LEXINGTON PSYCHIATRIC GROUP, PSC
1030 Monarch Street, Suite 100
Lexington, KY 40513
(859) 296-0066
(859) 296-1155 fax

Charles I. Shelton, D.O.
Certified American Board Psychiatry & Neurology

Dear New Patient,

Let me take this opportunity to welcome you to our practice on behalf of my staff and myself. We appreciate that you have selected our psychiatric practice to provide you with excellent care. We are committed to providing quality behavioral health care in a comfortable, caring and professional environment.

During your initial visit, an evaluation must be performed to determine psychiatric diagnosis. A suitable treatment plan will be discussed with you at that time, which may include medication and other pertinent recommendations.

The allotted time for the initial evaluation is up to 60 minutes with a fee of $350.00. Full prepayment is required and must be received prior to seeing Dr. Shelton. We have enclosed a copy of our current fee schedule for you to review.

By working together to develop a mutual understanding and clarify our expectations of one another, we have enclosed screening tools, various office policies and other forms, which must be completed prior to seeing Dr. Shelton. In an attempt to guarantee the allotted time for you initial evaluation, it is required that you either mail the payment to us or give us a credit card payment over the phone. Please bring all completed forms with you when you come to your appointment.

We understand the value of your time and are confident you will return the courtesy. Emergency situations do occur, however, and we make every effort to notify our patients of changes or delays in the daily schedule. Should you need to reschedule your appointment, please keep in mind there may be other patients who need or have requested an earlier appointment, therefore, we require a 24-hour advance notice for follow up appointments, and a 72-hour advance notice for the initial evaluation appointment. This will also ensure that charges will not be incurred due to lack of advance notice.

Should you have any questions about our services, please contact our office at 859-296-0066. My staff and I look forward to meeting your behavioral health needs.

Respectfully,

Charles Shelton, D.O. & Staff

IMPORTANT INFORMATION AND GUIDELINES

Our staff is dedicated to establishing a caring and comprehensive practice to diagnose and treat psychiatric illness. We ask that our patients adhere to the following guidelines as a means of optimizing their experience and treatment while under our care. Please keep this information for future-reference.

Initial Visit
An examination must be performed to determine psychiatric diagnosis. A treatment plan will then be designed, which may include medication and other pertinent recommendations.

Appointments
Patient visits are by appointment only. Our office hours are Monday through Thursday, 9:00 a.m. to 5:00 p.m. and Friday, 10:00 a.m. to 2:00 p.m. We will make every effort to adhere to our schedule so that you are seen on time. However, emergencies do occur and you will be advised if we are running behind. In turn, we ask that you be punctual for your appointment. If you are more than 10 minutes late for your scheduled time, you may be asked to reschedule your appointment. In the event we can find time to see you, it may not be for the allotted time initially scheduled; however, you will still be charged for the initial allotted time. Should you need to cancel your appointment, it is required that you do so 24 hours in advance. Patients that frequently miss scheduled appointments may be at risk of termination from the practice for noncompliance.

Patient Responsibility
Please notify our office of any changes made to your name, address, telephone numbers or insurance. Always be truthful with the information you give to the physician and staff. To achieve successful treatment, always follow the treatment plan given to you by the physician.

Termination of Care
Either party can terminate the physician/patient relationship for any reason he or she deems appropriate. Reasons that could lead to termination of care include, but are not limited to:

- Providing misleading or untruthful information
- Not following the agreed treatment plan
- Using medication outside of the prescribed directions resulting in requests for early refills
- Excessive, unwarranted telephone calls
- Failure to keep scheduled appointments
- Failure to comply with our financial policies
- Aggressive, abusive or inappropriate behavior
- Breech of controlled substance contract

Prescriptions, Refills, Samples and Patient Assistance
Prescriptions are written at the time of your appointment with sufficient quantities and refills, if necessary, to last until your next appointment. If, by chance, you run out of medication before your next appointment, please call our office and choose the prescription refill line option. Refill requests called in after 1:00 p.m. may not be called into the pharmacy until the following business day. Prescription requests for Schedule II medications (i.e. Ritalin, Dexedrine, Adderall, Concerta) must be requested at least two business days in advance for pick-up at the office. If you request the prescription to be mailed, please allow 5 business days to receive your prescription. Patients that have been prescribed controlled medications are requested to use the same pharmacy each time for refills. All patients will be asked to sign a Controlled Substance Contract with Dr. Shelton.

Emergencies
Emergencies are defined as situations in which a delay in contacting the physician could lead to potential harm or death. Dr. Shelton or another designated qualified person is available in the event of an emergency. Please abide by the following guidelines in the event of an emergency.

1. **During office hours** call and either talk directly with one of our Office Coordinators, or leave a message on the emergency voice mail.
2. **After hours** the phones will be diverted to the on call physician. If, after leaving a message on the emergency voicemail, you have not received a call back in 20-30 minutes, please call the office number again.

