Psychiatry at Richmond Family Medicine

Welcome to Psychiatry at Richmond Family Medicine. We are a group of three psychiatric nurse practitioners, working together and in collaboration with the primary care providers at RFM to provide comprehensive mental health and wellness care to the patients of RFM. Our services include comprehensive psychiatric evaluations, psychiatric medication management, and psychotherapy.

Prior to and before your initial appointment with Louise Moon Rosales, DNP, APRN, Stephanie Bless, MSN, APRN or Lauren Bierman, DNP, APRN, you will be provided with paperwork to be completed which will be reviewed at the beginning of the intake process. Included in the intake packet is our Authorization for Medical Records Access, our Refill Policy, our Communications Policy and several screening tools that we ask you to review and complete. In addition, we follow the same procedures and policies of RFM, including the Privacy, No Show and Billing policies.

Initial psychiatric appointments at RFM are scheduled for 60-90 minutes, and follow up appointments are typically 20-30 minutes in length. Frequency of appointments is determined after the initial evaluation and at further follow up appointments.

All services are strictly confidential. No information about you will be released to any other person without your consent. The only exceptions, as required by law, are when there is reason to believe that abuse or neglect of a child or elder adult may have occurred or if you indicate intent to harm yourself or someone else, or if information is requested by a court order.

Please note that there are times when your psychiatric NP may be out of the office and unavailable. During those times, one or both of the other psychiatric NPs will be covering and responding to urgent requests. **If you usually communicate directly with your provider, and are not receiving a response, please call the office at (802) 434-4123 to speak with a staff member**, who can connect you with the covering provider. In addition, **if you are experiencing a mental health emergency, or you have an urgent need, please call your local crisis center or go to your local emergency department.** The number for Howard Crisis in Chittenden County is 1-802-488-7777.

TELEHEALTH CONSENT FORM

I,_____ hereby consent to engage in Telehealth with_____.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person appointments. The same mandatory and permissive exceptions to confidentiality also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my provider, that my sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my provider may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my provider may record the sessions without the other party's written permission.
9. I have discussed the fees charged for Telehealth with my provider and agree to them [or for insurance patients: I have discussed with my provider and agree that my provider will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information.

10. I understand that my provider will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my provider may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my provider and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

_____ _____

Patient's Signature Date

_____

Patient's Printed Name

Verbal Consent Obtained

Provider reviewed Telehealth Consent Form with Patient, Patient understands and agrees to the above advisements, and Patient has verbally consented to receiving services from Provider via Telehealth.

_____ _____

Provider Signature Date

Consent for Communication

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. The RFM psychiatric team respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. The RFM psychiatric providers will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to. **We are encouraging those patients/clients who prefer texting for communications to download and use the OhMD app, which is a HIPPA compliant texting platform.** Let us know if you would like to use that option. **Another HIPPA compliant communication option strongly encouraged is the use of the RFM patient portal.**

If at any time you are unable to reach your provider, call Richmond Family Medicine at (802) 434-4123 to speak to someone who can help.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ❏ I do not consent to any voicemail, email or texting communication.
- ❏ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means (check all that you consent to):
  - ❏ Email
  - ❏ Text
  - ❏ Voicemail

- ❏ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means (check all that you consent to):
  - ❏ Email
  - ❏ Text
  - ❏ Voicemail

E-mail address you are consenting to communicate through:
Phone number you are consenting to communicate through:

Patient Signature: Date:

Authorized Representative/Guardian Signature: Date:

Refill Policy

Richmond Family Medicine Psychiatric providers participate with electronic prescribing directly to your mail order and local pharmacies. Our providers also participate in the Vermont Prescription monitoring program.Our goal is to assist our patients with prescription requests in an efficient and timely manner. Due to the volume of prescription requests, we have created the following guidelines to help meet these goals.

1. It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days, so do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.

2. Medication refills will only be addressed during regular office hours (Monday – Friday (8:00am – 5:00pm). Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.

