

## New Patient Information

Please bring this form with your insurance card to your first visit; complete as much as you can.

NAME (First, Last)	M.I.	BIRTH DATE	TODAY'S DATE
STREET ADDRESS		CITY	STATE / ZIP
WORK PHONE	HOME PHONE	CELL PHONE	
<p><i>Circle which phone you prefer we call first.</i></p> <p><b>If needed, may we leave a message on your answering machine?    Yes    No</b></p>			
EMAIL (you may enter up to 3 emails for appointment reminders)			
PHARMACY Name, Phone and Street / City if known		MAIL ORDER PHARMACY (if using)	
<p><b>In case of an emergency, is there someone we can contact (list below):</b></p>			
NAME	PHONE	RELATIONSHIP	

### Insurance Information\*

If you plan to use insurance, complete and sign the following and bring your insurance ID card.

NAME OF POLICY HOLDER	POLICY HOLDER'S ID #	EMPLOYER'S NAME
INSURANCE PLAN NAME	POLICY GROUP OR FECA #	IS THIS YOUR ONLY PLAN?
<p><b>Enter the policy holder's information, if different from yours:</b></p>		
ADDRESS	CITY	STATE / ZIP
PHONE	BIRTH DATE, GENDER	RELATIONSHIP TO YOU

*You may need to call you insurer to obtain the following information:*

AUTHORIZATION #, IF NEEDED	COPAY	DEDUCTIBLE	DATE DEDUCTIBLE BEGINS

**\*Note: We are in-network for Blue-cross Blue-shield, Cigna, United Behavioral Health, Wellpath, CBHA, Primary Physician Care and Conoco. However, if you also have medicare or medicaid in addition to one of these plans our services will not be covered. Also note that in rare occasions your primary insurer may "carve out" your mental health services to another provider that we are not in-network for (such as Magellan); if this is the case please contact your insurer to clarify if we are covered (in our experience the bcbs plan for federal employees carves out to Magellan and will cover our services with prior authorization; other Magellan plans do not cover our services).**





**Signature to allow communication with others (optional)**

If there are people whom you would like to be involved in your treatment, and would like us to be able to discuss your treatment with them in case they contact us, please list them and sign below (you can change this at a later date).

NAME OF PERSON INVOLVED	RELATIONSHIP	PHONE NUMBER

We will not discuss your treatment with anyone else without your permission unless it is your doctor, pharmacist or therapist we need to speak to. If there is anyone you want to make sure we have no contact with, please list their name here as an extra precaution:

NAME OF PERSON WE SHOULDN'T SPEAK WITH	RELATIONSHIP

\_\_\_\_\_  
Signature of Patient (or Parent/Legal Guardian if under 18)      Date

*The remaining pages are designed to help you think about and gather important information about your condition prior to our visit. They contain rating scales that you may complete your self and, if you feel comfortable, versions for a close friend or relative to complete.*



## Recent Symptoms

In the past week, about how many days did you feel well? \_\_\_\_\_

In the past week, what is the most \_\_\_\_\_ and least \_\_\_\_\_ you slept in a 24-hr period?

Please rate your mood symptoms for *the past week*...

	None	Mild (infrequent or rarely causing a problem)		Moderate (often or causing some problems)		Severe (constant or causing many problems)	
Depression, including lack of pleasure/motivation	0	1	2	3	4	5	6
Inactive, withdrawing or not doing much	0	1	2	3	4	5	6
Trouble making decisions, concentrating, planning or organizing	0	1	2	3	4	5	6
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3	4	5	6
Anxiety, fear, or nervousness	0	1	2	3	4	5	6
Irritability (check if it was: verbal <input type="checkbox"/> , physical to objects <input type="checkbox"/> , physical to people <input type="checkbox"/> )	0	1	2	3	4	5	6
Unusually high energy / motivation or decreased need for sleep	0	1	2	3	4	5	6
Feeling so good or hyper that it was noticeable to others	0	1	2	3	4	5	6
Doing things that others might think are risky, impulsive or excessive	0	1	2	3	4	5	6
Rapid thoughts that move so fast it's hard to follow them	0	1	2	3	4	5	6
Difficulty sustaining attention, such as reading, lectures, conversation, TV	0	1	2	3	4	5	6
Distracted by noises around you or by your own thoughts	0	1	2	3	4	5	6
Procrastinating, avoiding tasks or not finishing them	0	1	2	3	4	5	6