Hospitalization
If hospitalization is required, we refer our patients to either, Samaritan Hospital, The Ridge or UK Chandler Medical Center. These facilities include programs for adult mental health, geriatric psychiatry and alcohol/substance abuse treatment. There are billing charges from the hospital, as well as the doctor's fees for care while in the hospital. If you do not have medical insurance, special arrangements must be with the hospital prior to admission.

Medical Records
All records concerning your treatment are strictly confidential and will not be released without written consent from you. Such information is available to referring and treating physicians and other interested parties at your request, and only with your written consent except in circumstances that are explained in the Patient Information Authorization Form. A signed release can be filled out at this office when necessary however, your information may be disclosed to your insurance carrier as part of the insurance contract for payment. Requests for copies of medical records must be given at least 10 working days in advance and a signed Release of Information, specifically stating mental health or psychiatric records, must be on file in order to release requested records.

Forms & Telephone Calls
Patients will be billed for time spent filling out forms and dictation of letters. There may be charges involved for telephone consultations, depending on the extent and duration of the call. Insurance companies do NOT pay for telephone consultations or any fees involving the prescribing of medications by the physician.

CONTROLLED SUBSTANCE CONTRACT

The purpose of the enclosed contract is to establish an agreement between the physician and patient on conditions for prescribing and use of controlled substances during your treatment. This agreement is essential in maintaining the trust and confidence necessary in the physician/patient relationship. Should controlled medication be a part of your treatment, the frequency and type of medication prescribed is, and must be, under the control of Dr. Shelton, who is charged by the state of Kentucky, as well as the federal government, with the careful administration of controlled substances.

Your treatment may require the use of controlled substances which may include, but not limited to, hypnosedatives or stimulants. The use of controlled substances carry several risks, such as physical dependency, when used on an extended daily basis. Side effects from hypnosedatives and stimulants include, but are not limited to, drowsiness, fatigue, impaired coordination, irritability, memory impairment, lightheadedness, dizziness, sexual difficulties, depression, confusion, weakness, constipation, changes in appetite or weight, palpitations, increased hear rate and/or blood pressure, psychotic episodes, restlessness, overstimulation, insomnia, euphoria, tremor, exacerbation of tics, dry mouth or possible worsening of clinical condition. Taking more medication than as prescribed could result in some dangerous situations including coma, organ damage or even death. Another serious problem associated with prescribing controlled medications is the diversion of controlled substances for resale.

Withdrawal symptoms from hypnosedatives may include, but not limited to, insomnia, muscle cramping, vomiting, sweating, tremors, convulsions or death. Withdrawal symptoms from stimulants may include, bot not limited to, depression, intense fatigue and sleepiness.

Tolerance can occur with these medications and is defined as requiring increasing doses of the medication to obtain the same effect. Tolerance is differentiated from addiction. Addiction involves abnormal social behavior to obtain controlled substances such as stealing, lying or abusing the medications that have been prescribed. Addiction is not typical in patients who do not have a prior history of addiction to controlled substances, alcohol or illicit substances.

By signing the enclosed contract, this acknowledges you have read and understand the terms as outlined. The rules of this agreement may seem extremely strict and demanding. These rules are intended to protect you and others from the improper use of controlled substances. Dr. Shelton believes that these rules are fair and necessary. Your understanding of these liabilities is important and appreciated by all of your health care professionals. The enclosed contract must be signed and returned upon your initial visit. Please keep this information for future reference.

Lexington Psychiatric Group, PSC
Standard Fee Schedule
Effective 9.4.2007

CPT CODE	DESCRIPTION	LENGTH OF APPT.	CHARGE
90801	Initial Evaluation	60 minutes (approximately)	$ 350.00
90862	Medication Management	5-15 minutes	$ 95.00
90805	Follow-up appointment	20-30 minutes	$ 175.00
90807	Follow-up appointment	45-60 minutes	$ 225.00
90846	Family Appt. w/o patient	5-15 minutes	$ 95.00
	Family Appt. w/o patient	20-30 minutes	$ 175.00
	Family Appt. w/o patient	45-50 minutes	$ 225.00
90899	Completion of letters or forms	Contingent on time	$ 25.00 minimum
IME	Independent Medical Evaluation	Prepaid retainer	$1200.00
		Hourly rate	$ 300.00
FME	Forensic Medical Evaluation	Prepaid retainer	$2500.00
		Hourly rate	$ 300.00
PC 1	Brief Telephone Consult		N/C
PC 2	Intermediate Telephone Consult		$ 45.00
PC 3	Complex Telephone Consult		$ 90.00

The fees listed above reflect our standard fee schedule. Should you have Bluegrass Family Health as your insurance carrier and have questions regarding contracted fees pertinent to your deductible or coinsurance due, please call us at 859.296.0066. Our billing department will gladly answer your questions.

PATIENT INFORMATION

This form must be completed and returned upon the initial visit.

