Nystrom & Associates, Ltd.

Psychiatric Medication Management Consent and Information Form

Thank you for choosing Nystrom & Associates, Ltd. for your care. It is important for you to read each item carefully and initial in the space provided to the left each item. By initialing you are indicating you have read and understand the content of each item. If you have any questions about the items below, please discuss with your provider at your appointment.

General:

_____ I am consenting to be evaluated to undergo possible medication treatment for my mental illness. Medication options will be discussed with your provider. Some of these options may include antidepressants, or psychotropic medications. I may also be recommended to participate in other forms of mental health care treatment.

_____ NAL does not offer after- hours services. If you have a concern, please contact us using FollowMyHealth or by calling your clinic. Your message will first be triaged through our nursing team who will contact you within one business day.

_____ If you have an emergency, such as severe suicidal thoughts, thoughts to hurt someone else, or a severe drug reaction, you should call 911, go to your local urgent care, or go to the emergency room.

_____ Legal guardians must attend all appointments with minors and adult patients who are not their own legal guardians for treatment to occur, unless exceptions have been approved by the Office Manager prior to the appointment.

Medication Refill Requests:

_____ You should contact your pharmacy or use FollowMyHealth first for all medication refill requests.

_____ Refill authorizations can take up to 5 business days.

_____ Controlled medication refills will not be authorized more than 3 days before they are due for refill. If you have questions regarding early refills, please speak with your provider.

Appointment Scheduling and Cancelations:

_____ Appointments canceled without a 24 hour notice may be assessed a fee up to $120.00.

_____ If you miss 3 appointments in a 12 month period with your medication provider, we will end care with you.

_____ You may be able to schedule a same day or cancelation appointment if you 1) have missed your appointment, 2) need forms completed, or 3) have other treatment concerns.

_____ Many of our providers work with medical or nursing students. You should inform your provider if you do not want a student participating in your appointments.

Forms:

_____ Our providers require an appointment to complete any forms. Any forms needing completion should be dropped off at the front desk. Your provider will review the forms and notify staff how long to schedule your forms appointment for. Any forms completed outside of an office visit will be assessed a fee, requiring prepayment.

Turn page over

Laboratory & Psychological Testing:

_____ Your provider will request you complete certain laboratory tests before initiating or continuing certain medications. Laboratory tests may include, but are not limited to: saliva, hair follicle, urine, blood serum, electrocardiograms, psychological testing, genomic testing, etc.

_____ Laboratory testing fees are your responsibility. If your insurance plan will not cover the cost for laboratory, psychological, or other testing, you will be responsible for all costs incurred.

Billing and Insurance:

_____ You are responsible for understanding your insurance coverage.

_____ Co-pays are due at the time of check-in.

_____ Your insurance will be charged for services received. You are responsible for all patient balances due to co-pays, co-insurances, deductibles, tax, billing charges, late or no show charges, laboratory and psychological testing, emergency transportation, etc.

_____ A charge for psychotherapy in addition to a medication management billing code may appear on your billing statement. Psychotherapy is a standard psychotherapy add-on code that all NAL medication providers use to reflect psychotherapy services that occur in session. Psychotherapy is defined in Current Procedural Terminology (CPT) by the American Medical Association as "the attempt to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development" (2012).

Genoa Pharmacy:

We have an on-site pharmacy at our New Brighton, Duluth, Eden Prairie and Woodbury locations to provide you with the convenience of filling all of your medications in the privacy of our clinic. However, Genoa can also fill prescriptions for you at all other locations. Genoa can specially pre-package your medication or mail them to your residence, and they will match the pricing of other pharmacies.

_____		_____
Patient's Name		Patient's Date of Birth
_____	_____	_____
Patient or Parent/Legal Guardian Signature	Date	Witness Signature
_____		_____
Emergency Contact Printed Name		Emergency Contact Phone Number

NYSTROM & ASSOCIATES, LTD.

PSYCHIATRIC MEDICATION ADULT PATIENT INFORMATION FORM

Today's Date: _____

Name: _____ Date of Birth: _____

Nickname/Preferred Name: _____

History of Present Illness and Reason for Visit

I would like to discuss the following symptoms or concerns in my initial visit with my provider: _____

_____

_____

_____

Approximately when did these symptoms first begin? _____

Have these symptoms worsened recently? _____

How do these symptoms impair your ability to function, work, or relate to other people?

_____

_____

Has anything happened in the last year or so that has been very stressful for you such as serious health problems in your home or a family member, death of a close friend or family member, work stress, loss of job, loss of home, financial problems, legal issues, physical or sexual assault?