Circle if you recently had trouble with any of these symptoms:

Current Weight: \_\_\_\_\_

**Mental:** 1) emotional numbing 2) paranoid sensations 3) panic attacks (how many per week \_\_\_?) 4) Hearing voices or seeing things 5) fatigue 6) memory problems **Sleep:** 7) needing > 10 hr sleep 8) needing < 4 hr sleep 9) vivid dreams 10) sleep-walking 11) snoring **Neurologic:** 12) inner tension or restlessness 13) muscle stiffness 14) slowing of movements or muscles 15) unwanted muscle movements 16) imbalance 17) dizziness 18) fainting or falling 19) tremor 20) sensory changes 21) taste changes 22) headaches 23) teeth grinding **General:** 24) flu-like feelings 25) sexual difficulties 26) physical pain (rate 1-10, 10=worst: \_\_\_\_\_) **Eyes:** 27) blurry vision 28) visual changes 29) double vision **Stomach:** 30) increased appetite 31) bingeing or purging 32) appetite loss 33) stomach pain 34) nausea 35) diarrhea 36) constipation 37) dry mouth 38) excess thirst 39) excess salivation **Skin:** 40) rash 41) acne 42) excess sweating 43) itch 44) easily sunburned 45) unusual bruising 46) hair loss **Heart:** 47) palpitations **Urinary:** 48) frequent urination 49) difficulty urinating **Female:** 50) menstrual changes 51) breast changes

For each substance, let us know your average daily use over the past week...

Caffeine \_\_\_ cups/day. Nicotine \_\_\_ pack/day. Alcohol: \_\_\_ drinks/day. Other substances: \_\_\_\_\_

Sleep meds: \_\_\_ #/week. If taking an anxiety-med as needed, how many do you use? \_\_\_\_\_ per day / week / month. ☺



## Sample Medication Names

### Mood Stabilizers

*Lamictal, lamotrigine*

*Lithium, lithobid, eskalith*

*Depakote, valproate*

*Trileptal, oxcarbazepine*

*Tegretol, carbamazepine*

*Atypicals (aripiprazole, abilify, zyprexa, olanzapine, risperdal, risperidone, seroquel, quetiapine, geodon, ziprasidone, saphris, asenapine)*

### Antidepressants

*SSRIs (fluoxetine, prozac, sertraline, zoloft, paroxetine, paxil, fluvoxamine, luvox, citalopram, celexa, escitalopram, lexapro)*

*SNRIs (effexor, venlafaxine, cymbalta, duloxetine, pristin, desvenlafaxine, savella, milnacipran)*

*Wellbutrin (bupropion, budeprion, aplenzin)*

*Remeron, mirtazipine*

*Serzone, nefazodone*

*Trazodone, desyrel*

*Tricyclics (imipramine, clomipramine, amitriptyline, nortriptyline, doxepin, protriptyline, elavil)*

*MAOIs (emsam, selegiline, nardil, phenelzine, parnate, tranylcypromine)*

*St John's Wort*

### Sleep Medicines

*Newer hypnotics (ambien, zolpidem, sonata, zaleplon, lunesta, eszopiclone)*

*Melatonin agonist (rozerem, ramelton)*

*Benzodiazepines (ativan, lorazepam, klonopin, clonazepam, xanax, alprazolam, oxazepam, restoril, temazepam, etc.)*

*Trazodone, desyrel*

### Anti-addiction

*Campral*

*Naltrexone*

*Wellbutrin*

*Chantix*

*Antabuse*

### Antianxiety

*Benzodiazepines (ativan, lorazepam, klonopin, clonazepam, xanax, alprazolam, oxazepam, restoril, temazepam, etc.)*

*SSRIs (fluoxetine, prozac, sertraline, zoloft, paroxetine, paxil, fluvoxamine, luvox, citalopram, celexa, escitalopram, lexapro)*

*SNRIs (effexor, venlafaxine, cymbalta, duloxetine, pristin, desvenlafaxine, savella, milnacipran)*

