DR'S. L'ECUYER, BREWINGTON, MARTIN, LEGG, AND RACHAEL JAMES

Patient's Name: _____ Marital Status: M O S Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Cell: (_____) _____ SS# _____
(We need 2 numbers to reach you)
Place of Employment _____ Work Phone: (_____) _____

Emergency Contact: _____ Phone: (____) _____ Relationship: _____

Presenting Problem: _____

Referred by: _____ Phone: (____) _____

Primary Care Dr.: _____ Phone: (____) _____

Person Responsible for bill if other then patient (not an insurance company)
Name: _____ Address: _____
Date of Birth: _____ SS#: _____ Phone #: _____

I give permission for this office to speak to the responsible party about my bill. _____(Patient signature)
(Dr. L'Ecuyer's patients only) I give permission for my doctor to communicate with me by texting _____(initial) or email_____(initial) at the Email address:_____.

Co-pays and all patient balances are due at the appointment time. Patients showing no reasonable effort at being responsible for overdue accounts will receive one written warning before being referred elsewhere for care. The overdue account may be turned over to a collection agency. Services that are "non-covered", "non-authorized" "exceeding yearly maximum" or ruled "not medically necessary" by your insurance company are payable by you.

Missed appointments (or those not cancelled at least 24 business hours in advance) will be billed to you at $100.00. Insurance does NOT cover missed appointments or late cancellations. Your doctor may refer you elsewhere for treatment after three (3) missed appointments or late cancellations.

All reminder calls for upcoming appointments are a courtesy; it is up to you to remember appointment dates and times. For all patients **there is a fee for telephone conversations and administrative work longer than 5 minutes, both scheduled and un-scheduled**, and we do not bill this to insurance. None of the doctors are Medicare or Medicaid -- "private contracting fees" will apply instead (for example, if you are 65 or more years old, or are on Social Security Disability at any age).

Please take care of routine medicine refills during regular appointments. When this is not possible, have your pharmacy call or fax us during office hours (M-Th 8-5 and Fri 8-11:30 a.m.). All stimulant medication prescriptions (e.g. Ritalin, Adderall-not Strattera) must be picked up from the office, as we do not mail them. Call at least 3 days in advance when needing a written Rx; and there is a $10 fee for these being written outside of an appointment.

We file your insurance as a courtesy to you. If you feel the payment from your insurance company is not correct, YOU will need to call your insurance company. If you have two insurance carriers, please make sure you know which one is primary. If you change insurance it is your responsibility to inform us immediately. We are required to file a claim for visits once you have given us a copy of your insurance card. We do not backdate filings, but we will file from the date we receive your (new) insurance information. If you have a visit limit per year (or day), you will need to keep track of this. (Policies above subject to change.)

I authorize payment of medical benefits to the above-named health providers. I authorize the release of medical information to my insurance company as needed for benefit certification. I authorize my doctor in this office to send a written letter to the referring doctor or therapist about my care; and to discuss my case with my other doctors and/or therapists (if applicable) whenever necessary for my treatment.

I consent to the evaluation and treatment of myself (or my child) by the above doctor.

Signature of Patient (or Parent/Guardian, if applicable): _____ Date: _____

(You are the responsible person for the bill.)

Revised: 1-14/2-14/4-14/12-14/1-15/11-18/1-20

Name:_____ Date _____

Presenting Problem:_____

Allergies to Medications:

_____
_____

Past Psychiatric Medications/Side Effects if applicable:

_____
_____
_____
_____

Current Psychiatric Medications/Side Effects if applicable:

_____
_____
_____
_____
_____

Past Surgeries:

_____
_____
_____
_____

Current Medications/Conditions

_____
_____
_____
_____
_____

Current Over the Counter Medications/Vitamins

_____
_____
_____
_____

PLEASE ARRIVE EARLY TO COMPLETE THIS ONE PAGE PRIOR TO EVERY APPOINTMENT

Patient Name: _____ Date: _____/_____/_____ Age: _____ DOB: _____/_____/_____

Review of Systems/Symptoms: (Circle any current symptoms within the last **TWO WEEKS** or check **NONE**)