_____

_____

Current Medications

IF YOU ARE TAKING ANY PSYCHIATRIC MEDICATIONS, WE MUST HAVE A RELEASE OF INFORMATION FOR RECORDS FROM THE MOST RECENT PRESCRIBER (see page 5).

Please list ALL of your current medications and supplements in the table below:

MEDICATION	DOSE	NUMBER OF PILLS TAKEN			
		MORNING	NOON	AFTERNOON	BEDTIME
Example Medication (1 twice per day, 2 at night)	0.5MG	1	0	1	2

Name_____ Date of Birth_____

Nystrom & Associates, Ltd.

Controlled Medication Agreement

Controlled substance medications have potential for misuse. They are intended to improve function and/or ability to work, and are not simply to feel good.

- Our providers may not prescribe standing doses of benzodiazepines with stimulant medications.
- Our providers do not prescribe pain medication or medical cannabis.
- If you are taking narcotic pain medication, medical cannabis, or are abusing drugs or alcohol, our providers may not prescribe controlled medications to you.
- If you are pregnant or have certain medical or psychiatric conditions, controlled medications may not be appropriate for you.
- Your medication provider may request records from other medical providers, permission to talk to family members, drug screens and other laboratory tests, psychological tests, and may review the state controlled medication profile, before starting or continuing controlled medication.
- Drug screens, laboratory test, and counts of remaining pills may be requested while you are taking controlled medications, and must be completed within 24 hours.
- Our providers must follow Nystrom & Associates, Ltd. maximum dosing guidelines for controlled medications.

I have been told and understand that:

1. I may get addicted to this medication. Your risk for addiction is higher if you have a family history of alcohol or drug addiction. If I need to stop this medication, I must do it in under the direction of a medical provider, including the possible need for admission to a medical detox facility, or I may get very sick.
2. I can be found guilty of Driving Under the Influence (DUI) if taking these medications and driving, even if no alcohol has been consumed.
3. I may not be prescribed controlled medication if I am currently living in a residential chemical dependency treatment center or participating in chemical dependency treatment program. I understand I must remain sober for 12 months minimum after completing a residential or outpatient chemical dependency program before controlled medications will be considered, if at all.
4. I am responsible for scheduling my next appointment so I do not run out of medication between office visits. Stimulant refills will not be given outside of appointments, unless my provider cancels my appointment.
5. I will participate in all other types of treatments for my condition that I am asked to participate in.
6. If I am arrested or incarcerated related to illegal drug charges (including alcohol), controlled medications will be stopped and cannot be restarted during the duration of my care at Nystrom & Associates, Ltd.
7. My provider may not grant early refills for any reason (i.e. lost, stolen, damaged) for any controlled medication.
8. If I am taking medical cannabis, methadone, suboxone or other any other narcotic based medications on an ongoing basis, controlled medications will be stopped while I am taking these other medications. Taking stimulants or tranquilizers with these medications can be life threatening and cancel out their effects. If I do not tell my provider about using any drugs or controlled medications on my own or from any other providers, my care will be permanently ended.
9. If I sell, trade, share, fill early, or increase the dose of controlled medications on my own, they will be stopped and cannot be restarted during the duration of my care at Nystrom & Associates, Ltd.
10. If I have an emergency such as severe suicidal thoughts, thoughts to hurt someone else or if I am having a severe drug reaction, I will call 911 or go to the emergency room. I will notify my provider as soon as possible.
11. I will treat the staff at the office respectfully at all times. I understand if I am disrespectful (including but not limited to yelling, foul language, bullying or harassing) to any staff (office, nursing staff or providers) or if I disrupt the care of other patients, my treatment will be permanently stopped at Nystrom & Associates, Ltd.
12. I may be asked to only use one pharmacy to get my medicine. My provider may talk with the pharmacist about my medicines.
13. Drug screens requested by my provider must be completed within 24 hours or will be considered positive.
14. I will inform all my other physicians of the controlled substance medication I am receiving through Nystrom & Associates, Ltd. Likewise, I will inform my Nystrom & Associates, Ltd. medication provider of any other controlled substance medication I receive from another physician.

_____ _____ _____

Patient/Legal Guardian Signature Date Provider's Initials

Releases of Information

In order for us to provide the best care to you, we will need you to complete Release of Information forms to review records and possibly discuss your care with current and past health care providers. Without your consent for these Releases of Information, we may decide that we will be unable to provide care to you. Release of Information forms can be found with our front desk staff or on our website.