Patient Name (Last, First, MI):______________________ ☐ Male ☐ Female

Address:______________ City:__________ State:_____ Zip:_______

Telephone (Home):__________ (Work):__________ (Cell/Other)__________

Social Security Number:__________ Date of Birth:__________ Age:______

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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Employer's Name (if applicable): ______________________

Address: ______________ City:__________ State:_____ Zip:_______

Employment: ☐ Full time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student

Student Status (if applicable): ☐ Full time ☐ Part Time

In case of an emergency, whom should we contact?

Name:

____

Address:______________ City:__________ State:_____ Zip:_______

Telephone (Day)__________ Telephone (Night)__________

Referring Physician (if applicable):______________________

Address:______________ City:__________ State:_____ Zip:_______

Health Insurance Carrier: ______________________

Policy ID #: __________ Group #: __________

Claims Mailing Address: ______________________

____

Pharmacy: ______________________

Address:______________ City:__________ State:_____ Zip:_______

Telephone: ______________________

***Please bring insurance card with you so that we may make a copy for our files.**

CONTROLLED SUBSTANCE CONTRACT

This form must be completed and returned upon the initial visit.

By signing this form, I understand and agree:

- All controlled substances will be taken only as prescribed.
- That I have been informed of the risks and side effects of controlled substances.
- To contact Dr. Shelton's office to seek approval should I feel my medication should be altered in any way other than prescribed.
- To exercise caution when performing activities, such as driving or operating heavy machinery.
- Not to use any illegal substances, including marijuana, cocaine, etc.
- Not to use the medication with any alcoholic beverages.
- Not to share, sell or trade my medication for any reason, including money, goods or services.
- Not to attempt to obtain controlled substances from any other health care provider without disclosing the current medications prescribed by Dr. Shelton.
- To bring any remaining controlled substances in their proper containers at the request of Dr. Shelton. These medications may be counted and disposed of by Dr. Shelton or one of his staff members.
- It is my responsibility to protect any medications prescribed to me, which may not be replaced if lost or stolen.
- To obtain all of my controlled medications from only one pharmacy.
- To notify Dr. Shelton's office immediately should I change pharmacies.
- To furnish my new pharmacy with the address and telephone number of my old pharmacy.
- To authorize Dr. Shelton and my pharmacy to fully cooperate with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale or diversion of my controlled substances.
- To authorize Dr. Shelton to provide a copy of this agreement to my pharmacy.
- Medication refill requests will only be considered during office hours from Monday through Thursday, 9:00 a.m. to 4:00 p.m., and Friday, 10:00 a.m. to 2:00 p.m..
- To submit to a blood or urine test, at random, if requested by Dr. Shelton to determine my compliance with this contract.
- Failure to comply with this contract may result in the withdrawal of all controlled substances, which may result with referral to a detoxification and substance treatment program, as well as termination of the therapist/patient relationship.
- Agree to release Dr. Shelton and the staff of Lexington Psychiatric Group, PSC, from all responsibilities and obligations of the physician/patient relationship should I breech this contract and am terminated as a patient.

I have read, fully understand and agree to comply with this contract.

____________________ Patient Name (please print)	____________________ Witness Name (please print)
____________________ Patient Signature	
____________________ Parent or Guardian Signature	____________________ Witness Signature
____________________ Date	____________________ Date

AUTHORIZATION FOR TREATMENT

This form must be completed and returned upon the initial visit.

Patient's Name: ___________________________________ Date of Birth: ____________________

Social Security Number: __________________________ Treatment Dates: ____________________

By signing this form, I give permission for Dr. Charles Shelton to render treatment to me. I authorize the exchange of information regarding my care to the physician on call. My treatment and care will be confidential, except under the following circumstances:

- Threat of imminent harm to others or myself.
- Allegations of recent or ongoing abuse of another individual.
- Court-ordered subpoena of medical records.

The documentation maintained regarding my treatment is the property of Lexington Psychiatric Group, PSC. Only with my written authorization can this information be released to another caregiver, service provider or agency, unless otherwise stipulated within this authorization form.

Termination of Care
Either party can terminate the therapist/patient relationship for any reason he or she deems appropriate. Reasons that could lead to termination of care include, but not limited to the following:

- Providing misleading or untruthful information
- Not following the agreed treatment plan
- Using medication outside of the prescribed directions
- Excessive, unwarranted telephone calls
- Failure to keep scheduled appointments
- Failure to comply with our financial policies
- Aggressive, abusive or inappropriate behavior
- Breech of controlled substance contract

The undersigned hereby authorizes treatment to be rendered by Dr. Charles Shelton:

_________________________________ _________________________________
Patient Name (please print) Witness Name (please print)

____
Patient Signature

_________________________________ _________________________________
Parent or Guardian Signature Witness Signature

_________________________________ _________________________________
Date Date

CANCELLATION/MISSED APPOINTMENT POLICIES

This form must be completed and returned upon the initial visit.

We make every effort to accommodate each and every patient. It is important that you keep your scheduled appointment. Should you fail to adhere to this policy, you will be at risk for termination from this practice. If a termination letter is sent, it will state that we will only provide emergency care for 60 days to allow you adequate time to find alternative care. Included will be prescriptions, if applicable, to last for 60 days from the date of termination.

