loss of memory
- ❑ Insomnia (not being able to sleep)
- ❑ Loss of appetite/increased appetite
- ❑ Uncontrollable anxiety or worry
- ❑ Lacking self-confidence
- ❑ Feeling fat
- ❑ Eating and then vomiting to control weight
- ❑ Excessive use of alcohol
- ❑ Abuse of non-prescription drugs
- ❑ Getting into trouble at school/work
- ❑ Feeling inferior to others
- ❑ Under too much pressure and feeling stressed
- ❑ Feeling down or unhappy/depressed mood
- ❑ Excessive anxiety or worry
- ❑ Feeling lonely
- ❑ Suspicious feelings toward other people
- ❑ Afraid of being on your own
- ❑ Angry feelings
- ❑ Concerns about finances
- ❑ Inability to concentrate while at school/work
- ❑ Crying spells
- ❑ Feeling "on top of the world"
- ❑ Nightmares
- ❑ Loss of interest in usual activities/lack of motivation
- ❑ Obsessions or compulsions with specific activities
- ❑ Inability to control thoughts
- ❑ Feeling trapped in rooms/buildings
- ❑ Hearing voices
- ❑ Feeling that people are "out to get you" or that you are being watched
- ❑ Angry outbursts
- ❑ Excessive fear of specific places or objects
- ❑ Difficulty making friends
- ❑ Difficulty maintaining friendships
- ❑ Feeling as if you'd be better off dead
- ❑ Feeling manipulated or controlled by others
- ❑ Difficulty making decisions
- ❑ Loss of interest in sexual relationships

- ❑ Feeling "numb" or cut off from emotions
- ❑ Concerns about physical health
- ❑ Concerns about emotional stability
- ❑ Tremors
- ❑ Delusions
- ❑ Feeling sexually attracted to members of your own sex
- ❑ Feeling distant from God
- ❑ Hallucinations
- ❑ Hypersomnia (sleeping all the time)
- ❑ Not being able to say what you really think or feel

❑ Other: _____

_____

_____

What would you like to gain from counseling? _____

_____

How did you hear about us? _____

SPIRITUALITY

Do you believe in God? ❑ Yes ❑ No What is your religious preference? _____

Are you a member of a church? ❑ Yes ❑ No If yes, what church? _____

How much influence does your religion have on your day-to-day activity? ❑ A lot ❑ A moderate amount ❑ A little ❑ None

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

(Next of Kin – Other than Spouse)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

Stonebriar Psychiatric Services, P.A. Policies

OFFICE HOURS:

Monday through Thursday, 8:00 a.m. to 4:00 p.m. The office is closed major holidays and the week between Christmas Eve and New Year's.

APPOINTMENTS:

Sessions are by appointment only during regular office hours. Fees are based on time and sessions that go over will be charged accordingly. With the exception of emergency situations over which we have no control, our appointments begin promptly as scheduled. Your appointment time is reserved for you and you are encouraged to be certain that you arrive on time. If you are late, you will cut into your appointment time but will be responsible for the fee for the full time. **It is your responsibility to keep track of your appointments**. We make efforts to provide a courtesy reminder, but cannot guarantee that the reminder will be made or that it has been received. Reminders will normally be made via email, the day prior to the appointment if you have signed permission for us to email, but this is not guaranteed and should not be relied.

APPOINTMENT CHANGES/CANCELLATIONS:

Patients agree to notify the office of appointment changes or cancellations as far in advance of the scheduled time as possible to allow another patient to utilize the time. There is a required **mimimum** notice of 24 business hours for individual sessions, a **minimum** notice of 48 hours for extended sessions (75, 90 and 120 minutes) and a **minimum** 1 week notice for scheduled intensives (over 120 minutes in one day) and all appointments during a holiday week, to avoid being charged for the time reserved. Monday appointments must be cancelled by the corresponding time on Thursday to avoid being a late cancel. If this minimum notice is not respected, patient will be charged the full fee for the time reserved. In the case of inclement weather, call the office first thing in the morning to see if the office has been closed. If not, and you are uncomfortable driving, you may have a phone session instead. In that case, you must call the office **prior to your appointment by at least 10 minutes and** give the receptionist your credit card information/authorization so you will be ready to be connected for your phone session. Receipts will be e-mailed to you if you have signed the authorization to do so. If you do not call or come to your appointment, you will be charged.

