Jeffrey Young, PHD, CBSM

Psychologist (PSY 15577)
Sleep, Mood, & Anxiety Disorders
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Certified in Behavioral Sleep Medicine by the American Academy of Sleep Medicine (136)

Welcome to my practice!

Below you will find an outline of important information that relates to the professional practice of psychology. I realize that reading through this very detailed material with its legalistic tone can be a bit tedious; however, it is in your best interest to have a good understanding of both the legal and ethical elements that guide the practice of professional psychology before beginning the assessment and treatment process.

It is useful to point out that any licensed health clinician is subject to the rules and guidelines that you will read about below. This is to say that there is nothing here that is outside the norm. However, because psychologists and other mental health professionals are likely to work with more sensitive and private information, we work to outline these points in much greater detail than what you might find in other health specialties. For example, your dentist or dermatologist are also held to these practice standards but may not go into the level of detail seen here because the information encountered in their practices is seen by most patients as having a less sensitive and private nature.

Please make note of all the areas where you are asked to either **Initial or Sign.** Your initial or signature indicates your understanding and agreement.

Additionally, you should feel free to leave any portion of this form unsigned or any portion of any attached questionnaires blank, should you want additional clarification from me of any questions or concepts.

Today's Date _____

Name _____

Date of Birth/Age _____

Driver's License/ID No. _____

Insurance Company (name only) _____

Home Address (where confidential billing or clinical information may be sent)

_____

Phone Numbers (for each number please indicate **Cell, Home, or Work** and if a message can be left with either a person who may answer or on voice mail): Identify the **Best Number**.

_____

_____

_____

Reason for seeking Treatment _____

Emergency Contact (Name, Relationship, Phone) _____

Please list below other clinicians who are currently involved in your healthcare.

Psychologist: Name, City, State, and Phone

_____

Primary Care Physician/Other Relevant Physician: Name, City, State, and Phone

_____

Psychiatrist: Name, City, State, and Phone

_____

Who referred you to my office? Name, City, State, and Phone

_____

Please sign here _____ to indicate that I have your consent to communicate with the clinicians listed above as needed/indicated for proper coordination of care

Jeffrey Young, PHD, CBSM (PSY 15577) Tel: 818-905-7121, Fax: 818-453-8961
HIPAA Secure Email: dryoung@drjeffreyyoung.com.

Informed Consent

General Principles of Nature of Psychotherapy and Psychological Assessment

Psychotherapy is a collaborative process that is designed to help relieve psychological/emotional distress, improve behavioral functioning, and improve overall life satisfaction. Collaborative here means that we are both involved in the process of deciding a best course of action and that your input and your participation in the work is essential to getting the best results. You should understand that my role as your psychologist is not to necessarily push you in one direction versus another but to help increase your level of clarity around the issues you present so that you can make more effective decisions.

Although my approach to psychotherapy is informed by many schools of thought, the primary modality I use is called Cognitive-Behavioral Therapy which is often referred to as CBT. Simply put, CBT examines your thoughts and behaviors, your assumptions about yourself, others, and the world. Its aim is to understand how these factors influence your how you feel and behave. CBT also provides strategies to help you more effectively navigate the problems you are having. CBT is a very well researched and highly regarded form of psychotherapy and is used by many clinicians to help people with depression, anxiety, stress, sleep, and relationship difficulties.

Psychotherapy can be a very enjoyable process which can ultimately lead to substantial improvements in functioning and life satisfaction. However, there are some risks involved: These risks include experiencing periodic increases in sadness, anger, frustration, guilt, or may involve your deciding to alter the nature of the relationships you have with others or, perhaps, even to terminate these relationships which may then carry its own set of risks and benefits.

Additionally, while I maintain that there is every reasonable expectation that you can be helped by our work together (e.g., improved mood or sleep, maintenance of a level of functioning through continuous support), I cannot guarantee that you will ultimately benefit from treatment. To this point, we will be discussing, as indicated, your experience of therapy and my approach to make sure that you are getting what you want from treatment. **If you are feeling stuck in some way and not feeling that you are making the kind of progress you want, you should always feel free to discuss this with me**. We will address this concern by discussing our therapy process together. Similarly, if I feel that progress is not being made, I will address this concern with you as well. In either case, this may involve a decision to shift my approach with you or may involve exploring whether another clinician might be of greater help to you.