To maintain continuity of care and to avoid disruptions of prescribed medications (which may lead to worsening of condition), it is your responsibility to schedule and keep follow-up appointments as specified by Dr. Shelton. Medications will be prescribed in the amount to last until your next scheduled appointment. If follow-up appointments are not kept or scheduled, you may be prescribed only enough medication to last until you are seen in the office. This will be per Dr. Shelton's clinical discretion. This service will include a charge.

Cancellations

It is required that you give a 24-hour notice should you need to cancel and reschedule your appointment. This allows our staff ample time to schedule a patient waiting to be seen in your place. Therefore, if you cancel with a 24-hour notice, you will not incur a fee. If you cancel in less than 24 hours of your appointment, you will be charged with a minimum fee in the amount of $50.00. If you simply do not call to cancel your appointment and do not show for your scheduled time allotted, you will be charged the full amount of the allotted time scheduled for your appointment. Please refer to the missed appointment policy below.

Missed Appointments

In the event you do not show for your appointment, you will be charged the full standard fee for the time we allotted for your appointment. Please refer to the enclosed fee schedule reflecting our rates.

Inactive Status

If you have not been seen by Dr. Shelton at Lexington Psychiatric Group, PSC, within one year, you will no longer be considered as an active patient. You agree to release any form of medical liability for events occurring one year after your last scheduled appointment.

Your insurance or worker's compensation carrier will not cover any of the fees stipulated above. These fees are solely your responsibility.

By signing this agreement, you agree to the terms described above. You will be held responsible for payment of these fees, if applicable, as charged.

____

Patient Name (please print)

____

Patient Signature

____

Parent or Guardian Signature

____

Date

It is our goal to provide you with the highest quality of care. It is important that you fully understand our financial policy, which is necessary in order to maintain this health care practice for patients and the community. Please read this policy statement carefully.

Bluegrass Family Health
Our practice is contracted with Bluegrass Family Health. Upon registration, a copy of your health insurance card will be made. It is advised that you review your benefits for outpatient mental health services so you are aware of your financial obligations. Co-pays, deductibles and/or coinsurance are due and will be collected at the time services are rendered. Our staff will obtain your benefits prior to your appointment.

Self –Pay/Other Insurance
If you have another form of insurance or are self-pay, you are responsible for payment in full at the time services are rendered. Per your request, we will file a claim to your health insurance carrier as a courtesy. Payment in full is still required from you. Should we receive payment from your health insurance carrier, we will issue you a reimbursement check.

Returned Checks
You will be charged a fee of $25.00 should your check be returned for any reason, including insufficient funds or closed accounts.

Non-Medical Services
You may be billed separately for non-medical services required for your care, including but not limited to, telephone consultations, prescription refills after hours, completion of forms, letters and/or reports and hospital charges.

Delinquent Accounts
In the event you accumulate a balance and fail to adhere to any prior payment arrangements made by this office, you will be charged interest at the rate of 18% per annum.

Accounts over 90 days will be considered delinquent and sent to collections. If your account is assigned to an attorney for collection and/or suit, this practice will be entitled to reasonable attorney fees and costs of collection.

If unusual circumstances make it impossible for you to meet our financial terms, it is required that you discuss this with our Director of Finances prior to your appointment. We will make every effort to assist you. For your convenience, we accept cash, American Express, Discover, MasterCard and Visa.

PLEASE NOTE: Failure to comply with our financial policy may result in termination of care.
By signing this policy, I am requesting that payment of authorized benefits be made on my behalf. I assign any benefits that I am entitled to, including private health insurance, worker's compensation and any other health plans to Lexington Psychiatric Group, PSC. This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges incurred, whether or not paid by said insurance.

I have read, understand and agree to comply with this financial policy. If I fail to comply, I am at risk of termination as a patient.

____
Patient Name (please print)

____
Patient Signature

____
Parent or Guardian

____
Date

RELEASE OF MEDICAL/PSYCHIATRIC RECORDS

Name:______________________________ Date of Birth: ____________________

Social Security Number: ____________________

Information contained in your records could be considered privileged, sensitive or embarrassing. With your signature, you agree that this practice and/or your physician are not negligent or responsible for any illness or problems related to the release of this information. It is understood that this authorization for release of information is subject to revocation at any time in writing.

Pursuant to KRS 422.317, you, your attorney or your authorized representative is entitled to one free copy of your medical records. Thereafter, you, your attorney or your authorized representative will be charged $1.00 per page for each additional copies.

Prohibition of Redisclosure
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR, Part 3). The federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR, Part 3. A general authorization for this release of medical/psychiatric records or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patients who test positive for AIDS/HIV. KRS 214.181(5)(c)9.e.