3. Prescription refills require close monitoring by your provider to ensure its safety and effectiveness. Your provider will prescribe the appropriate number of prescription refills to last until your next scheduled appointment. Generally, when you are down to zero refills, it is time to schedule a follow up appointment. We prefer you request any refills of your medications at the beginning of your office visit.

4. Patients requesting new prescriptions must be seen for an appointment.

5. Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

6. Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

7. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills.

8. If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately.

9. We reserve the right to charge an administrative fee for if there are multiple requests for prescriptions requested outside of a visit.

RICHMOND Family Medicine

CONSENT TO DISCLOSE HEALTH INFORMATION

I, _____ (_____)
Patient Name (print) *Date of Birth*

Authorize _____
*Name, fax # and address of person/agency **SENDING** information*

To disclose to: _____
*Name of person/agency **RECEIVING** the disclosure. If not Richmond Family Medicine, specify fax # and address*

The **PURPOSE** of this disclosure is:

❑ I am transferring my medical care ❑ Coordination of care with another medical provider
❑ Legal ❑ Life or other insurance ❑ Other:_____

I would like to disclose the following information:			
❑	My medical record, including a medical summary and detail for the last 2 years		
❑	My medical record, including a medical summary and detail for from (____/____/____ through ____/____/____)		
❑	My medical record, including all available records regardless of date		
OR (select all that apply)			
❑	Medications	❑	Progress notes
❑	Test Results	❑	Diagnosis/Problem information
❑	Immunization history	❑	Appointment history
❑	HIV/AIDS Diagnosis & Treatment information	❑	Psychiatric/Mental Health records
❑	Billing/insurance related records	❑	Other

★**Please provide *any exceptions, restrictions or limitations* for this disclosure: (time limits, specific tests, etc.):** ★

_____

_____

This consent to disclose information will expire on: _____. I understand that if I do not note a date or event, then this consent will expire one year from the last date of service to me at the facility. I also understand I have the option to revoke this consent at any point. If revoking consent, please provide today's date here:_____.

I understand that information released may include medical, mental health, and/or drug and alcohol information. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it before I revoked it. A photocopy or facsimile of this consent is as valid as the original. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for any other purposes. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility from all liability and damage resulting from the lawful release of my protected health information. I also understand that any fees as a result of this request are my responsibility.

_____ _____
Patient Signature Date

_____ _____ _____
Parent, Guardian, Legal Representative Signature (Relationship) Date

Was any assistance provided in completing this form? ❑ Y ❑ N Name of assistant:_____

Summary of assistance provided:_____

ATTENTION FACILITIES SENDING RECORDS TO RICHMOND FAMILY MEDICINE: Electronic records are preferred. Inbound faxes are received in a secure system, directly routed to our EHR. We also are enrolled in the SureScripts Net2Net network.

Richmond Family Medicine ● 30 West Main Street ● Richmond, VT 05477 ● Phone: 802.434.4123 ● Fax 802.434.3130

RICHMOND
Family Medicine

Authorization for Medical Records Access via UVM Medical Center Electronic Records

I, _____, authorize (select from the following)

- ❑ Louise M. Rosales, APRN
- ❑ Lauren Bierman, APRN
- ❑ Stephanie Bless, APRN

And their associated staff to access my medical records via approved electronic methods or requested hard copies. This will include office notes, lab reports, and consultation notes.

Thank you for your assistance in the continuity of my medical care.

Patient signature: _____

Name: _____

Date of birth: _____

RICHMOND
Family Medicine

Authorization for Medical Records Access via Richmond Family Medicine Electronic Records

I, _____, authorize (select from the following)

- ❑ Louise M. Rosales, APRN
- ❑ Stephanie Bless, APRN
- ❑ Lauren Bierman, APRN

And their associated staff to access my medical records via approved electronic methods or requested hard copies. This will include office notes, lab reports, and consultation notes.

