ACHIEVE PSYCHIATRY OHIO

EDAN GILAT, M.D BOARD CERTIFIED PSYCHIATRIST

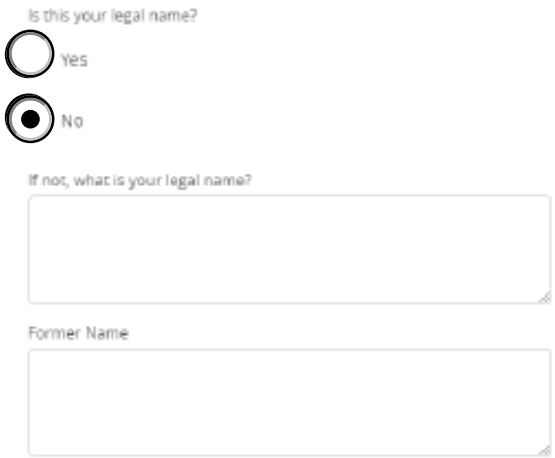
https://achieve-psychiatry.com/

https://portal.wecounsel.com/directory/edan_gilat_md

Client Intake Form

Patient Information

Name (First, middle, surname):



Contact

Phone (call or text): (740) 913 1189

Fax: (855) 671-4843

Email : DrG@achieve-psychiatry.com

Title

- ( ) Mr.
- (•) Mrs.
- ( ) Miss
- ( ) Ms.

Marital Status

- (•) Single
- ( ) Married
- ( ) Divorced
- ( ) Separated
- ( ) Widowed

Birth Date (mm/dd/yyyy)

Age

Sex

- ( ) Male
- (•) Female
- ( ) Other

Contact Information

Street Address:

City:

State:

Zip:

Cell Phone

Home Phone

Email Address

Occupation

Employer

Employer Number

Pharmacy Information

Pharmacy Name

Pharmacy Address

Pharmacy Phone Number

Please describe any history of substance abuse problems and/or treatment

Please list any medical allergies

Please list all medications currently prescribed for the patient (include both psychiatric and non-psychiatric medications).

Medication 1:

Medication 2:

Medication 3:

Any additional medications:

Please List Any Additional Medications, Vitamins, Herbs, Supplements Etc.

Clinical History

Reason for seeking treatment

Current and /or prior mental health treatment

History of harm to self or others or thoughts of harm to self or others

Yes ◯

No ◯

Please descibe:

Any Other Relevant Information

Questions? Comments? Concerns?

I hereby certify that the above statements are true and correct to the best of my knowledge.

Signature:

Date:

PTSD CheckList – Civilian Version (PCL-C)

Date of Birth:_____

Client's Name: _____ Date: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?	☐	☐	☐	☐	☐
2.	Repeated, disturbing *dreams* of a stressful experience from the past?	☐	☐	☐	☐	☐
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?	☐	☐	☐	☐	☐
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?	☐	☐	☐	☐	☐
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?	☐	☐	☐	☐	☐
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?	☐	☐	☐	☐	☐
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?	☐	☐	☐	☐	☐
8.	Trouble *remembering important parts* of a stressful experience from the past?	☐	☐	☐	☐	☐
9.	Loss of *interest in things that you used to enjoy?*	☐	☐	☐	☐	☐
10.	Feeling *distant* or *cut* off from other people?	☐	☐	☐	☐	☐
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	☐	☐	☐	☐	☐
12.	Feeling as if your *future* will somehow be *cut short*?	☐	☐	☐	☐	☐
13.	Trouble *falling* or *staying asleep*?	☐	☐	☐	☐	☐
14.	Feeling *irritable* or having *angry outbursts*?	☐	☐	☐	☐	☐
15.	Having *difficulty concentrating*?	☐	☐	☐	☐	☐
16.	Being *"super alert"* or watchful on guard?	☐	☐	☐	☐	☐
17.	Feeling *jumpy* or easily startled?	☐	☐	☐	☐	☐

Electronic Signature: _____

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

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

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). 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 ◯

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Edan Gilat, MD to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

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