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Return forms and a copy of your photo identification and insurance card via email to manager@missionservicesorg.com prior to your appointment. If you are not able to keep your scheduled appointment, please contact the office to reschedule to avoid the risk of not being able to be rescheduled in this office.

Patient Information

Name ______________________________

Address ______________________________

____

Phone ______________________________

Cell ______________________________

Social Security # ______________________________

Birthdate ________________ Age ________

Race (optional) ______________________________

Marital Status Single Married Divorced Widowed

Patient Email ______________________________

Patient Employer

Name ______________________________

Phone ______________________________

Guarantor Info (If pt under age 18 or you have Guardianship forms)

Name ______________________________

Address ______________________________

____

Phone ______________________________

Guarantor Employer

Name ______________________________

Phone ______________________________

Emergency Contact

Name ______________________________

Phone ______________________________

Relation ______________________________

Preferred Pharmacy

Name ______________________________

Phone ______________________________

Name of Primary Care Doctor ______________________________

Address/Phone for Primary Care Doctor ______________________________

____

Who referred you to our office? ______________________________

Please initial according to your preference:

(_____) I give permission for this office to speak to the responsible party above about my bill.

(_____) I give permission for this office (including my clinician) to contact me via email and I accept the ordinary limitation of privacy with email (eg. Someone may look at my emails).

(_____) I give permission for this office (including my clinician) to contact me via text and I accept the ordinary limitation of privacy with texts (eg. Someone may look at my texts).

Patient Name ________________________ Todays Date ________________

1. Describe the reason (s) for seeking help ____

____

____

2. Please list medications you are currently taking, including both psychiatric and those for other medical conditions

Name of Medication	Strength	Dosage/Directions

3. Do you have other medical conditions/surgeries? Ex high blood pressure, heart disease, thyroid, etc.

____

____

4. Please list allergies to any medications, if any ________________________________

____

5. Past psychiatric medications and side effects ________________________________

____

____

GAD-7 (Modified Anxiety Rating Scale)

Over the last **TWO WEEKS**, how often have you been bothered by any of the following	**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 stop or control worrying	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
ADD EACH CIRCLED COLUMN				
OVERALL TOTAL				
10. If you circledd ANY problem(s) above, how difficult has it been to do your work, take care of things at home, or get along with other people	Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult

Mood Disorder Questionnaire (MDQ) – Modified Please **Circle** the answer to each question to the best of your ability. **Has there ever been a period of time when you were NOT your usual self and …**		
… you got much LESS sleep than usual and found you didn't really miss it?	YES	NO
… you had much MORE energy than usual?	YES	NO
… you were much MORE active or did many more things than usual?	YES	NO
… you were so EASILY distracted by things around you that you had trouble concentrating or staying on track?	YES	NO
… your thoughts RACED through your head, or you couldn't slow down your mind?	YES	NO
… you did things that were IRRITABLE that you shouted at people or started fights/arguments?	YES	NO
… you did things that were UNUSUAL for you or that other people might have thought were excessive, foolish, risky, or impulsive?	YES	NO
… you were MUCH more interested in sex than usual?	YES	NO
… SPENDING money got you or your family in trouble?	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 in trouble?	YES	NO
… you felt much MORE self-confident than usual?	YES	NO
… you were much MORE social or outgoing than usual, for example, you telephone friends in the middle of the night, etc.?	YES	NO
… you were much MORE talkative or spoke much FASTER than usual?	YES	NO
Total CIRCLED YES'S from above = _____ out of 13		
If you checked YES to more than one of the above, have several of these ever happened during the same time period?	YES	NO
How much of a problem did any of this cause you, like being able to work; having family, money or legal troubles; getting into fights/arguments? **Please circle ONE response** No Problem Minor Problem Moderate Problem Serious Problem		
Have any of your blood relatives (children, siblings, parents, grandparents, aunts/uncles) had manic-depressive illness or bipolar disorder?	YES	NO
Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	YES	NO

Alcohol Screening Questionnaire (AUDIT)

Answer the following questions and add up final score.

	0 Pts p/?	**1 pt p/?**	**2 pts p/?**	**3 pts p/?**	**4 pts p/?**
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times p/month	2-3 times p/week	4+ times p/week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+
How often do you have more than 5 drinks in one sitting?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found that you could not stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do something that was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse about your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured because of your drinking?	No		Yes, but in the last year		Yes, during the last year
Has a relative, friend, doctor or other health worker been concerned about your drinking and suggested you cut down?	No		Yes, but in the last year		Yes, during the last year
			Total Pts		

Do you smoke cigarettes? Yes No/Never No/ I used to

If yes how much do you smoke? ____________________

If No/I used to, when did you quit? ____________________

Do you use marijuana? Yes No

If yes, how often / how much? ______________________________