



2655 State Road 580, Suite 202 - Clearwater, Florida 33761

7011 Ridge Road – Port Richey, Florida 34668

Patient Name: _____ Date of Birth: _____

Referred by: _____

Reason for Visit: _____

Current psychiatric medications and doses: _____

PHARMACY INFORMATION:

Name of Pharmacy: _____

Phone Number: _____

Fax Number: _____

Address: _____

PRIMARY CARE PHYSICIAN INFORMATION:

Is it okay to contact your Primary Care Doctor?

Yes No I do not have one

(If yes, please fill out accompanying Release of Information at the end of the packet)

Doctor's Name: _____

Phone Number: _____

Fax Number: _____

Address: _____

Please check all that apply:

<ul style="list-style-type: none"> <input type="checkbox"/> Depressed mood <input type="checkbox"/> Hopeless or helpless <input type="checkbox"/> Don't do pleasure or leisure activities like I use to <input type="checkbox"/> Feelings of guilt <input type="checkbox"/> Feelings of worthlessness <input type="checkbox"/> Low self-esteem <input type="checkbox"/> Decreased energy <input type="checkbox"/> Decreased concentration <input type="checkbox"/> Appetite or weight changes <input type="checkbox"/> Moving slower or speaking slowly <input type="checkbox"/> Feeling fidgety or have feeling of inner restlessness <input type="checkbox"/> Sex drive changes <input type="checkbox"/> Fatigued / tired most days <input type="checkbox"/> Feel irritable often for no reason <input type="checkbox"/> Harder to make decisions than I use to <input type="checkbox"/> Sleep problems <ul style="list-style-type: none"> Hard to get to sleep, but I stay asleep Hard to stay asleep, but I get to sleep okay Hard to get to sleep and hard to stay asleep <input type="checkbox"/> Ideas of suicide or death <input type="checkbox"/> Anxious <input type="checkbox"/> Panic attacks <input type="checkbox"/> Fear of social situations <input type="checkbox"/> Obsessions <input type="checkbox"/> Compulsions 	<ul style="list-style-type: none"> <input type="checkbox"/> Mood swings or irritability <input type="checkbox"/> Anger outbursts <input type="checkbox"/> Decreased need for sleep <input type="checkbox"/> More talkative <input type="checkbox"/> Racing thoughts <input type="checkbox"/> At times, I become overly distractible where even small things pull me away from important things. <input type="checkbox"/> At times, I do more risky things than usual or I spend money of control or get involved in sex or other adventures that often turn out badly <input type="checkbox"/> At times, I do more impulsive than usual and do things that are totally out of character for me <input type="checkbox"/> At times, I start many projects or get into so many activities that I can't complete and I jump from one to another rapidly <input type="checkbox"/> At times, I am unusually irresponsible and take action that cause moderate to severe problems (legal, financial, relationship) for me and my family
<ul style="list-style-type: none"> <input type="checkbox"/> Do you feel threatened or scared? <input type="checkbox"/> Are people out to get you? <input type="checkbox"/> Can you read people's thoughts? <input type="checkbox"/> Can other people read your mind or know your thoughts? <input type="checkbox"/> Does the TV or radio talk to you? <input type="checkbox"/> Hear voices others can't? <input type="checkbox"/> See things others can't? <input type="checkbox"/> I have intrusive thoughts that are not my own <input type="checkbox"/> I have special abilities or powers others do not have <input type="checkbox"/> Thoughts are put inside my head by others <input type="checkbox"/> I sometimes have out of body experiences 	<ul style="list-style-type: none"> <input type="checkbox"/> I have experienced a traumatic event <input type="checkbox"/> I often have the same nightmare or bad dream <input type="checkbox"/> Memories come into my mind when I don't want them <input type="checkbox"/> Sometimes I feel numb all over when I have some memories <input type="checkbox"/> I avoid certain people and places I go <input type="checkbox"/> Sometimes I feel so much fear that I detach myself or feel disassociation from people or places <input type="checkbox"/> I am hyper-vigilant / hyper-aware even when no danger is present <input type="checkbox"/> I have many body aches and pains <input type="checkbox"/> I have neck, back and other chronic pain <input type="checkbox"/> I have headaches / migraines often <input type="checkbox"/> I have had a head injury in the past



2655 State Road 580, Suite 202 - Clearwater, Florida 33761

7011 Ridge Road – Port Richey, Florida 34668

Psychiatric History

Past Psychiatrist / Therapist: _____

Date Last Seen: _____

Past Psychiatric Diagnosis: _____

Past Psychiatric Medications: _____

1. Have you ever been hospitalized for any psychiatric reasons? YES NO

If yes, how many times? _____

What was the reason? _____

What was the date? _____

Where were you hospitalized? _____

2. Have you ever been placed under a Baker Act? YES NO

If yes, why were you Baker Acted? _____

What was the date/dates? _____

3. Have you ever attempted to commit suicide? YES NO

If yes, **how** did you attempt to kill yourself? _____

How many times did you attempt suicide? _____

What was the date(s)? _____



2655 State Road 580, Suite 202 - Clearwater, Florida 33761

7011 Ridge Road – Port Richey, Florida 34668

Medical History

Current Medical Issues: _____

Current Non-psychiatric Medications: _____

Allergies: _____

Surgical History

Past Surgeries (Include date/hospital/physician): _____



2655 State Road 580, Suite 202 - Clearwater, Florida 33761

7011 Ridge Road – Port Richey, Florida 34668

Family Psychiatric History (please check all that apply & list family member):

- Depression - family member(s): _____
- Anxiety - family member(s): _____
- Bi-polar - family member(s): _____
- Schizophrenia - family member(s): _____
- Suicidal Attempts-family member(s): _____
- ADD / ADHD - family member(s): _____
- Alcoholism - family member(s): _____
- Drug abuse - family member(s): _____
- Dementia - family members(s): _____

Social History

Smoking status (please check one that applies):

- Current Smoker Former Smoker Never Smoker

Alcohol consumption (please check one that applies):

- Non-Drinker Occasional Social Rare

Daily, _____ Drinks per day.