Thank you for your assistance in the continuity of my medical care.

Patient signature: _____

Name: _____

Date of birth: _____

Consent to Discuss Medical and/or Billing Information with Others

Richmond Family Medicine, including its providers, staff and covered representatives are restricted from discussing any aspect of your care with friends or family members. These restrictions are in place due to State and Federal regulations, including HIPAA, and are ultimately intended to protect your privacy. There are circumstances where you may wish for us to have open communication with one or more individuals to help support you in your medical treatment, and we will be happy to support that request with this signed consent.

Statement of Consent to Discuss:

By signing this release form I, _____ (patient name) do hereby give permission for Richmond Family Medicine's Providers and Staff to discuss issues related to my health care with the following person:

_____ _____

Name of authorized party *Relation to Patient*

I understand that this permission applies to any and all aspects of my medical care and would like to further specify this permission **EXCLUDE** the following data:

- ☐ Billing information
- ☐ Mental health and/or substance use history
- ☐ Lab results
- ☐ Imaging results
- ☐ Other:_____

☐ Additionally, I wish to designate the individual named above as an "Authorized Representative" for my patient portal account. I understand once granted an account, this individual will have COMPLETE access to my electronic patient chart.
Patient initials (required):_____ NOTE – if exclusions exist, this access cannot be granted

Patient Signature:_____ Date:_____
Printed Name:_____ Date of Birth:_____
Expiration date for Consent:_____ or check here for no expiration: ☐ *

** Forms older than one year may require renewal as circumstances evolve*

Staff Witness Name:_____ If not completed in office, this form must be certified by an unrelated Notary Public:

State of _____, County of _____ On this _____ day of _____, 20___
_____ did prove to me his/her identity
through satisfactory evidence and this instrument was signed or attested before me:
Printed Name & Signature:_____. Commission expires_____

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
Did you lose a parent through divorce, abandonment, death, or other reason?	☐
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
Did you live with anyone who went to jail or prison?	☐
Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
Did you feel that no one in your family loved you or thought you were special?	☐
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ◯ **Not Much** ◯ **Some** ◯ **A Lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

5/5/20

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

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 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?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four 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, in 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, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions:	**YES**	**NO**
1. Have you ever felt that you ought to cut down on your drinking or drug use?	□	□
2. Have people annoyed you by criticizing your drinking or drug use?	□	□
3. Have you ever felt bad or guilty about your drinking or drug use?	□	□
4. Have you ever had a drink or used drugs first thing in the morning **to steady your nerves or to get rid of a hangover?**	□	□

Scoring
Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited:	**Sensitivity**	**Specificity**
One or more **Yes** responses	0.79	0.77
Two or more **Yes** responses	0.70	0.85

(Brown 1995)

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" 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*____ = ____ + ____ + ____)

PATIENT HEALTH QUESTIONNAIRE-9 (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 any problems, how difficult 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**
☐	☐	☐	☐

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	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 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 in 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? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

ID # _____

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you…

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

   YES NO

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

   YES NO

3. been constantly on guard, watchful, or easily startled?

   YES NO

4. felt numb or detached from people, activities, or your surroundings?

   YES NO

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

   YES NO

Name _____ **MR #** _____ **Date** _____ **Updated** _____ _____ _____ _____

Start in the "ever taken" column by marking the treatments you have received in your lifetime. Complete the rest of the questions for each marked treatment. ***This information is important as it will help us determine the course of action in treating your symptoms.***

