



Magnolia Psychiatry

Magnolia Psychiatry
17510 Huffmeister Rd. #103
Cypress, TX 77429
www.magnoliapsychiatry.clinic
p. 281-724-7980
f. 281-746-6268

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Suffix (Circle): Jr. Sr. III IV Date of Birth: _____ Gender: Male Female other

Parent/Legal Guardian Name (If Applicable): _____

Marital Status: Single Married Divorced Separated Widowed SSN: _____

Spouse Name: _____ Spouse Number: () _____ - _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: () _____ - _____ Mobile Phone: () _____ - _____

*Email: _____

*An email address and social security number is required to access our patient portal.

EMERGENCY CONTACT

Full Name: _____ Relationship: _____

Home Phone: () _____ - _____ Mobile Phone: () _____ - _____

PATIENT EMPLOYMENT/SCHOOL DETAILS

Employment Status: Full-Time Part-Time Not Employed Self-Employed Military

Employer Name: _____ Work: () _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Student Status: Full-Time Part-Time Not a Student School Name: _____

REFERRAL AND PHARMACY INFORMATION

Referring person: _____ Phone: () _____ - _____

How did you hear about us? _____

Clinician Referral: ___ Google: ___ Social Media: ___ Friend/Family: ___ Other: _____

Please let us know which pharmacy you prefer:

Walgreens CVS HEB Kroger Target Sam's Club Walmart Other: _____

Address: _____

Phone Number: _____

Mail Order Pharmacy: CVS Caremark Express Scripts Prime Mail Other:

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CONSENT FOR RELEASE OF INFORMATION/HEALTH CARE COORDINATION FORM

Patient's Name: _____ Date of Birth: ___/___/___ Social Security Number: ___ - ___ - ___
Home Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____ - _____ Mobile Phone: (____) _____ - _____ Email: _____

I hereby authorize Magnolia Psychiatry to release/receive the following health information:

_____ Initial Evaluation/Assessment	_____ Psychological Reports & Testing Results
_____ Medical History and Information	_____ Laboratory Results/Reports
_____ Psychotherapy Notes	_____ Billing Records/Information
_____ Office Visit/Progress Notes	_____ Transfer/Discharge Summary
_____ Complete Medical Record	_____ Other: _____

Please release the requested information for these treatment dates: _____

[] Records to be released to: _____ [] Records to be requested/received from: _____

Name: _____ Relationship: _____

Health Care Provider Name: _____ Address: _____

Telephone Number: (____) _____ - _____ Fax: (____) _____ - _____

I acknowledge that I have the right to revoke this authorization in writing at any time by sending such written notification to the releasing person/agency. I understand that my revocation will not be effective to the extent that Magnolia Psychiatry has already taken action in reliance of this authorization or if this authorization was obtained as a condition of, obtaining insurance coverage and the insurer has the legal right to contest the claim. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be required as indicated in the copy of the Notice of Privacy Practices of Magnolia Psychiatry, that I have received and reviewed. I acknowledge that the authorized recipient may accomplish the re-disclosure of my protected health information and that Federal Privacy Rule will no longer protect it. I acknowledge and understand that I am waiving my right to confidentiality with respect to the information or records released pursuant to this consent and I hereby release Magnolia Psychiatry and its staff from any and all liability arising from the release and disclosure of the information or records. A photocopy or fax of this authorization is as valid as the original. Please note: This authorization will automatically expire one year from signing unless other date of expiration is specified here: _____

I acknowledge that I have read this authorization for release of information in its entirety and I fully understand its terms and implications. I freely, voluntarily and without and coercion, agree with the terms and conditions contained in this authorization.

Patient's Name: _____ DOB: _____

Signature of adult patient OR the parent/legal guardian of a minor patient (under 18 years old)

Date

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 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 + +

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

<p>10. If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
<i>Add the score for each column</i>	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name	Today's Date				
Instructions <i>Please answer the questions below, rating yourself on a scale of 1 through 5 on each of the criteria as shown to the right. As you answer each question in a way that best describes how you have felt and conducted yourself in the past 6 months. Please give this completed checklist to your healthcare professional to discuss during your appointment.</i>	1	2	3	4	5
	Never	Rarely	Sometime	Often	Always
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?					
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 to much when you are in social situations?					
16. When you are 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?					
Total Score: Inattention, Subscale A					
Total Score: Hyperactivity, Subscale B					

The Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist was developed in conjunction with the World Health Organization (WHO), and the Workgroup on Adult ADHD that included the following team of psychiatrists and researchers: Lenard Adler, MD, Associate Professor of Psychiatry and Neurology, New York University Medical School; Ronald C. Kessler, PhD, Professor, Department of Health Care Policy, Harvard Medical School; and Thomas Spencer, MD, Associate Professor of Psychiatry, Harvard Medical School.

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?	<input type="radio"/>	<input type="radio"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="radio"/>	<input type="radio"/>
...you felt much more self-confident than usual?	<input type="radio"/>	<input type="radio"/>
...you got much less sleep than usual and found you didn't really miss it?	<input type="radio"/>	<input type="radio"/>
...you were much more talkative or spoke faster than usual?	<input type="radio"/>	<input type="radio"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="radio"/>	<input type="radio"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="radio"/>	<input type="radio"/>
...you had much more energy than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more active or did many more things than usual?	<input type="radio"/>	<input type="radio"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="radio"/>	<input type="radio"/>
...you were much more interested in sex than usual?	<input type="radio"/>	<input type="radio"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="radio"/>	<input type="radio"/>
...spending money got you or your family in trouble?	<input type="radio"/>	<input type="radio"/>
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? <i>Please check 1 response only.</i>	<input type="radio"/>	<input type="radio"/>
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? <i>Please check 1 response only.</i>		
<input type="radio"/> No problem <input type="radio"/> Minor problem <input type="radio"/> Moderate problem <input type="radio"/> Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	<input type="radio"/>	<input type="radio"/>
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	<input type="radio"/>	<input type="radio"/>

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.**

Severity of Posttraumatic Stress Symptoms—Adult*

*National Stressful Events Survey PTSD Short Scale (NSESSS)

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

Please list the traumatic event that you experienced: _____

Date of the traumatic event: _____

Instructions: People sometimes have problems after extremely stressful events or experiences. How much have you been bothered during the PAST SEVEN (7) DAYS by each of the following problems that occurred or became worse after an extremely stressful event/experience? **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
		Not at all	A little bit	Moderately	Quite a bit	Extremely	Item score
1.	Having “flashbacks,” that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
2.	Feeling very emotionally upset when something reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
3.	Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
4.	Thinking that a stressful event happened because you or someone else (who didn’t directly harm you) did something wrong or didn’t do everything possible to prevent it, or because of something about you?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
5.	Having a very negative emotional state (for example, you were experiencing lots of fear, anger, guilt, shame, or horror) after a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
6.	Losing interest in activities you used to enjoy before having a stressful experience?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
7.	Being “super alert,” on guard, or constantly on the lookout for danger?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
8.	Feeling jumpy or easily startled when you hear an unexpected noise?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
9.	Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
Total/Partial Raw Score:							
Prorated Total Raw Score: (if 1-2 items left unanswered)							
Average Total Score:							