- I usually drink Beer Wine Liquor

Do you have a history of substance or alcohol abuse? YES NO

If so, please explain: _____

Have you ever been treated for substance abuse? YES NO

If so, where were you treated? _____

What was the date? _____



2655 State Road 580, Suite 202 - Clearwater, Florida 33761

7011 Ridge Road – Port Richey, Florida 34668

Marital Status (please check one that applies):

Single Married Divorced Widowed

How long: _____

Children: _____

Employment Status (please check one that applies):

Employment Unemployed Disability Retired

Employer: _____

IF on disability, please explain why: _____

Education Level: _____

Currently Residing With (please check one that applies):

- I am living alone
- I am living with a family member
- I am living with a spouse or significant other

Other: _____



2655 State Road 580, Suite 202 - Clearwater, Florida 33761

7011 Ridge Road – Port Richey, Florida 34668

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name _____ Date _____

Provider _____ Patient ID # _____

	Over the last 2 weeks, how often have you be bothered by any of 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

Add Columns:

Healthcare professional: For interpretation of TOTAL)

+

+

Please refer to accompanying scoring card.)

10 If you checked off any problems, how difficult 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 _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, Contact Dr. Spitzer at ris8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright © 1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc. ZT274388



2655 State Road 580, Suite 202 - Clearwater, Florida 33761

7011 Ridge Road – Port Richey, Florida 34668

Living will and Appointment of Healthcare Surrogate

OPATION A

I, _____, have not yet established an advance directive.

OPATION B

I, _____, want to choose how I will be treated by my physicians and other healthcare providers. If there comes a time when I am unable to communicate or make my own healthcare decisions because of illness or injury, I direct my physicians, my healthcare surrogate, and my family to honor this living will.

In the event I am unable to communicate or I am incapable of making decisions about receiving, withholding, or withdrawing medical procedures or other treatments, I designate my healthcare surrogate to make choices for me according to his/her understanding of my wishes and values.

My Appointed Healthcare Surrogate is:

Name: _____

Relationship to patient: _____

Address: _____

Phone: _____

Alt. Phone: _____

If my surrogate is unable or unwilling then my next choice (Alternate Surrogate) is:

Name: _____

Relationship to patient: _____

Address: _____

Phone: _____

Alt. Phone: _____



2655 State Road 580, Suite 202 - Clearwater, Florida 33761

7011 Ridge Road – Port Richey, Florida 34668

EMERGENCY ON-CALL AFTER HOURS SERVICE

PLEASE NOTE:

A charge of \$50 will be applied to patient accounts if after hour calls placed are non-emergent in nature.

(i.e. medication refills—please review refill policy; appointment questions; any other questions that could have been addressed during scheduled appointment time)

**** If there is a serious medical emergency, please call 911 or proceed to nearest emergency department****

I acknowledge the above:

Signature: _____

Date: _____



2655 State Road 580, Suite 202 · Clearwater, FL 33761
Phone: (727)733-6111 Fax: (727) 733-6002
www.healthandpsychiatry.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Name _____ SSN _____ DOB _____

I hereby give permission to/from: Dr. Dinar Sajan, M.D.
(Agency/ individual releasing information)

To disclose medical, including HIV, ARC any/or AIDS diagnosis _____ (initials), psychiatric, psychological, educational, alcohol and/or drug abuse information, or any other records of a sensitive nature, and may be released by copies of records, viewing of records or verbal exchange.

This information is to be released to/from: _____
(Agency/ individual releasing information)

Street Address	City	State	Zip Code	Phone	Fax
----------------	------	-------	----------	-------	-----

For the purpose of: **Coordination of Care**
The specific information to be disclosed is:

- | | | |
|--|--|--|
| <input type="checkbox"/> Psychiatric Information | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Other Specify: Medical Status |
| <input type="checkbox"/> Initial Assessment | <input type="checkbox"/> Labs/X-Ray/Test Result | |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Treatment Plan | |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Drug/Alcohol Abuse and/or History | |

I understand a general medical authorization or subpoena duces tecum without specific authorization to release psychiatric/psychological information MUST have this waiver from the patient/client or empowered representative. I understand that my records have a privileged and confidential status and that I am waiving that status for the purpose contained within this authorization. I understand that I have the right to refuse to sign this authorization. My refusal will no way hinder me from receiving treatment.

I understand this authorization may be revoked at any time upon written notification at the facility in which I received treatment, but revocation has no effect on action already taken as a result of this authorization. I understand that law prohibits any redisclosure of this information by receiving agency, not by the Federal Privacy Law, but by the Federal and State Laws.

This authorization is for { } singular or { } continuing disclosure valid for 365 days after the date of my signature.

Signature of Patient/Client	Date	Signature of Witness	Date
-----------------------------	------	----------------------	------

Signature of Legal Guardian/Representatives	Date	Relationship to Patient
---	------	-------------------------

If patient/client is a minor or unable to sign, legal representative/guardianship must be sustained with legal documentation accompanying this authorization