If, for any reason, SPS must cancel an appointment, the patient will be advised as soon as possible.

FEES AND PAYMENT:

Payment is required at or before the time of the appointment. We provide coded receipts for patients who wish to file for reimbursement on their own, but we do not deal directly with health insurance companies, nor do we complete or sign forms, provide treatment plans, or forward records. Please keep the documentation given to you at time of treatment. Additional copies will incur a fee to research and photocopy receipts. You may also use this documentation to file your claim if you participate in a cafeteria or medical reimbursement plan at your place of employment. There is a $ 40.00 charge for bounced checks and a $ 30.00 fee for declined credit cards. Unpaid balances are charged a late fee of $50.00/month. Fees stated are subject to change.

EMERGENCY CALLS:

During office hours, for calls that are urgent but not life threatening, please speak to the staff. For those that represent a life threatening emergency, always call 911 immediately or go to your local emergency room. When you are expecting a return call and your telephone **Caller ID** does not accept "Private or Blocked Calls", we will not be able to return your phone call. Please **unblock** your **Caller ID** prior to placing your call. Fees will be charged based on time required to listen to your message, return the call and document the interaction.

REPORTS, LETTERS, RECORDS, DISABILITY FORMS

May be provided at doctor's discretion and incur a fee, depending on the complexity of the document and time involved.

CONTACT POLICY:

Except in extreme situations, contact will normally be restricted to session time. There will be a routine charge for phone calls based on the time spent per call. For more extensive phone calls, please schedule a phone appointment with your physician.

Although we have e-mail available, patients are advised that e-mail transmissions are not secure and therefore may not be confidential. We will not conduct e-mail therapy sessions.

PRESCRIPTION POLICY:

If you have been given a controlled prescription, it is regulated by our state government. Please be aware that these prescriptions **must be filled within 21 days**, and no refills are allowed. If you do not fill the prescription in the 21 day time period you will be required to pay the **$30.00 fee to re-issue it**. **PRESCRIPTIONS FOR CONTROLLED SUBSTANCES CANNOT BE CALLED IN AND MUST BE PICKED UP OR MAILED.** When requesting a refill, please provide all information regarding the prescription you are requesting, including your pharmacy name and number. Prescription refills incur a $30.00 fee during office hours and $45.00 outside of office hours. A mail out fee of $10.00 is charged for prescriptions requested to be mailed. Fees stated are subject to change. Prescription preauthorizations incur a $35.00 fee.

Take all medication as prescribed. As with all medications, these have been prescribed for you exclusively, based on knowledge of your personal needs and medical background. Sharing these medications is both medically contraindicated and illegal. Your cooperation is appreciated. Prescriptions will **only** be called in for those who are *current patients and who maintain their regularly scheduled appointments*. We do not participate in "auto refills". You will generally have enough refills on your prescriptions to last until your next appointment and it is your responsibility to schedule and keep your appointments as suggested. If you cancel or fail to schedule your next appointment, you will need to make arrangements to be seen prior to receiving a refill. Refills may be requested between 9:00 am and 4:00 pm on weekdays. **We will not be able to provide immediate refills to walk-in patients, nor do we issue refills in the evenings or on weekends or holidays.**

TERMINATION POLICY:

Patients are under no obligation to continue services should they decide to terminate at any time. However, we strongly urge that the doctor be notified in person during a session regarding this decision so that it can be discussed openly. Dr. Tharp's goal is to make all terminations as therapeutically helpful as possible. We reserve the right to terminate treatment for individuals who repeatedly fail to make or keep appointments or follow treatment recommendations.

ACCEPTANCE OF POLICIES:

Stonebriar Psychiatric Services, PA is committed to providing professional services of the highest quality and standards. In order to serve our patients efficiently and responsibly we require agreements be made as to the policies stated above. Patients are encouraged to ask questions before signing.

I have read the policies, understand, and agree to abide by them.

Patient's Signature	Date	Guardian's Signature (if minor)

Stonebriar Psychiatric Services, PA.