You should be aware that in addition to CBT psychotherapy, other forms of treatment do exist. This would include other forms of psychotherapy as well as psychotropic medications (e.g., Antidepressants). I understand that Dr. Young will advise me regarding these options, if indicated, and will make appropriate referrals, if needed. I do not prescribe medications or recommend or supervise the use of over the counter preparations. While I might have substantial scientific knowledge of many of these biological preparations, and will gladly discuss what I know, any direct advice must come from a licensed prescriber and you should rely on his or her expertise when deciding whether to start, stop, or modify any biological preparation.

Finally, you should know that you have no obligation to take any psychological tests that you may find uncomfortable and that you have no obligation to answer any questions that you do not feel comfortable answering. You also may end or suspend your treatment at any time without concern.
My Signature below affirms my understanding and acceptance of the above.

_____

Name (Print) ***Signature*** ***Date***

Confidentiality of Your Protected Health Information (PHI)

Unless a disclosure is mandated by state or federal law or by a valid subpoena/court order, OR there is reasonable suspicion of your being the victim or perpetrator of child, elder/dependent adult, domestic violence OR knowingly possessing, exchanging, streaming child pornography, OR you are deemed a danger to self/others
I cannot give out any information (PHI) or even confirm or disconfirm that you are a patient even if this person is a family member, spouse/partner, or is paying for your treatment. The only way I can disclose information in this circumstance is by you giving me verbal and/or written consent __ Initial

Contact with your referring clinician and other clinicians involved in your care.

This might be another psychologist who is treating you for another problem, or a physician prescribing medication. I understand that Dr. Young will wish to speak with these clinicians and your referring clinician as needed to properly coordinate care (this may involve sending a written report). Current law allows me to coordinate care without prior consent. However, I believe it is always a best practice to obtain written or verbal consent. If you have any concern with me speaking to any clinician you may identify as providing treatment, please let me know and we will discuss it. _____Initial

Contact Person in Case of Emergency

The emergency contact you have identified will only be used in an emergency or at a time when I feel you might be in some danger or at a level of distress that would require that person's knowledge or involvement. The information I share in this circumstance would be limited to only that which is necessary to resolve the situation _____ Initial

Contact with Persons or Entities with whom I have a Business Associates Agreement

Dr. Young will ensure that any person or business entity that might have access to any of your health information will have signed a **Business Associates Agreement**. Doing so obligates that person or entity to maintain the security and confidentiality of your health information in accordance with HIPPA regulations. For example my Electronic Health Record systems (Office Ally & Therapy Notes) has signed a business associates agreement. _____ Initial

Record Keeping

Legal and Ethical standards require me to keep a formal written record of the care provided to you and to safeguard that record within the limits of the law.

Your record (PHI) may include but is not limited to:
Notes on your reported history (Psychological, Medical, Social), assessment forms, treatment plan, progress in treatment, consults and reports from other clinicians, relevant email and phone contacts between you and me, your descriptions of life stressors and reactions to them. Not every record will necessarily contain all of these elements. Generally, I try to maintain records that give at the very least a general sense of the problem worked on, treatment plan, and your progress in treatment. I may or may not formally render a psychiatric diagnosis even though diagnostic possibilities may be documented. _____Initial

I understand that Dr. Young uses a **HIPAA compliant Electronic Health Record** system that is provided by the company, **Office Ally and Therapy Notes**. I have a **Business Associates Agreement with Office Ally and Therapy Notes**. All or parts of your health record will be transmitted and stored in an encrypted and secure state on this system. Some parts of your record may be stored in traditional paper files which are under lock and key or as an encrypted file (a file deemed unable to be read without a passcode) on my computer. _____Initial

I understand that Dr. Young may change his record keeping practices without notice (for example, changing health record companies) but that any change will comply with the highest standards as prescribed by law and ethics _____Initial

Audio or Video Recordings of Sessions

Audio and/or Video recordings of sessions constitutes a record of sorts and is prohibited by office policy and state law ***unless there is mutual written consent***. I (Dr. Young) and you (or persons you authorize as adjuncts to your treatment-family members attending a session, for example) are not allowed to make Audio and/or Video recordings of sessions that take place in the office or by phone unless there is a mutual written consent agreement. _____ Initial

Contacting me & Use of Email/Fax/Text to Communicate with me

You may send confidential information to me at my HIPAA compliant email or my Fax:
dryoung@drjeffreyyoung.com, or 818-453-8961
My UCLA email j.young@ucla.edu is not as secure and is not HIPAA compliant. Only use email if you are confident that *your email server* is sufficiently secure. To begin using email you must sent an email to me initially from the account you will use to help prevent mistakes. It is always a good idea to call my office and leave a message that an email has been sent so I know to look for it.
Your authorized email is: _____
The best way to contact me is by calling 818-905-7121 and leaving a voice message. Please note that you can text if you wish but I may not be checking text messages routinely. ____Initial

My Availability

My time for in-office appointments and phone sessions can vary during the week depending upon what obligations I have scheduled out of the office (e.g., teaching schedule). However, I do make every effort to see you at a time most convenient for you.