☐ **I request information to be released from:**

☐ Lexington Psychiatric Group, PSC
Charles I. Shelton, D.O.
1030 Monarch Street, Suite 100
Lexington, KY 40513
T: 859-296-0066 F: 859-296-1155

to: ____________________

____

____

Or

☐ ____________________

____

____

to: Lexington Psychiatric Group, PSC
Charles I. Shelton, D.O.
1030 Monarch Street, Suite 100
Lexington, KY 40513
T: 859-296-0066 F: 859-296-1155

Information to be released:
Medical/Psychiatric records and information

Purpose of release:
Correspondence/Records release

Other (please specify): ____

The undersigned hereby authorizes the release of information from the medical health record of:

____
Patient Name (please print)

____
Witness Name (please print)

____
Patient Signature

____
Witness Signature

____
Parent or Guardian Signature

____
Date

____
Date

PATIENT HISTORY

This form must be completed and returned upon the initial visit.

Full Name: ______________________________ Date of Birth: _____/_____/_________

Please list any medications and dosage that you are currently taking, including over-the-counter medication(s) used on a regular basis:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Name(s) of previous psychiatrist(s) therapist(s) seen: ______________________________

____

Reason you are no longer under care of above listed: ______________________________

____

Name(s) of previous psychiatric medication(s) tried, if applicable: ______________________

____

Check any serious illnesses that you have experienced, past or present:

- ☐ Seizures
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Anemia (Low Blood)
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Lung or Respiratory Disease
- ☐ Joint or Back Pain
- ☐ Stomach or Bowel Disease
- ☐ Female Gynecological Problems
- ☐ Pregnancy Problems/Miscarriage
- ☐ Urinary Tract Infections/Disorders
- ☐ Sexual Dysfunction
- ☐ Depression
- ☐ Panic Disorder
- ☐ Nerves
- ☐ Alcoholism
- ☐ Drug Abuse
- ☐ Medication Overdose
- ☐ Suicide Attempt
- ☐ Violence
- ☐ Attention Deficit Disorder
- ☐ Learning Disorder
- ☐ Bi-Polar (Manic/Depressive)
- ☐ Schizophrenia
- ☐ Eating Disorder
- ☐ Neurological Disorder

Please list any drug or food allergies that you have: ______________________________

____

Briefly, why are you seeking psychiatric care? ______________________________

____

____

The mood disorder questionnaire

Patient ______________________ Score ____________ Date __________

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?	O yes	O no
...you were so irritable that you shouted at people or started fights or arguments?	O yes	O no
...you felt much more self-confident than usual?	O yes	O no
...you got much less sleep than usual and found you didn't really miss it?	O yes	O no
...you were much more talkative or spoke much faster than usual?	O yes	O no
...thoughts raced through your head or you couldn't slow your mind down?	O yes	O no
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	O yes	O no
...you had much more energy than usual?	O yes	O no
...you were much more active or did many more things than usual?	O yes	O no
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	O yes	O no
...you were much more interested in sex than usual?	O yes	O no
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	O yes	O no
...spending money got you or your family into trouble?	O yes	O no

2. ***If you checked YES to more than one of the above, have several of these ever Happened during the same period of time?*** O yes O no

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?***

O No Problem O Minor Problem O Moderate Problem O Serious Problem

-Adapted with permission from Robert M.A. Hirschfeld, MD.

Patient Health Questionnaire

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name____________________ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**________

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered**	**Bothered a little**	**Bothered a lot**
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods	☐	☐	☐
e. Pain or problems during sexual intercourse	☐	☐	☐
f. Headaches	☐	☐	☐
g. Chest pain	☐	☐	☐
h. Dizziness	☐	☐	☐
i. Fainting spells	☐	☐	☐
j. Feeling your heart pound or race	☐	☐	☐
k. Shortness of breath	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. 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	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

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3. Questions about anxiety.

		NO	YES
a.	In the <u>last 4 weeks</u>, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐

If you checked "NO", go to question #5.

		NO	YES
b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come <u>suddenly out of the blue</u> — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

4. Think about your last bad anxiety attack.

		NO	YES
a.	Were you short of breath?	☐	☐
b.	Did your heart race, pound, or skip?	☐	☐
c.	Did you have chest pain or pressure?	☐	☐
d.	Did you sweat?	☐	☐
e.	Did you feel as if you were choking?	☐	☐
f.	Did you have hot flashes or chills?	☐	☐
g.	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐
h.	Did you feel dizzy, unsteady, or faint?	☐	☐
i.	Did you have tingling or numbness in parts of your body?	☐	☐
j.	Did you tremble or shake?	☐	☐
k.	Were you afraid you were dying?	☐	☐

5. Over the <u>last 4 weeks</u>, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days
a.	Feeling nervous, anxious, on edge, or worrying a lot about different things.	☐	☐	☐

If you checked "Not at all", go to question #6.

		Not at all	Several days	More than half the days
b.	Feeling restless so that it is hard to sit still.	☐	☐	☐
c.	Getting tired very easily.	☐	☐	☐
d.	Muscle tension, aches, or soreness.	☐	☐	☐
e.	Trouble falling asleep or staying asleep.	☐	☐	☐
f.	Trouble concentrating on things, such as reading a book or watching TV.	☐	☐	☐
g.	Becoming easily annoyed or irritable.	☐	☐	☐

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'.
Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

6. Questions about eating.

		NO	YES
a.	Do you often feel that you can't control what or how much you eat?..........	☐	☐
b.	Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐

If you checked "NO" to either #a or #b, go to question #9.

