NAME ______________________________ DOB __________ AGE ______ SS# ____________

ADDRESS ________________________________ CITY/ST __________________ ZIP _______

PHONE #______________________________ SECONDARY PHONE # ____________________

EMPLOYER _____________________________ PHONE# ___________________________

PARENT/GUARDIAN (IF MINOR) ________________ PH# ____________ SS# ___________

PARENT EMPLOYER ____________________________ PHONE# ______________________

EMERGENCY CONTACT __________________________ PHONE # ____________________

PRIMARY CARE PROVIDER________________________ PHONE # ____________________

PRIMARY INSURNACE ___________________________________ (PLEASE PRESENT CARD)

SECONDARY INSURANCE _________________________________ (PLEASE PRESENT CARD)

*__PLEASE NOTE: ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.__ *

MD FEES
$300.00 INITIAL EVAULUATION
$120.00 FOLLOW-UP APPTS.

FLORA GARB FEES:
$135.00 INITIAL VISIT
$110.00 FOLLOW-UP APPTS.
$160.00 FAMILY THERAPY

GAIL BRENZ FEES:
$225.00 INITIAL VISIT (90)
$90.00 FOLLOW-UP APPTS.
$135.00 INITIAL HEALING TOUCH

Additional fees will apply as follows:
Late Cancellations and Missed Appointments- $75
Patient Assistance Enrollment and Prior Authorizations (Multiple Correspondences)- $25
Medical Records, Reports, Forms, and Letters- Minimum $25
Processing Fee for Invalid Credit/Debit Cards- $3

I hereby give my consent for treatment of medical/mental care as deemed necessary by the treating provider, to include treatment with medications.

I have read and understand the above charges. I promise to pay Aneta Schuenemeyer, MD., for services rendered to the above named patient by the providers, Aneta Schuenemeyer, MD., Joseph Simpson, MD., Nancy Daniels, RN., Flora Garb, LCSW and/or Gail Brenz, RN. With the exception of Dr. Schuenemeyer, I understand this office will be my insurance and that non-covered services are my responsibility.

____
Print Patient (Legal Guardian)/ Responsible Party

______________________________ ____________________
Signature Patient (Legal Guardian)/ Responsible Party Date

OFFICE POLICIES & PATIENT'S RESPONSIBILITIES

APPOINTMENTS: ____________ initials

Patients receiving medications are required to be seen a minimum of once every three months unless the provider states otherwise. This will allow for appropriate face to face evaluation of your condition. If you have a change in your health condition or need additional medication before your next appointment, please call the office for an earlier appointment.

Patients are expected to schedule an appointment at the end of each visit, and it is the patient's responsibility to keep the appointment. The staff will make reminder calls the day before your appointment, if time allows. These are strictly a courtesy. No show fees will not be waived if you do not receive the courtesy call. Appointments must be cancelled 48 hours in advance to avoid late cancellation fees. Monday appointments may be canceled by leaving a message on our answering machine.

PRESCRIPTIONS AND REFILLS: __________ initials

Prescriptions are written or called in for a quantity to last until the next scheduled appointment. If lost, stolen, misplaced or taken in excess of your doctor's instructions, medications will NOT be refilled. Prescriptions for the treatment of ADHD, are only good for twenty-one (21) days. If it expires, a fee of $30.00 will be incurred to rewrite the prescription. Medications will not be refilled after hours or on weekends including Fridays.
Dr. Simpson and Nancy Daniels charge $10 for each prescription.

HEALTH INSURANCE: ___________ initials

If you have health insurance, it should be understood that this is an agreement between you and your insurance company to pay your copay for your visit. Your doctor/therapist bill is an agreement between you and your provider. You are responsible for payment in full if your claim is denied by your insurance company.

DISABILITY/WORKERS COMP: ________ initials

I understand that this office does not provide any type of services related to evaluation of disability more any type of written reports substantiating a condition of disability.

OPIOID TREATMENT/ SUBOXONE PROGRAM: _______ initials

If you are being seen for the Suboxone Treatment Program, services are rendered on a cash basis only. PLEASE NOTIFY THE STAFF IMMEDIATELY IF YOU ARE HERE FOR THE SUBOXONE TREATMENT PROGRAM.

I acknowledge that I have read and received a copy of Office Policies/ Patient Responsibilities and Notice of Privacy Practices.

____
Signature

____
Date

Depression Screener

Nearly 20 million Americans experience depression,[1] but many will never seek treatment. The Depression Self-Rating Test is a simple 16-question quiz that can help identify common symptoms of depression and their severity. Remember—depression is more than just feeling down—it is a real medical condition that can be effectively treated.