Systems	**Signs/Symptoms**				
1. General/Constitutional	☐ None	Fevers	Weight Loss	Weight Gain	Other:
2. Eyes	☐ None	New Blurred Vision			Other:
3. Ears/Nose/Mouth/Throat	☐ None	Dry Mouth	Ears Ringing		Other:
4. Cardiovascular	☐ None	Fast Heart Rate	Chest Pain	Chest Tightness	Other:
5. Respiratory	☐ None	Shortness of Breath		Cough	Other:
6. Gastrointestinal	☐ None	Constipation	Diarrhea	Nausea/Vomiting	Other:
7. Genitourinary	☐ None	Urinary Problems	Low Libido		Other:
8. Muscular/Skeletal	☐ None	Muscle/Joint Pain	Weakness	Falls	Other:
9. Integumentary/Skin	☐ None	Increased Sweating		Rash	Other:
10. Neurological	☐ None	Memory Problems	Headache	Dizziness	Other:
11. Endocrine	☐ None	Heat/Cold Intolerance		Tremor	Other:
12. Hematologic/Lymphatic	☐ None	Easy Bruising/Bleeding		Blood Clots	Other:
13. Allergies/Immune	☐ None	Anaphylactic Shock		Hives	Other:
14. Psychiatric	See Below				

PHQ-9 (Modified Mood/Depression Rating Scale)

Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems? *(CIRCLE the # 0, 1, 2, OR 3 for each row/question)*	**Not at All**	**Several days**	**More than half the days**	**Nearly every Day**
1. Felt down, depressed, sad, tearful, and/or hopeless	0	1	2	3
2. Trouble falling asleep, staying asleep, waking up too early, OR sleeping too much	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Felt worthless, hopeless, helpless, guilt, and/or failure	0	1	2	3
5. Low energy, feeling tired, or fatigued	0	1	2	3
6. Trouble with concentration (watching TV, reading, work, etc…), indecisiveness, and/or maintaining focus	0	1	2	3
7. Poor appetite or overeating	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed; OR, the opposite, feeling so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
9. Thoughts of not wanting to be alive, wishing to be dead, or considering harming yourself	0	1	2	3
ADD EACH CIRCLED COLUMN	-	+	+	
OVERALL TOTAL =				

10. If you circled 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? *(**Check ONE** answer to the **right**)*	Not difficult at all ☐	Somewhat difficult ☐	Very Difficult ☐	Extremely difficult ☐

GAD-7 (Modified Anxiety Rating Scale)

Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems? *(CIRCLE the # 0, 1, 2, OR 3 for each row/question)*	**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 =				

8. If you circled 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? *(**Check ONE** answer to the **right**)*	Not difficult at all ☐	Somewhat difficult ☐	Very Difficult ☐	Extremely difficult ☐

The Mood Disorder Questionnaire (MDQ) - Modified

Instructions: Please CIRCLE the answer to each question to the best of your ability.

Patient Name: _____ Date: _____/_____/_____ Age: _____ DOB: _____/_____/_____

A. Has there ever been a period of time when you were not your usual self and….		
1. …you got much **LESS SLEEP** than usual and found you didn't really miss it?	YES	NO
2. ...you had much **MORE ENERGY** than usual?	YES	NO
3. ...you were much **MORE ACTIVE** or did many more things than usual?	YES	NO
4. ...you were so easily **DISTRACTED** by things around you that you had trouble concentrating or staying on track?	YES	NO
5. …your **THOUGHTS RACED** through your head or you couldn't slow your mind down?	YES	NO
6. …you were so **IRRITABLE** that you shouted at people or started fights or arguments?	YES	NO
7. …you did things that were **unusual** for you or that other people might have thought were excessive, foolish, **risky** or **IMPULSIVE**?	YES	NO
8. …you were much more interested in **SEX** than usual?	YES	NO
9. …**SPENDING** money got you or your family into trouble?	YES	NO
10. …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**?	YES	NO
11. …you felt much more **SELF-CONFIDENT** than usual?	YES	NO
12. …you were much **MORE SOCIAL OR OUTGOING** than usual, for example, you telephoned friends in the middle of the night, etc…?	YES	NO
13. ...you were much more **TALKATIVE** or spoke much **FASTER** than usual?	YES	NO
TOTAL CIRCLED YES's from above = _____ out of 13	-	-
B. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	YES	NO
C. 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? *Please circle only one response below:* No Problem Minor Problem Moderate Problem Serious Problem	- - - -	- - - -
D. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	YES	NO
E. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	YES	NO

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

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 give this completed checklist to your healthcare professional to discuss during today's appointment.

	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 situations?					
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?					

Part B

AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

12 oz. of beer (about 5% alcohol) =

8-9 oz. of malt liquor (about 7% alcohol) =

5 oz. of wine (about 12% alcohol) =

1.5 oz. of hard liquor (about 40% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. 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	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at ***www.who.org***.