1. If you listed any psychiatric medications on Page 9, you will need to complete a Release of Information for the current or most recent prescriber of these medications.

2. Are you currently seeing a psychotherapist?
   - ☐ Yes (If yes, complete a Release of Information to exchange information with your therapist.)
   - ☐ No

3. Have you ever been psychiatrically hospitalized?
   - ☐ Yes (If yes, complete a Release of Information for the most recent hospitalization.)
   - ☐ No

   Please list all psychiatric hospitalizations starting with the most recent:

Hospital:	Approximate Dates of Hospitalization:
_____	_____
_____	_____
_____	_____
_____	_____

4. Have you ever been in chemical dependency treatment?
   - ☐ Yes (If yes, complete a Release of Information for the most recent treatment program).
   - ☐ No

   Please list all chemical dependency programs starting with the most recent:

Chemical Dependency Program:	Approximate Dates:
_____	_____
_____	_____
_____	_____
_____	_____

5. Please complete a Release of Information to exchange information with your current Primary Care Provider if you have not already done so.

Medication History

Please indicate if you have EVER taken any of the following psychotropic medications, the highest dose you remember taking, and the approximate dates it was prescribed:

Medication	Highest Dose	Dates (e.g. 2008-2010)	Side Effects/Comments
DEPRESSION AND ANXIETY MEDICATIONS			
Ascendin			
Anafranil/clomipramine			
Brintellix/vortioxetine			
Celexa/citalopram			
Cymbalta/duloxetine			
Desyrel/trazodone			
Effexor/venlafaxine			
Elavil/amitriptyline			
Emsam/selegiline			
Fetzima/levomilnacipran			
Lexapro/escitalopram			
Luvox/fluvoxamine			
Marplan/isocarboxazid			
Nardil/phenelzine			
Norpamin/desipramine			
Pamelor/nortriptyline			
Parnate/tranylcypromine			
Paxil/paroxetine			
Pristiq/desvenlafaxine			
Prozac/fluoxetine			
Remeron/mirtazapine			
Sarafem/fluoxetine			
Savella/milnacipran			
Serzone/nefazodone			
Sinequan/doxepin			
Surmontil/trimipramine			
Tofranil/imipramine			
Viibryd/vilazodone			
Vivactil/protriptyline			
Wellbutrin/bupropion			
Zoloft/sertraline			

ALCOHOL ABSTINENCE MEDICATIONS	Highest Dose	Dates (e.g. 2008-2010)	Side Effects/Comments
Revia/naltrexone			
Antabuse/disulfiram			
Campral/acamprosate			

ADHD MEDICATIONS	Please note: you MUST have had ADHD testing with a psychologist before we can prescribe these medications. NAL can provide this testing if needed. We do NOT prescribe these medications if you are taking narcotic pain medications, methadone, or suboxone.		
Adderall/amphetamine			
Adderall XR/amphetamine ER			
Concerta/methlylphenidate ER			
Daytrana/methylphenidate patch			
Desoxyn/methamphetamine			
Dexedrine/dextroamphetamine			
Dextrostat/dextroamphetamine			
Focalin/dexmethylphenidate			
Focalin XR/dexmethylphenidate ER			
Intuniv/guanfacine			
Metadate/methylphenidate			
Methylin/methylphenidate			
Ritalin/methylphenidate			
Ritalin SR/methylphenidate ER			
Ritalin LA/methylphenidate LA			
Strattera/atomoxetine			
Vyvanse/lisdexamfetamine			

ANTIANXIETY MEDICATIONS	Please note: we do NOT prescribe these medications if you are taking narcotic pain medications, methadone, suboxone, or ADHD medication.		
Atenolol			
Ativan/lorazepam			
Buspar/buspirone			
Catapres/clonidine			
Inderal/propranolol			
Klonopin/clonazepam			
Librium/chlordiazepoxide			
Serax/oxazepam			
Tranxene/clorazepate			
Valium/diazepam			
Vistaril/hydroxyzine			
Xanax/alprazolam			

ANTIPSYCHOTICS	Highest Dose	Dates (e.g. 2008-2010)	Side Effects/Comments
Abilify/aripiprazole			
Clozaril/clozapine			
Fanapt/iloperidol			
Haldol/haloperidol			
Invega/paliperidone			
Latuda/lurasidone			
Loxitane/loxapine			
Mellaril/thioridazine			
Moban/molindone			
Navane/thiothixine			
Prolixin/fluphenazine			
Rexulti/brexpiprazole			
Risperidol/risperidone			
Saphris/asenapine			
Seroquel/quetiapine			
Seroquel XR/quetiapine XR			
Stelazine/trifluoperazine			
Thorazine/chlorpromazine			
Trilafon/perphenazine			
Zyprexa/olanzapine			

