Peg Walsh, MS, CNS

PATIENT INFORMATION

Last Name_____First Name_____Middle_____

DOB_____Age_____

Phone #'s Home_____Can we leave a message____

Cell_____ Can we leave a message____

Work_____Can we leave a message_____

Email Address _____

Address_____

City_____State_____Zip_____

Marital Status:_____Spouses Name _____
Employer/Occupation_____

How did you hear about us? _____

*Alternate Address*_____*City*_____*State*_____*Zip*_____
*(if applicable) When will you be at this address?*_____*Phone#* _____

EMERGENCY CONTACT INFORMATION

Name_____ Home #_____Work/Cell#_____
Relationship to you_____

.

By signing this intake form I am requesting and agreeing to receive therapy services from Peg Walsh, MS CNS

SIGNED_____ **DATE**_____

Health Questionnaire

Peg Walsh, CNS

Name_____**Date**_____

Allergies – Also list your response to this substance: _____

_____

_____

Current medication and dosages:

_____

_____

_____

_____

_____

_____

Current Health Problems:

_____

_____

_____

_____

_____

_____

_____

_____

Past Psychiatric Treatments- List Types of Therapies, ECT, etc..

_____

_____

_____

_____

Family History for Psychiatric of immediate or blood relatives including suicide

_____

_____

_____

_____

Please list medications that you have tried before.

List Good Effects and Bad effects of each:

_____

_____

_____

_____

_____

_____

_____

Hospitalizations and past surgeries - Please give dates if possible

_____

_____

_____

_____

_____

_____

Describe Alcohol Use:

Kind of beverage_____, # of Glasses _____

# of days per week_____; Total glasses per week _____

Social only_____

Recreational Drugs: Substance of choice and frequency:

_____

_____

_____

Describe your sleep: # of hours, trouble falling asleep, early wakening, is it restful?, do you awake refreshed?

_____

_____

_____

_____

_____

Your goals for seeking treatment now:

_____

_____

_____

_____

_____

_____

_____

_____

Reviewed by_____Date _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "f/" to indicate your answer)*	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

(For office coding: Total Score **T__** = + + _)

Developed by Ors. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use ",/ " to indicate your answer)*	**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 <u>any</u> problems, how <u>difficult</u> have these problems made it for 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**
D	D	D	D

THE MOOD DISORDER QUESTIONNAIRE

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

	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?	0	0
...you were so irritable that you shouted at people or started fights or arguments?	0	0
...you felt much more self-confident than usual?	0	0
...you got much less sleep than usual and found you didn't really miss it?	0	0
...you were much more talkative or spoke much faster than usual?	0	0
...thoughts raced through your head or you couldn't slow your mind down?	0	0
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	0	0
...you had much more energy than usual?	0	0
...you were much more active or did many more things than usual?	0	0
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	0	0
...you were much more interested in sex than usual?	0	0
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	0	0
...spending money got you or your family into trouble?	0	0
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	0	0
3. 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 one response only.* 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?	0	0
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	0	0

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

Margaret Walsh, MS, CNS

9990 Coconut Rd, Bonita Springs, Fl 34135

Name_____

I have received a copy of the Privacy Policies. I understand they are always available on the internet.

Signature_____ Date:_____