Please complete the following questionnaire and return it to your healthcare provider.

Name: ______________________ Date of Birth: ______________ Today's Date: ______________

Instructions: Please ***circle*** the one response to each item that best describes you for the past seven days.

1. *Falling asleep:*

- ***0*** I never take longer than 30 minutes to fall asleep.
- ***1*** I take at least 30 minutes to fall asleep, less than half the time.
- ***2*** I take at least 30 minutes to fall asleep, more than half the time.
- ***3*** I take more than 60 minutes to fall asleep, more than half the time.

2. *Sleep during the night:*

- ***0*** I do not wake up at night.
- ***1*** I have a restless, light sleep with a few brief awakenings each night.
- ***2*** I wake up at least once a night, but I go back to sleep easily.
- ***3*** I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. *Waking up too early:*

- ***0*** Most of the time, I awaken no more than 30 minutes before I need to get up.
- ***1*** More than half the time, I awaken more than 30 minutes before I need to get up.
- ***2*** I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
- ***3*** I awaken at least one hour before I need to, and can't go back to sleep.

4. *Sleeping too much:*

- ***0*** I sleep no longer than 7–8 hours/night, without napping during the day.
- ***1*** I sleep no longer than 10 hours in a 24-hour period including naps.
- ***2*** I sleep no longer than 12 hours in a 24-hour period including naps.
- ***3*** I sleep longer than 12 hours in a 24-hour period including naps.

5. *Feeling sad:*

- ***0*** I do not feel sad.
- ***1*** I feel sad less than half the time.
- ***2*** I feel sad more than half the time.
- ***3*** I feel sad nearly all of the time.

6. *Decreased appetite:*

- ***0*** There is no change in my usual appetite.
- ***1*** I eat somewhat less often or lesser amounts of food than usual.
- ***2*** I eat much less than usual and only with personal effort.
- ***3*** I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

7. *Increased appetite:*

- ***0*** There is no change from my usual appetite.
- ***1*** I feel a need to eat more frequently than usual.
- ***2*** I regularly eat more often and/or greater amounts of food than usual.
- ***3*** I feel driven to overeat both at mealtime and between meals.

8. *Decreased weight (within the last two weeks):*

- ***0*** I have not had a change in my weight.
- ***1*** I feel as if I've had a slight weight loss.
- ***2*** I have lost 2 pounds or more.
- ***3*** I have lost 5 pounds or more.

9. *Increased weight (within the last two weeks):*

- ***0*** I have not had a change in my weight.
- ***1*** I feel as if I've had a slight weight gain.
- ***2*** I have gained 2 pounds or more.
- ***3*** I have gained 5 pounds or more.

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10. *Concentration/Decision-making:*

0 There is no change in my usual capacity to concentrate or make decisions.

1 I occasionally feel indecisive or find that my attention wanders.

2 Most of the time, I struggle to focus my attention or to make decisions.

3 I cannot concentrate well enough to read or cannot make even minor decisions.

11. *View of myself:*

0 I see myself as equally worthwhile and deserving as other people.

1 I am more self-blaming than usual.

2 I largely believe that I cause problems for others.

3 I think almost constantly about major and minor defects in myself.

12. *Thoughts of death or suicide:***

0 I do not think of suicide or death.

1 I feel that life is empty or wonder if it's worth living.

2 I think of suicide or death several times a week for several minutes.

3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

13. *General interest:*

0 There is no change from usual in how interested I am in other people or activities.

1 I notice that I am less interested in people or activities.

2 I find I have interest in only one or two of my formerly pursued activities.

3 I have virtually no interest in formerly pursued activities.

14. *Energy level:*

0 There is no change in my usual level of energy.

1 I get tired more easily than usual.

2 I have to make a big effort to start or finish my usual daily activities (for example: shopping, homework, cooking, or going to work).

3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. *Feeling slowed down:*

0 I think, speak, and move at my usual rate of speed.

1 I find that my thinking is slowed down or my voice sounds dull or flat.

2 It takes me several seconds to respond to most questions, and I'm sure my thinking is slowed.

3 I am often unable to respond to questions without extreme effort.

16. *Feeling restless:*

0 I do not feel restless.

1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.

2 I have impulses to move about and am quite restless.

3 At times, I am unable to stay seated and need to pace around.

* If you or someone you know has thoughts of suicide, seek professional help immediately through your healthcare provider, or call 411 to get the phone number for the nearest local suicide hotline.