*Buspar, buspirone*

*Remeron, mirtazipine*

*Neurontin, gabapentin*

*Pregabalin, lyrica*

### Antipsychotics

*Atypicals (zyprexa, olanzapine, risperdal, risperidone, seroquel, quetiapine, geodon, ziprasidone, saphris, asenapine)*

*Typicals (haldol, haloperidol, thorazine, chlorpromazine)*

*Clozaril, clozapine*

### Stimulants and ADHD Treatments

*Stimulants (ritalin, methylphenidate, metidate, concerta, adderall, dexedrine, vyvanse, focalin)*

*Strattera, atomoxetine*

*Provigil, modafinil, nuvigil*

### Other

*Lyrica, pregabalin*

*Gabapril, tiagabine*

*Neurontin, gabapentin*

*Keppra, levetiracetam*

*Topamax, topiramate*

*Provigil, modafinil, nuvigil*

*Lightbox*

*Fish Oil, omega-3 fatty acid*

*Vitamin B, Folate/folic acid, Deplin*

*SAME*

*Chromium*

*Kava Kava*

*Electroconvulsive Therapy (ECT)*

*Transcranial Magnetic Therapy (TMS)*

NAME \_\_\_\_\_

DATE \_\_\_\_\_

## Mood Disorder Questionnaire

The following questions may help determine whether an antidepressant is appropriate for you. Circle yes or no, as you go. Your nurse or doctor will help you score the test.

<b>1</b> 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?	YES	NO
...you were so irritable that you shouted at people or started fights or arguments?	YES	NO
...you felt much more self-confident than usual?	YES	NO
...you got much less sleep than usual and found you didn't really miss it?	YES	NO
...you were much more talkative or spoke faster than usual?	YES	NO
...thoughts raced through your head or you couldn't slow your mind down?	YES	NO
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	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 much more social or outgoing than usual; for example, you telephoned friends in the middle of the night?	YES	NO
...you were much more interested in sex than usual?	YES	NO
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	YES	NO
...spending money got you or your family into trouble?	YES	NO
<b>2</b> If you checked YES to more than one of the above, have several of these ever happened during the <i>same period of time</i> ?	YES	NO
<b>3</b> How much of a <i>problem</i> did any of these cause you – like being unable to work; having family, money, or legal troubles; getting into arguments or fights?		
NO PROBLEM      MINOR PROBLEM      MODERATE PROBLEM      SERIOUS PROBLEM		

# Mood Spectrum Diagnostic Scale

Name \_\_\_\_\_

Date \_\_\_\_\_

Instructions: For each sentence, place a check in the box after it if you feel it describes you.

Some individuals notice that their mood and/or energy levels shift drastically from time to time . These individuals notice that, at times, their mood and/or energy level is very low, and at other times, very high . During their “low” phases, these individuals often feel a lack of energy; a need to stay in bed or get extra sleep; and little or no motivation to do things they need to do . They often put on weight during these periods . During their low phases, these individuals often feel “blue”, sad all the time, or depressed . Sometimes, during these low phases, they feel hopeless or even suicidal . Their ability to function at work or socially is impaired . Typically, these low phases last for a few weeks, but sometimes they last only a few days .

Individuals with this type of pattern may experience a period of “normal” mood in between mood swings, during which their mood and energy level feels “right” and their ability to function is not disturbed . They may then notice a marked shift or “switch” in the way they feel . Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do . Sometimes, during these “high” periods, these individuals feel as if they have too much energy or feel “hyper” . Some individuals, during these high periods, may feel irritable, “on edge”, or aggressive . Some individuals, during these high periods, take on too many activities at once . During these high periods, some individuals may spend money in ways that cause them trouble . They may be more talkative, outgoing, or sexual during these periods . Sometimes, their behavior during these high periods seems strange or annoying to others . Sometimes, these individuals get into difficulty with co-workers or the police, during these high periods . Sometimes, they increase their alcohol or non-prescription drug use during these high periods .