GENERAL CONSENT FOR TREATMENT

I authorize my psychiatrist/therapist to carry out psychological examinations, treatment, and diagnostic or medical procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

GENERAL CONSENT FOR TREATMENT (if patient is a child or dependent of beneficiary)

On behalf of the patient, _____ (name), I (the Legal Guardian or Legal Representative) legally authorize Stonebriar Psychiatric Services, PA to deliver mental health care services to the patient as decribed in the "**GENERAL CONSENT FOR TREATMENT"** paragraph above.

I also understand that all policies in this statement apply to the patient I represent. **I acknowledge that my child's records are considered confidential except in the stated exceptions listed under "CONFIDENTIALITY and AUTHORIZATION TO RELEASE INFORMATION".**

I understand that a Family Systems Assessment and follow-up family therapy sessions may be recommended as part of my child or adolescent's treatment. along with individual therapy sessions and medication management appointments, if the child/adolescent is on medication.

_____

Patient/Legal Representative Date

_____

Witness Date

Welcome to Stonebriar Psychiatric Services, PA.

Welcome! We are happy to have you or your family member as a patient and will do everything within our professional capacity to make the treatment as productive as possible.

The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals is essential for the best benefit of therapy. If you ever have questions about the nature of the treatment or any other aspect of your care, please do not hesitate to ask.

CONFIDENTIALITY and AUTHORIZATION TO RELEASE INFORMATION

It is understood that all information between patient and psychiatrist/therapist is held strictly confidential, and the psychiatrist/therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws.
2. The patient presents an imminent danger to self.
3. The patient presents an imminent danger to others.
4. Child/elder abuse/neglect is suspected.
5. As necessary for continuity of care.
6. If a judge determines that our discussions are not confidential, a judge may request specific information.
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3, and #4, the psychiatrist/therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. Our fees are based on professional time and patient and/or guardian is financially responsible for time spent on the above matters. Stonebriar Psychiatric Services, PA follows the "minimum necessary" rule when releasing information.

PATIENT CONSENT TO RELEASE OF INFORMATION

I consent to information release about my case (or my child's case) with the referral source and other co-treating health care providers and facilities for the purposes of treatment. I authorize that Stonebriar Psychiatric Services, PA providers may disclose any information, including drug and alcohol abuse and HIV status, regarding my or my child's treatment for purposes of continuity of care. I know I have the right to revoke this authorization which must be in writing and given to my provider. I understand that if I revoke this authorization, my providers may determine that treatment cannot be effective without continuity of care, and may elect to transfer my care to another provider. This Authorization is valid as long as I am treated at Stonebriar Psychiatric Services, PA, or by my revoking the authorization.

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Witness Date

Stonebriar Psychiatric Services, P.A.

Payment of Services and Missed Appointment Agreement Form

Our services are provided by appointment only and when a patient schedules an appointment, time is reserved for that patient and not available to others. Missed appointments, as well as those cancelled with less than a **minimum** 24 *business* hours' notice (48 hour **minimum** on extended sessions and 1 full week **minimum** notice on intensives, which are appointments including over 120 minutes scheduled in one day) will be charged the fee for the visit. Business hours are when staff are in the office.

This same credit card will be used in the event of a phone session or other service whether patient is in the office or not (prescription refills, reports, forms, letters, phone calls, phone calls to outside therapists, legal authorities, CPS, etc), as well as to cover checks returned for nonsufficient funds (NSF), or an outstanding unpaid balance.

Patient Name: _____

The fee for the visit will be charged on the day of the missed appointment (or day of the late-cancel) to the following credit card:

Visa MasterCard American Express Discover

Credit Card #: _____

Expiration Date: _____

Name as it appears on Card: _____

Security Code from back of card: _____

I, _____, cardholder for the credit card listed above, understand and agree that if I or my family member do not show up for a scheduled appointment or if I cancel a scheduled appointment with less than a minimum **24** *business* hours' notice (48 hour minimum *business* hours' notice extended sessions) **and 1 full week** minimum *business* hours' **notice on intensives, which are appointments including over 120 minutes scheduled in one day**), the above named credit card will be charged for the full amount of the reserved session. Additional fees as listed above will also be charged.