To Score:

Enter the highest score on any 1 of the 4 sleep items (1–4)	_____
Item 5	_____
Enter the highest score on any 1 appetite/weight item (6–9)	_____
Item 10	_____
Item 11	_____
Item 12	_____
Item 13	_____
Item 14	_____
Enter the highest score on either of the 2 psychomotor items (15 and 16)	_____
TOTAL SCORE (Range 0–27)	_____

Higher scores show the presence of symptoms that might be consistent with depression and indicate the need for an evaluation by a healthcare provider. Only a doctor can diagnose depression because there are other clinically relevant factors that must be considered to diagnose depression. Return this questionnaire to your doctor for formal evaluation

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Reference: 1. National Institute of Mental Health website. Depression Research at the National Institute of Mental Health Fact Sheet. Available at: http://counselingresource.com/quizzes/qids-depression/index.html. Accessed November 28, 2004.

Design: Anatstat Health Education Media, Newark, NJ.

HOW COMMON IS BIPOLAR DISORDER?

THE MOOD DISORDER QUESTIONNAIRE

Answer each of the following questions to the best of your ability, then talk with your healthcare provider.

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

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?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and is not to be used as a diagnostic tool. Always consult with your healthcare provider.

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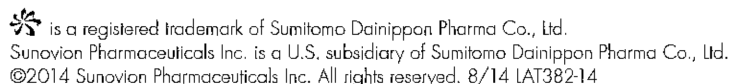
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QUICK MOOD ASSESSMENT (QMA)

Keeping the last week in mind, please tell us what troubles you have had . For each question, please circle YES or NO. Each question asks... DO YOU HAVE...

1.	Trouble with motivation?	YES NO
2.	Trouble having fun in life?	YES NO
3.	Trouble getting pleasure from things in your life?	YES NO
4.	Trouble with tiredness for fatigue?	YES NO
5.	Trouble with physical energy ?	YES NO
6.	Trouble with your memory	YES NO
7.	Trouble with feeling anxious a great deal?	YES NO
8.	Trouble with tearfulness?	YES NO
9.	Trouble with panicky feelings?	YES NO
10.	Trouble with irritability?	YES NO

On a scale of 1-10 please circle a number that best describes your mood this past week.

1	2	3	4	5	6	7	8	9	10
worst				average					best

On the 1-5 scale below, circle the number that best describes you functioning at home, at work, etc this past week.

1	2		3		4	5
bad	so-so	fair		good		very good

Adult Self-Report Scale (ASRS) 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, circle the correct number 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	Score

Question	Never	Rarely	Sometimes	Often	Very Often	Score
1. How often do you make careless mistakes when you have to work on a boring or difficult project?	0	1	2	3	4	
2. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	0	1	2	3	4	
3. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	0	1	2	3	4	
4. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	0	1	2	3	4	
5. How often do you have difficulty getting things in order when you have to do a task that requires organization?	0	1	2	3	4	
6. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	0	1	2	3	4	
7. How often do you misplace or have difficulty finding things at home or at work?	0	1	2	3	4	
8. How often are you distracted by activity or noise around you?	0	1	2	3	4	
9. How often do you have problems remembering appointments or obligations?	0	1	2	3	4	
				Part A – Total		
10. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	0	1	2	3	4	
11. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	0	1	2	3	4	
12. How often do you feel restless or fidgety?	0	1	2	3	4	
13. How often do you have difficulty unwinding and relaxing when you have time to yourself?	0	1	2	3	4	
14. How often do you feel overly active and compelled to do things, like you were driven by a motor?	0	1	2	3	4	
15. How often do you find yourself talking too much when you are in social situations?	0	1	2	3	4	
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?	0	1	2	3	4	
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	0	1	2	3	4	
18. How often do you interrupt others when they are busy?	0	1	2	3	4	
				Part B – Total		

ASRS SYMPTOM CHECKLIST COPYRIGHT ©2003 World Health Organization. Reprinted with permission of WHO. All rights reserved.

Epworth Sleepiness Scale

Name: ______________________________

Date: ______________________________

Your age: (Yr) ____________________ Your sex: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

Score:

0-10 Normal range
10-12 Borderline
12-24 Abnormal

The following questions ask about your eating patterns and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?	Yes	No

NOTE: IF YOU ANSWERED "NO" TO QUESTION 1, YOU MAY STOP. THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

2. Do you feel distressed about your episodes of excessive overeating?	Yes	No

Within the past 3 months...	Never or Rarely	Sometimes	Often	Always
3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?				
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?				
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
7. During the last 3 months, how often did you make yourself vomit as a means to control your weight or shape?				

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