MOOD STABILIZERS AND ANTICONVULSANT MEDICATIONS			
Depakote/valproate			
Keppra/levetiracetam			
Lithium/Eskalith/Lithiobid			
Lamictal/lamotrigine			
Symbax			
Neurontin/gabapentin			
Tegretol/carbamazine			
Topomax/topiramate			
Trileptal/oxcarbazepine			
Zonegran/zonisamide			

SLEEP / WAKE MEDICATIONS			
Ambien/zolpidem			
Ambien CR/zolpidem ER			

SLEEP / WAKE MEDICATIONS CONT.	Highest Dose	Dates (e.g. 2008-2010)	Side Effects/Comments
Belsomra			
Dalmane/flurazepam			
Desyrel/trazodone			
Gabitril/tiagabine			
Halcion/triazolam			
Intermezzo			
Lunesta/eszoplicone			
Nuvigil/armodafinil			
Periactin/cyproheptadine			
Provigil/modafinil			
Restoril/temazepam			
Rozerem/ramelteon			
Silenor/doxepin			
Sinequan/doxepin			
Sonata/zaleplon			
Xyrem/sodium oxybate			

MEDICATIONS USED FOR SIDE EFFECTS			
Cogentin/benzotropine			
Benadryl			
Artane/trihexyphenidyl			
Inderal/propranolol			
Atenolol			

ALZHEIMER'S DISEASE MEDICATIONS			
Aricept/donepezil			
Cognex/tacrine			
Exelon/rivastigmine			
Namenda/memantine			
Razadyne/galantamine			
Reminyl/galantamine			

Allergies

Please list all medication allergies:

_____

_____

_____

Psychiatric History

Have you ever received treatment for psychiatric reasons?

- ☐ Yes
- ☐ No

If yes, list the types of treatments you have participated in:

- ☐ Individual Therapy
- ☐ Group Therapy
- ☐ Couples Therapy
- ☐ Family Therapy
- ☐ Day Treatment
- ☐ DBT
- ☐ EMDR
- ☐ Biofeedback
- ☐ ECT: When? _____ Treatments: _____
- ☐ TMS
- ☐ VNS
- ☐ Other: _____

Have you ever attempted suicide or engaged in self-injurious behavior?

- ☐ Yes
- ☐ No

If yes, when and by what means? (Overdose, cutting yourself, etc.)

Means:	Year:
_____	_____
_____	_____
_____	_____

Social History

Were you born in the United States?

- ☐ Yes
- ☐ No

If no, where were you born? _____

How old were you when you came to the United States? _____

Why did you come to the United States? _____

What is your highest level of education?

- ☐ Dropped out in ____ grade because of _____
- ☐ GED
- ☐ High School Graduate/Diploma
- ☐ Vocational School
- ☐ Some College
- ☐ Associate's Degree, 2 year
- ☐ Bachelor's Degree, 4 year
- ☐ Advanced Degree
- ☐ Still in High School - ____ Grade
- ☐ Still in College or Vocational School

Have you ever been in the military?

- ☐ Yes
- ☐ No

If yes, please check appropriate boxes below

- ☐ Saw Active Combat
- ☐ Honorable Discharge
- ☐ Dishonorable Discharge because of _____

What is your religious affiliation?

- ☐ Protestant
- ☐ Catholic
- ☐ Jewish
- ☐ Muslim
- ☐ None
- ☐ Other:_____

If religious, do you regularly practice your faith?

- ☐ Yes
- ☐ No

Place of residence:

- ☐ Home
- ☐ Apartment
- ☐ Group Home: _____
- ☐ Board and Lodge: _____
- ☐ Foster Home: _____
- ☐ Other: _____

Who lives with you? _____

My current job, occupation, or career: _____

I am currently disabled. I have been disabled since _____ (year).

My prior occupation before becoming disabled: _____

Whom do you rely on for social support? _____

Relationship Status:

- ☐ Never Married
- ☐ Casually Dating
- ☐ Seriously Dating
- ☐ Married _____ years
- ☐ Cohabitating _____ years
- ☐ Separated
- ☐ Divorced - Number of previous marriages: _____
- ☐ Widowed

What is your current marital/relationship satisfaction?