Cardholder Signature _____ **Date** _____

Printed Name _____

Billing Address: _____

City: _____ Zip: _____ Day Phone_____

- ***To qualify for a timely cancellation on <u>individual</u> Monday appointments, the cancellation must be received by the corresponding time on the previous Thursday. Cancellations immediately preceding a holiday break must occur before the corresponding time on the last business day before the holiday. Voice mail and e-mail cancellations do not qualify as they can not be guaranteed as received.***

ADDITIONAL AUTHORIZATION

☐ Use this authorization to charge services for all my family member(s) who are also seen at the office. _____ (initial your approval) Otherwise a separate form will be required for each individual.

- ☐ All Family Members _____ (initial your approval)
- ☐ Specific family member(s)
  - ☐ _____ (name) _____ (initial your approval)
  - ☐ _____ (name) _____ (initial your approval)
  - ☐ _____ (name) _____ (initial your approval)
  - ☐ _____ (name) _____ (initial your approval)

Stonebriar Psychiatric Services, PA

CAGE and SCOFF screens

		Yes	No
1.	Have you ever felt you ought to cut down on your drinking?	☐	☐
2.	Have people annoyed you by criticizing your drinking?	☐	☐
3.	Have you ever felt bad or guilty about your drinking?	☐	☐
4.	Have you ever had an "eye-opener" to steady nerves in AM?	☐	☐
5.	Have you used substances more than intended this year?	☐	☐
6.	Do you make yourself **SICK** because you feel uncomfortably full?	☐	☐
7.	Do you worry you have lost **CONTROL** over how much you eat?	☐	☐
8.	Have you recently lost more than **ONE STONE (15 pounds)** in a three-month period?	☐	☐
9.	Do you believe yourself to be **FAT** when others say you are too thin?	☐	☐
10.	Would you say that **FOOD** dominates your life?	☐	☐

Stonebriar Psychiatric Services, PA
Mood Disorder Questionnaire

		YES	NO
1.	Has there ever been a period of time **when you were not your usual self** and …		
	… 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 much 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 able to work; having family, money or legal troubles; getting into arguments or fights?		
	☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem		
4.	Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5.	Has a health professional told you that you have manic-depressive illness or bipolar disorder	☐	☐

Stonebriar Psychiatric Services, PA

Adult ADHD Self-Report Scale Symptom Checklist

Patient Name					
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 turn in this completed checklist when you are finished.	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
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 situation					
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?					

PERSONALITY PROFILE NAME: _____ DATE: _____

DIRECTIONS: - Select one of the four words in each line that is most like you and place an X in front of that word. Continue through all forty lines. Be sure each numbered line is marked, and that each line has **only one** mark.

STRENGTHS

1.	___ Adventurous	___ Adaptable	___ Animated	___ Analytical
2.	___ Persistent	___ Playful	___ Persuasive	___ Peaceful
3.	___ Submissive	___ Self-sacrificing	___ Sociable	___ Strong-willed
4.	___ Considerate	___ Controlled	___ Competetive	___ Convincing
5.	___ Refreshing	___ Respectful	___ Reserved	___ Resourceful
6.	___ Satisfied	___ Sensitive	___ Self-reliant	___ Spirited
7.	___ Planner	___ Patient	___ Positive	___ Promoter
8.	___ Sure	___ Spontaneous	___ Scheduled	___ Shy
9.	___ Orderly	___ Obliging	___ Outspoken	___ Optimistic
10.	___ Friendly	___ Faithful	___ Funny	___ Forceful
11.	___ Daring	___ Delightful	___ Diplomatic	___ Detailed
12.	___ Cheerful	___ Consistent	___ Cultured	___ Confident
13.	___ Idealistic	___ Independent	___ Inoffensive	___ Inspiring
14.	___ Demonstrative	___ Decisive	___ Dry humor	___ Deep
15.	___ Mediator	___ Musical	___ Mover	___ Mixes easily
16.	___ Thoughtful	___ Tenacious	___ Talker	___ Tolerant
17.	___ Listener	___ Loyal	___ Leader	___ Lively
18.	___ Contented	___ Chief	___ Chartmaker	___ Cute
19.	___ Perfectionistic	___ Permissive	___ Productive	___ Popular
20.	___ Bouncy	___ Bold	___ Behaved	___ Balanced