	Medication	Ever taken?	Last taken? (month/year)	Taken as directed for >6 weeks?	Highest dose/level	Did it help?		Side effects? What?
						Yes	No	
SSRI	Fluoxetine (Prozac)							
	Paroxetine (Paxil)							
	Sertraline (Zoloft)							
	Citalopram (Celexa)							
	Escitalopram (Lexapro)							
	Fluvoxamine (Luvox)							
SNRI	Duloxetine (Cymbalta)							
	Venlafaxine (Effexor)							
	Desvenlafaxine (Pristiq)							
	Milnacipram (Savella)							
	Levomilnacipram (Fetzima)							
Other	Vilazodone (Viibryd)							
	Vorteoxetine (Brintellix)							
	Bupropion (Wellbutrin)							
	Mirtazapine (Remeron)							
	Nefazodone (Serzone)							
	Trazodone (Desyrel)							
	Agomelatine (Valdoxan)							
TCA	Clomipramine (Anafranil)							
	Imipramine (Tofranil)							
	Amitriptyline (Elavil)							
	Desipramine (Noripramin)							
	Nortriptyline (Pamelor)							
	Trimipramine (Surmontil)							
	Amoxapine (Asendin)							
	Maprotiline (Ludiomil)							
	Doxepin (Sinequan)							
	Protriptyline (Vivactil)							
MAOI	Phenelzine (Nardil)							
	Tranylcypromine (Parnate)							
	Isocarboxazid (Marplan)							
	Selegiline (Emsam patch)							

	Medication	Ever taken?	Last taken? (month/year)	Taken as directed for >6 weeks?	Highest dose/level	Did it help?		Side effects? What?
						Yes	No	
Antipsychotics	Aripiprazole (Abilify)							
	Quetiapine (Seroquel)							
	Olanzapine (Zyprexa)							
	Risperidone (Risperdal)							
	Paliperidone (Invega)							
	Ziprasidone (Geodon)							
	Clozapine (Clozaril)							
	Asanapine (Saphris)							
	Lurasidone (Latuda)							
	Haloperidol (Haldol)							
	Thioridazine (Mellaril)							
	Chlorpromazine-Thorazine							
	Perphenazine (Trilafon)							
	Trifluoperazine (Stelazine)							
Stabilizers	Lithium salts (Lithium)							
	Valproic acid / Depakote							
	Lamotrigine (Lamictal)							
	Carbamazepine (Tegretol)							
	Oxcarbazepine (Trileptal)							
Stimulants	Amphetamines (Adderall)							
	Dexamphetamine -Dexedrine							
	Dexmethylphenidate-Focalin							
	Lisdexamfetamine-Vyvanse							
	Ritalin/concerta							
	Modafinil (Provigil)							
	Armodafinil (Nuvigil)							
	Atomoxetine (Strattera)							
Other Agents	Buspirone (Buspar)							
	Liothyronine (Cytomel)							
	Gabapentin (Neurontin)							
	Pramipexole (Mirapex)							
	Omega 3 (Fish oil)							
	Methylfolate (Deplin)							
	Folate – Folic acid							

	Medication	Ever taken?	Last taken? (month/year)	Taken as directed for >6 weeks?	Highest dose/level	Did it help? Yes	Did it help? No	Side effects? What?
	Testosterone/Androgel							
	Estrogen							
	Topiramate (Topomax)							
	SAMe							
	Roprinole (Requip)							
	Inositol							
	Varenicline (Chantix)							
Benzodiazepines	Clonazepam (Klonopin)							
	Alprazolam (Xanax)							
	Lorazepam (Ativan)							
	Diazepam (Valium)							
	Temazepam (Restoril)							
	Oxazepam (Serax)							
	Chlordiazepoxide (Librium)							

Treatment	Ever received?	Last received/used? (month/year)	Type of stimulation: 1 side	Type of stimulation: 2 sides	# of sessions: <6	# of sessions: 6-12	# of sessions: >12	Did it help? Yes	Did it help? No	Side effects? What??
ECT										
TMS										
t-DCS										
VNS			[redacted]							
DBS										
Ketamine infusion										
S-Ketamine intranasal										
Light therapy										
Psychotherapy (CBT)										
Psychotherapy (DBT)										
Psychotherapy (Other)										

Source: University of Pennsylvania, School of Medicine. Developed by Mario A. Cristancho, MD, and John O'Reardon, MD