		NO	YES
c.	Has this been as often, on average, as twice a week for the last 3 months?..........	☐	☐

7. In the last 3 months have you often done any of the following in order to avoid gaining weight?

		NO	YES
a.	Made yourself vomit?	☐	☐
b.	Took more than twice the recommended dose of laxatives?	☐	☐
c.	Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d.	Exercised for more than an hour specifically to avoid gaining weight after binge eating?..........	☐	☐

	NO	YES
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?..........	☐	☐

	NO	YES
9. Do you ever drink alcohol (including beer or wine)?	☐	☐

If you checked "NO" go to question #11.

10. Have any of the following happened to you more than once in the last 6 months?

		NO	YES
a.	You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	☐	☐
b.	You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	☐	☐
c.	You missed or were late for work, school, or other activities because you were drinking or hung over.	☐	☐
d.	You had a problem getting along with other people while you were drinking.	☐	☐
e.	You drove a car after having several drinks or after drinking too much..........	☐	☐

11. If you checked off any problems on this questionnaire, 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
☐	☐	☐	☐

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank. Alc Abu if any of #10a-e is 'YES'.

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

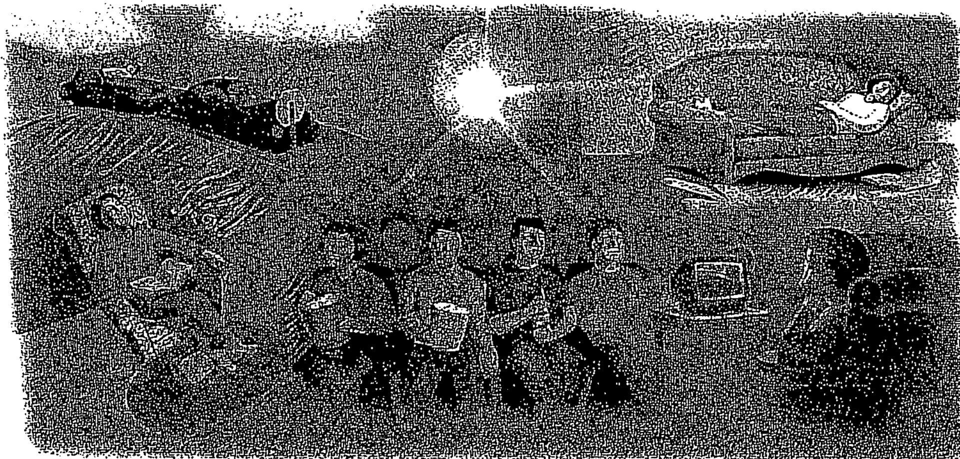
AT 26390 PRINTED IN USA. 3000033936 0303150 ASRS SYMPTOM CHECKLIST COPYRIGHT © 2003 World Health Organization. Reprinted with permission of WHO. All rights reserved.

Do you suffer from excessive daytime sleepiness?

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different, routine, daytime situations. Answers to the questions are rated on a reliable scale called the *Epworth Sleepiness Scale* (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:
0 = would never doze 2 = moderate chance of dozing
1 = slight chance of dozing 3 = high chance of dozing
It is important that you put a number (0 to 3) in each of the 8 boxes.



Situation	**Chance of dozing (0 – 3)**
Sitting and reading	⓪ ① ② ③
Watching television	⓪ ① ② ③
Sitting inactive in a public place, for example, a theater or meeting	⓪ ① ② ③
As a passenger in a car for an hour without a break	⓪ ① ② ③
Lying down to rest in the afternoon	⓪ ① ② ③
Sitting and talking to someone	⓪ ① ② ③
Sitting quietly after lunch (when you've had no alcohol)	⓪ ① ② ③
In a car, while stopped in traffic	⓪ ① ② ③

Please turn page over to determine the results of your score.

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Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your own level of daytime sleepiness. It's simple. Just add up the numbers you put in each box to get your total score.

The Epworth Sleepiness Scale key

Total score of less than 10 suggests that you are not suffering from excessive daytime sleepiness.

A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Your next steps

This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all your symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

PRO159 March 2003

SPI

COPELAND SYMPTOM CHECKLIST FOR ADULT ATTENTION DEFICIT DISORDERS

Attention Deficit Hyperactivity Disorder (ADHD) and Undifferentiated Attention Deficit Disorder (ADD)

This checklist was developed from the experience of many specialists in the field of Attention Disorders and Hyperactivity. It is designed to help determine whether you, or someone you are rating, has ADHD or ADD, to what degree, and if so, in which area(s) difficulties are experienced. Please mark all statements. Thank you for your assistance in completing this information.

Name ______________________ **Date** __________

Completed by ______________________

Directions: Place a checkmark (✓) by each item below, indicating the degree to which the behavior is characteristic of yourself or the adult you are rating.