WEAKNESSES

21.	___ Blank	___ Bashful	___ Brassy	___ Bossy
22.	___ Undisciplined	___ Unsympathetic	___ Unenthusiastic	___ Unforgiving
23.	___ Reticent	___ Resentful	___ Resistant	___ Repetitious
24.	___ Fussy	___ Fearful	___ Forgetful	___ Frank
25.	___ Impatient	___ Insecure	___ Indecisive	___ Interrupts
26.	___ Unpopular	____ Uninvolved	___ Unpredictable	___ Unaffectionate
27.	___ Headstrong	___ Haphazard	___ Hard to please	___ Hesitant
28.	___ Plain	___ Pessimistic	___ Proud	___ Permissive
29.	___ Angered easily	___ Aimless	___ Argumentative	___ Alienated
30.	___ Naïve	___ Negative attitude	___ Nervy	___ Nonchalant
31.	___ Worrier	___ Withdrawn	___ Workaholic	___ Wants credit
32.	___ Too sensitive	___ Tactless	___ Timid	___ Talkative
33.	___ Doubtful	___ Disorganized	___ Domineering	___ Depressed
34.	___ Inconsistent	___ Introvert	___ Intolerant	___ Indifferent
35.	___ Messy	___ Moody	___ Mumbles	___ Manipulative
36.	___ Slow	___ Stubborn	___ Show-off	___ Skeptical
37.	___ Loner	___ Lord over	___ Lazy	___ Loud
38.	___ Sluggish	___ Suspicious	___ Short-tempered	___ Scatterbrained
39.	___ Revengeful	___ Restless	___ Reluctant	___ Rash
40.	___ Compromising	___ Critical	___ Crafty	___ Changeable

Stonebriar Psychiatric Services, P.A.
Child Development Questionnaire

PREGNANCY

1. Duration of pregnancy: ☐ full term ☐ early by _____ ☐ late by _____

2. Did mother smoke during pregnancy? ☐ yes ☐ no
   Number daily: _____

3. Did mother ingest alcohol during pregnancy? ☐ yes ☐ no
   Type and amount: _____

4. Did mother ingest drugs during pregnancy? ☐ yes ☐ no
   Details: _____
   _____

5. Was mother on medications during preganacy? ☐ yes ☐ no
   Details: _____
   _____

6. Complications: _____
   _____
   _____

DELIVERY:

7. Was labor ☐ spontaneous ☐ induced

8. Duration of labor: _____ hours

9. Delivery was ☐ normal ☐ breach ☐ cesarean

10. ☐ premature _____ weeks

11. Birth weight _____ lbs _____ ozs. Length _____ inches

12. Infant days in hospital

13. APGAR scores _____ _____

14. Complications: _____
    _____

MILESTONES

15. Describe motor skill development: _____
    _____

16. Describe language development:
    _____
    _____

17. Describe social development / attachment:

_____

_____

18. Problems during infancy / early childhood:

_____

_____

_____

ABUSE HISTORY:

19. Has there been any

Type of Abuse	If yes, by whom?	How long did it last?	How old was the child	Was it reported to authorities?
Physical				
Sexual				
Emotional/Verbal				
Abuse/Neglect				

20. Witness of abuse?
    - ☐ physical Details: _____
    - ☐ sexual _____

21. Perpetrator of abuse:
    - ☐ physical Details: _____
    - ☐ sexual _____

Medication History

It is very important that we have this information on ALL medications you have been on, the dosage, and length of time on the dosage. It is also important that we know how much benefit you felt you received while on this medication. Please indicate any side effects as well as the severity. If you do not complete this information, we will have to gather it during your session, which may cause the session to go over the allotted time and result in a higher fee. If you exceed the number of lines on this form, you may reprint it on the reverse side or on a second sheet of paper. **This information is extremely important in assessing your treatment options.** If you need to contact pervious physicians for this, please do so prior to your appointment. Thank you.

Medication	Dosage	Date & Length of Time on This Dose	Results or Benefits	Side Effects Experienced