Now that you have read this passage, please check one of the following four boxes (consider your whole life when you answer, including recent times):

- |  |   |
|--|---|
| <input type="checkbox"/> This story fits me very well, or almost perfectly           | 6 |
| <input type="checkbox"/> This story fits me fairly well                              | 4 |
| <input type="checkbox"/> This story fits me to some degree, but not in most respects | 2 |
| <input type="checkbox"/> This story does not really describe me at all               |   |

## For a friend or relative to complete...

NAME of person you are completing this for \_\_\_\_\_ DATE \_\_\_\_\_

YOUR NAME and relationship \_\_\_\_\_

The following questions may help determine which medication is appropriate for your friend or relative. Circle yes or no, as you go.

<b>❶ Has there ever been a period of time when you noticed they were not their usual self and...</b>		
...they seemed to feel so good or so hyper that you thought they weren't their normal self, or they were so hyper they got into trouble?	YES	NO
...they were so irritable that they shouted at people or started fights or arguments?	YES	NO
...they acted much more self-confident than usual?	YES	NO
...they got much less sleep than usual and seemed to not really miss it?	YES	NO
...they were much more talkative or spoke faster than usual?	YES	NO
...they had many ideas at once or their thoughts raced from topic to topic?	YES	NO
...they were so easily distracted by things around them that you had trouble following their train of thought?	YES	NO
...they seemed to have much more energy than usual?	YES	NO
...they were much more active or did many more things than usual?	YES	NO
...they were much more social or outgoing than usual; for example, telephoning friends in the middle of the night?	YES	NO
...they were much more interested in sex than usual?	YES	NO
...they did things that were unusual for them or that you thought were excessive, foolish, or risky?	YES	NO
...they spent money to the point that it got them or their family into trouble?	YES	NO
<b>❷ If you checked YES to more than one of the above, have several of these ever happened during the <i>same period of time</i>?</b>	YES	NO
<b>❸ How much of a <i>problem</i> did any of these cause – like being unable to work; having family, money, or legal troubles; getting into arguments or fights?</b>		
NO PROBLEM      MINOR PROBLEM      MODERATE PROBLEM      SERIOUS PROBLEM		

## For a friend or relative to complete...

NAME of person you are completing this for \_\_\_\_\_ DATE \_\_\_\_\_

YOUR NAME and relationship \_\_\_\_\_

**Instructions:** For each sentence, place a check in the box after it if you feel it describes your friend or relative.

Some individuals notice that their mood and/or energy levels shift drastically from time to time . These individuals notice that, at times, their mood and/or energy level is very low, and at other times, very high . During their “low” phases, these individuals often feel a lack of energy; a need to stay in bed or get extra sleep; and little or no motivation to do things they need to do . They often put on weight during these periods . During their low phases, these individuals often feel “blue”, sad all the time, or depressed . Sometimes, during these low phases, they feel hopeless or even suicidal . Their ability to function at work or socially is impaired . Typically, these low phases last for a few weeks, but sometimes they last only a few days .

Individuals with this type of pattern may experience a period of “normal” mood in between mood swings, during which their mood and energy level feels “right” and their ability to function is not disturbed . They may then notice a marked shift or “switch” in the way they feel . Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do . Sometimes, during these “high” periods, these individuals feel as if they have too much energy or feel “hyper” . Some individuals, during these high periods, may feel irritable, “on edge”, or aggressive . Some individuals, during these high periods, take on too many activities at once . During these high periods, some individuals may spend money in ways that cause them trouble . They may be more talkative, outgoing, or sexual during these periods . Sometimes, their behavior during these high periods seems strange or annoying to others . Sometimes, these individuals get into difficulty with co-workers or the police, during these high periods . Sometimes, they increase their alcohol or non-prescription drug use during these high periods .

Now that you have read this passage, please check one of the following four boxes (consider their whole life when you answer, including recent times):

- This story fits my friend or relative very well, or almost perfectly 6
- This story fits my friend or relative fairly well 4
- This story fits my friend or relative to some degree, but not in most respect 2
- This story does not really describe my friend or relative at all

# Notice of Privacy Practices for the Mood Treatment Center

This notice describes how your medical information may be used, disclosed and safeguarded, and how you can get access to this information. Please review it carefully.