- ☐ Not in a relationship
- ☐ Good
- ☐ Poor
- ☐ My partner/spouse abuses chemicals/alcohol
- ☐ There has been abuse in my relationship

Names and ages of children: _____

Do you have custody of children? (Yes or no) _____

Legal History

Have you ever been charged with a serious crime?

- ☐ Yes
- ☐ No

If yes, what were you charged with? _____

Do you have a history of serving jail or prison time?

- ☐ Yes
- ☐ No

If yes, at what facility? _____ For how long? _____

Are you currently on probation?

- ☐ Yes
- ☐ No

If yes, I am on probation until _____

Family History

Did your parents remain married?

- ☐ Yes
- ☐ No

If not, how old were you when they separated? _____

How many brothers and sisters do you have? _____

What is the order of your birth? (e.g. oldest, youngest, 2nd of 5) _____

Please complete the table below regarding any type of abuse you may have experienced:

Type of Abuse	Yes	No	If yes, by whom?	How long did the abuse take place?
Verbal				
Physical				
Sexual				
Emotional				

Do any relatives have a history of a mental illness or chemical dependency?

- ☐ Yes
- ☐ No

If yes, please complete the table below:

ILLNESS	RELATIONSHIP TO YOU (e.g. mother, father, brother, sister, grandfather, cousin, aunt, etc.)
ADD/ADHD	
ALCOHOLISM	
ANXIETY, PANIC DISORDER, PTSD, OCD	
BIPOLAR DISORDER	
DEMENTIA	
DEPRESSION	
DRUG ABUSE	
LEARNING DISABILITY OR LOW IQ	
SCHIZOPHRENIA OR PSYCHOSIS	
SUICIDE ATTEMPTS	

Medical History

Please list all of your physical medical illnesses/conditions (problems with your heart, lungs, liver, stomach, bowel, skin, joints, thyroid, etc. including if you are currently pregnant).

Condition: _____ Year Diagnosed: _____

_____ _____

_____ _____

_____ _____

_____ _____

How often do you exercise? _____ times per week.

Have you ever had a seizure or have you ever been diagnosed with epilepsy?

- ☐ Yes
- ☐ No

Are you or is there a chance you may be pregnant?

- ☐ Yes
- ☐ No

Have you ever had a period of unconsciousness (coma, knocked out, brain injury, concussion)?

- ☐ Yes
- ☐ No

If yes, please describe what happened and how long you were unconscious:

_____

_____

_____

Surgical History

Please list all surgeries you have had:

Surgical Procedure: Year:

_____ _____

_____ _____

_____ _____

Additional Comments:

_____

_____

_____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date: _____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screener/Recent – Self-Report

Name: _____

Dae of Birth: _____

	In The Past Month	
Answer Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts about killing yourself?***		
If **YES** to 2, answer questions 3, 4, 5, and 6. If **NO** to 2, go directly to question 6		
3) ***Have you thought about how you might do this?***		
4) ***Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?***		
5) ***Have you started to work out or worked out the details of how to kill yourself?*** ***Do you intend to carry out this plan?***		
	In the Past 3 Months	
6) ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
In your entire lifetime, how many times have you done any of these things?		

Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

DOB: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Circle 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	0	1	2	3

Add columns _____ + _____ + _____

Total: _____

10. 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	_____ _____ _____ _____

Substance Use History

Do you use ANY alcohol or have you EVER used or abused any drugs?

- ☐ Yes
- ☐ No

If yes, please complete the table below:

Drug	List the specific name of what you use(d).	Typical Amount Used	Date of Last Use	How Many Times Per Week or Month Do You Use?
Alcohol				
Illicit Drugs Marijuana, Methamphetamine, Crank, Heroin, Ecstasy, Speed				
Prescription Drugs **Pain Medications** (oxycodone, oxycontin, Percocet, codeine, Darvon, Vicodin) **Tranquilizers** (Xanax, Valium, Ativan, Klonopin) **Stimulants** (Ritalin, Adderall, Metadate, etc.)				

If you use ANY alcohol or drugs, please complete the table below:

STATEMENT	Yes	No
I feel the need to reduce my use of alcohol or drugs.		
People have complained to me about my use of alcohol or drugs.		
I feel guilty about my use of alcohol or drugs.		
I have used alcohol or drugs to help me get through the day.		

Caffeine/Tobacco Use

How many caffeinated beverages do you have per day? _____

Do you use tobacco?

- ☐ Yes
- ☐ No

If yes, what type of tobacco do you use (chewing tobacco, cigarettes, etc.)? _____

How much per day? _____

I consent to undergo psychiatric treatment at Nystrom & Associates, Ltd.

Signature: _____ Date: _____