	Not at all	Just a little	Pretty much	Very much	Score	%
I. INATTENTION/DISTRACTIBILITY, especially						
1. A short attention span, especially for low-interest activities.						
2. Difficulty completing tasks.						
3. Daydreaming.						
4. Easily distracted.						
5. Nicknames such as: "spacey," or "dreamer."						
6. Engages in much activity but accomplishes little.						
7. Enthusiastic beginnings but poor endings.					___ / 21 =	___%
II. IMPULSIVITY						
1. Excitability.						
2. Low frustration tolerance.						
3. Acts before thinking.						
4. Disorganization.						
5. Poor planning ability.						
6. Excessively shifts from one activity to another.						
7. Difficulty in group situations which require patience and taking turns.						
8. Interrupts frequently.					___ / 24 =	___%
III. ACTIVITY LEVEL PROBLEMS						
A. Overactivity/Hyperactivity						
1. Restlessness — either fidgetiness or being constantly on the go.						
2. Diminished need for sleep.						
3. Excessive talking.						
4. Difficulty listening.						
5. Motor restlessness during sleep. Kicks covers off — moves around constantly.						
6. Dislike of situations which require attention & being still—church, lectures, etc.					___ / 18 =	___%
B. Underactivity						
1. Lethargic.						
2. Daydreaming, spaciness.						
3. Failure to complete tasks.						
4. Inattention.						
5. Lacking in leadership.						
6. Difficulty in getting things done.					___ / 18 =	___%

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COPELAND SYMPTOM CHECKLIST FOR ADULT ATTENTION DEFICIT DISORDERS (Continued)

IV. NONCOMPLIANCE	Not at all	Just a little	Pretty much	Very much
1. Does not cooperate. Determined to do things own way.				
2. Argumentative.				
3. Disregards socially-accepted behavioral expectations.				
4. "Forgets" unintentionally.				
5. "Forgets" as an excuse (intentionally).				

____ / 15 = ____%

V. UNDERACHIEVEMENT/DISORGANIZATION/LEARNING PROBLEMS	Not at all	Just a little	Pretty much	Very much
1. Underachievement in relation to ability.				
2. Frequent job changes.				
3. Loses things — keys, wallet, lists, belongings, etc.				
4. Auditory memory and auditory processing problems.				
5. Learning disabilities or learning problems.				
6. Poor handwriting.				
7. "Messy" or "sloppy" work.				
8. Work assignments are often not completed satisfactorily.				
9. Rushes through work.				
10. Works too slowly.				
11. Procrastinates. Bills, taxes, etc., put off until the last minute.				

____ / 33 = ____%

VI. EMOTIONAL DIFFICULTIES	Not at all	Just a little	Pretty much	Very much
1. Frequent and unpredictable mood swings.				
2. Irritability.				
3. Underreactive to pain/insensitive to danger.				
4. Easily overstimulated. Hard to stop once "revved up."				
5. Low frustration tolerance. Excessive emotional reaction to frustrating situations.				
6. Angry outbursts.				
7. Moodiness/lack of energy.				
8. Low self-esteem.				
9. Immaturity.				

____ / 27 = ____%

VII. POOR PEER RELATIONS	Not at all	Just a little	Pretty much	Very much
1. Difficulty following the rules of social interactions.				
2. Rejected or avoided by peers.				
3. Avoids group activities; a loner.				
4. "Bosses" other people. Wants to be the leader.				
5. Critical of others.				

____ / 15 = ____%

VIII. IMPAIRED FAMILY RELATIONSHIPS	Not at all	Just a little	Pretty much	Very much
1. Easily frustrated with spouse or children. Overreacts. May punish children too severely.				
2. Sees things from own point of view. Does not negotiate differences well.				
3. Underdeveloped sense of responsibility.				
4. Poor manager of money.				
5. Unreasonable; demanding.				
6. Spends excessive amount of time at work because of inefficiency, leaving little time for family.				

____ / 18 = ____%

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COPELAND SYMPTOM CHECKLIST FOR ATTENTION DEFICIT DISORDERS

Attention Deficit Hyperactivity Disorder (ADHD) and Undifferentiated Attention Deficit Disorder (ADD)

This checklist was developed from the experience of many specialists in the field of Attention Deficit Disorders and Hyperactivity. It is designed to help you assess whether your child/student has ADHD or ADD, to what degree, and if so, in which area(s) difficulties are experienced. Please mark all statements. Thank you for your assistance in completing this information.

Name of Child ______________________________ **Date** ______________

Completed by ____

Directions: Place a checkmark (✓) by each item below, indicating the degree to which the behavior is characteristic of your child/student.