## I. Our Responsibilities

The confidentiality of your personal health information is very important to us. Your health information includes both clinical (symptoms, diagnoses, treatments) and administrative (billing, dates) material. Generally speaking, we are required to:

- ▶ Maintain the privacy of your health information as required by law;
- ▶ Provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain;
- ▶ Follow the terms of this Notice currently in effect.

## II. Uses and Disclosures of Information

Under federal law, we are permitted to use and disclose personal health information for *treatment, payment, and health care operations* without authorization. Whenever possible, we will obtain your consent before disclosing any such information. Here are some examples to clarify:

**Treatment:** we consult with your therapist or family doctor about your condition.

**Payment:** Your health information is disclosed to your insurer to obtain reimbursement. In these cases, we will disclose only the minimum information necessary.

**Health Care Operations:** This refers to administrative activities such as services or audits that relate to the operation of our practice.

## III. Other Uses and Disclosures

In the following situations we may be ethically or legally obligated to use or disclose your personal information without authorization:

### *Serious Threat to Health or Safety*

We may disclose your health information to protect you or others from a serious threat of harm by you.

### *Abuse, Neglect, or Domestic Violence*

If you give us information which leads us to suspect child abuse, neglect, or death due to maltreatment of a child; or that a disabled adult is in need of protective services, we must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information relevant to a child protective services investigation, we must do so.

### *Minors*

If you are an unemancipated minor under North Carolina law, there may be circumstances in which we

disclose health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

### *Parents*

If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you.

In some circumstances, we may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

### *Judicial or Administrative Proceedings*

In cases where you are involved in a court proceeding and a request is made for your personal health information, this information is privileged under state law and we will not release it without your consent or a court order.

### *Workers' Compensation*

We may disclose health information about you for purposes related to workers' compensation, as required and authorized by law.

### *Health Care Oversight*

We may disclose health information about you for oversight activities authorized by law or to an authorized health oversight agency to facilitate auditing, inspection, or investigation related to our provision of health care, or to the health care system.

### *Food and Drug Administration (FDA)*

We may disclose health information about you to the FDA, or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.

### *Required By Law*

We may disclose health information about you as required by federal, state, or other applicable law. You will be notified, as required and when allowed by law, of any such disclosures.

#### IV. Psychotherapy Notes

In the course of your care with us, we may keep separate notes about our conversations. These notes, known as “psychotherapy notes”, are kept apart from the rest of your medical record and their confidentiality is subject to greater protection. They do not include basic medical information about your diagnosis or treatment.

Psychotherapy notes may be disclosed only after you have given written authorization to do so. (Limited exceptions exist, e.g. in order for us to prevent harm to yourself or others, and to report child abuse/neglect). You cannot be required to authorize the release of your psychotherapy notes in order to obtain health-insurance benefits for your treatment, or enroll in a health plan. Psychotherapy notes are also not among the records that you may request to review or copy (see discussion of your rights in section VII below). If you have any questions, feel free to discuss this subject with us.

#### V. Your Health Information Rights

Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

- ▶ Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.
- ▶ Request that we communicate with you by alternative means. We will accommodate reasonable requests for such confidential communications; for example, if you do not want a family member to know you are seeing us we can send correspondence to an alternate address.
- ▶ Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.
- ▶ Request that we amend the health information about you that is maintained in our files and the files of our business associates (if applicable). Your request must explain why you believe our records about you are incorrect, or otherwise require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing with the decision. This statement will be added to your records.
- ▶ Request a list of our disclosures of your health information. This list, known as an “accounting” of

disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations.

- ▶ Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit your request in writing to us. If you have questions about your rights, please speak with us in person or by phone during normal office hours.

#### VI. For More Information or to Report a Problem

If you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to:

Chris Aiken, M.D.  
1615 Polo Road  
Winston-Salem, NC 27106  
(336) 722-7266

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to us. You may complain to the Secretary of Health and Human Services (HHS) at:

Office for Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019; OCRprivacy@hhs.gov.

We cannot, and will not, make you waive your right to file a complaint with HHS as a condition of receiving care from us, or penalize you for filing a complaint with HHS.

#### VII. Revisions to this Notice

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area of our office, make copies available to our patients and others, and post it at [www.moodtreatmentcenter.com](http://www.moodtreatmentcenter.com).

#### VIII. Effective Date: January 1, 2000