• denotes ADD with Hyperactivity (ADHD).
● denotes ADD without Hyperactivity (Undifferentiated ADD)

	Not at all	Just a little	Pretty much	Very much	Score	%
I. INATTENTION/DISTRACTIBILITY						
•● 1. A short attention span, especially for low-interest activities.						
•● 2. Difficulty completing tasks.						
● 3. Daydreaming.						
•● 4. Easily distracted.						
● 5. Nicknames such as: "spacey," or "dreamer."						
•● 6. Engages in much activity but accomplishes little.						
•● 7. Enthusiastic beginnings but poor endings.					___ / 21	= ___ %
II. IMPULSIVITY						
• 1. Excitability.						
•● 2. Low frustration tolerance.						
•● 3. Acts before thinking.						
•● 4. Disorganization.						
•● 5. Poor planning ability.						
•● 6. Excessively shifts from one activity to another.						
• 7. Difficulty in group situations which require patience and taking turns.						
•● 8. Requires much supervision.						
•● 9. Constantly in trouble for deeds of omission as well as deeds of commission.						
•●10. Frequently interrupts conversations; talks out of turn.					___ / 30	= ___ %
III. ACTIVITY LEVEL PROBLEMS						
A. Overactivity/Hyperactivity						
•● 1. Restlessness — either fidgetiness or being constantly on the go.						
• 2. Diminished need for sleep.						
• 3. Excessive talking.						
• 4. Excessive running, jumping and climbing.						
• 5. Motor restlessness during sleep. Kicks covers off — moves around constantly.						
• 6. Difficulty staying seated at meals, in class, etc. Often walks around classroom.					___ / 18	= ___ %
B. Underactivity						
● 1. Lethargy.						
● 2. Daydreaming, spaciness.						
● 3. Failure to complete tasks.						
•● 4. Inattention.						
•● 5. Poor leadership ability.						
•● 6. Difficulty in learning and performing.					___ / 18	= ___ %
IV. NON-COMPLIANCE						
•● 1. Frequently disobeys.						
•● 2. Argumentative.						
• 3. Disregards socially-accepted standards of behavior.						
● 4. "Forgets" unintentionally.						
5. Uses "forgetting" as an excuse (intentional).					___ / 15	= ___ %

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COPELAND SYMPTOM CHECKLIST FOR ATTENTION DEFICIT DISORDERS (Continued)

	Not at all	Just a little	Pretty much	Very much
V. ATTENTION-GETTING BEHAVIOR				
• 1. Frequently needs to be the center of attention.				
• 2. Constantly asks questions or interrupts.				
• 3. Irritates and annoys siblings, peers and adults.				
• 4. Behaves as the "class clown."				
• 5. Uses bad or rude language to attract attention.				
• 6. Engages in other negative behaviors to attract attention.				

___ / 18 = %

	Not at all	Just a little	Pretty much	Very much
VI. IMMATURITY				
•• 1. Behavior resembles that of a younger child. Responses are typical of children 6 months to 2-plus years younger.				
•• 2. Physical development is delayed.				
•• 3. Prefers younger children and relates better to them.				
•• 4. Emotional reactions are often immature.				

___ / 12 = %

	Not at all	Just a little	Pretty much	Very much
VII. POOR ACHIEVEMENT/COGNITIVE & VISUAL-MOTOR PROBLEMS				
•• 1. Underachieves relative to ability.				
•• 2. Loses books, assignments, etc.				
•• 3. Auditory memory and auditory processing problems.				
•• 4. Learning disabilities/learning problems.				
•• 5. Incomplete assignments.				
•• 6. Academic work completed too quickly.				
•• 7. Academic work completed too slowly.				
•• 8. "Messy" or "sloppy" written work; poor handwriting.				
•• 9. Poor memory for directions, instructions and rote learning.				

___ / 27 = %

	Not at all	Just a little	Pretty much	Very much
VIII. EMOTIONAL DIFFICULTIES				
•• 1. Frequent and unpredictable mood swings.				
•• 2. High levels of irritability.				
• 3. Underreactive to pain/insensitive to danger.				
• 4. Easily overstimulated. Hard to calm down once over-excited.				
•• 5. Low frustration tolerance.				
• 6. Temper tantrums, angry outbursts.				
• 7. Moodiness.				
•• 8. Low self-esteem.				

___ / 24 = %

	Not at all	Just a little	Pretty much	Very much
IX. POOR PEER RELATIONS				
• 1. Hits, bites, or kicks other children.				
• 2. Difficulty following the rules of games and social interactions.				
•• 3. Rejected or avoided by peers.				
• 4. Avoids group activities; a loner.				
• 5. Teases peers and siblings excessively.				
• 6. Bullies or bosses other children.				

___ / 18 = %

	Not at all	Just a little	Pretty much	Very much
X. FAMILY INTERACTION PROBLEMS				
1. Frequent family conflict.				
2. Activities and social gatherings are unpleasant.				
3. Parents argue over discipline since nothing works.				
4. Mother spends hours and hours on homework with ADD child leaving little time for others in family.				
5. Meals are frequently unpleasant.				
6. Arguments occur between parents and child over responsibilities and chores.				
7. Stress is continuous from child's social and academic problems.				
8. Parents, especially mother, feel: ☐ frustrated ☐ angry ☐ helpless ☐ hopeless ☐ guilty ☐ disappointed ☐ alone ☐ afraid for child ☐ sad and depressed				

___ / 24 = %

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