I do check phone messages often and can typically get back to you within a few hours, if not sooner. However, because I do not have a live person 24 hour answering service, I cannot guarantee that I can get back to you immediately if an emergency situation were to arise. As such, if you find that you are faced with a psychological and/or medical emergency that cannot wait, please call **911 or go to your Nearest Emergency Room**. Then, as soon as feasible, you, a trusted person, or a medical staff member should call me and leave a message which includes the best way to reach you.

If I plan to be away for an extended period of time such that I will not be able to respond to calls, I will arrange to have a licensed colleague available for you to call, if needed.

If you call me, email me, or fax, and do not hear back within 24 hours, please contact me again -- not all messages get through for various reasons (calls get dropped or are unreadable, email can be sent to spam or junk, and faxes can fail). The best way to contact me is by using voicemail as I check that most often
I acknowledge and understand Dr. Young's availability and its limits _____Initial

Fees are as follows:

$200.00 for a 90 minute Initial Evaluation Session _____ Initial
$150.00 for a 50 minute Follow-Up session (Regular/Minimum hourly Fee) _____ Initial
$150.00 per hour for any non-routine work done on your behalf such as: extended consultations with other professionals or persons whom you designate, report writing, travel time, time spent pursuant to a hospital admission. _____ Initial
These fees are also applied to sessions done by phone. Any fee reductions will be noted
Fees are due at the end of each session and can be paid using cash or check.

Cancellations: Please give at least 24 hours in advance or a full charge may be made. _____Initial
Legal Work: If Dr. Young needs to be involved in a legal proceeding the fee for those services (if applicable by law) will be negotiated at that time and will likely be at minimum $300.00/Hour for any work performed. The reason for this higher fee is that legal work often leads to a significant disruption of practice (e.g., being in court instead of office). You should know that I do not become involved in or have the proper training to participate in child custody matters.

Also, please let me know now*, if you are currently involved or expect to be involved in a lawsuit or other legal matter which might require or compel me to deliver testimony and records or create a report on your behalf (e.g., Disability Claims, Workers Comp, A Claim of Emotional Distress). Also, let me know now if a child custody issue is active or pending*. I ask this so that we can have a clear understanding of what is at issue from the outset and have an opportunity to discuss the matter before assessment or treatment begins. _____Initial

Use of Insurance/Third Party Payment

I understand that Dr. Young does not work directly with any insurance companies other than **UCLA Medical Group** and that Dr. Young does not have the capability to directly submit bills to insurance companies other than to UCLA Medical Group. Dr. Young will, however, gladly give you a statement that you can submit to your insurance company for reimbursement. _____Initial

Although rare, if additional PHI (e.g., Progress Notes, Conversations with Insurance Peer Review) is needed from an insurance company other than UCLA Medical Group, I understand that Dr. Young reserves the right to charge the hourly rate above to provide this service. _____Initial

Additionally, I understand that Dr. Young has opted-out of Medicare. This formal opt-out allows him to see patients who have Medicare and to negotiate a private rate and contract. Please let me know, if you are a Medicare patient as you will need to sign an acknowledgement required by the Medicare office. _____Initial

I understand that I am ultimately responsible for payment even if I am using insurance for full or partial reimbursement and even if your treatment is being paid for by another party. _____Initial

By my signature below

1) I hereby acknowledge that I understand and agree to the provisions of all 8 pages of this document and have had any questions regarding this document answered to my satisfaction by Dr. Jeffrey Young.
2) I have received a copy of the HIPPA portion of this Document.
3) You will become a patient of record only after you are formally seen in the office we decide to work together.

Patent Name (print) Signature Date

Dr Young's signature below affirms that we have decided to work together and that you are now a patient of record as of the date below.

_____

Jeffrey Young, PHD, CBSM Date

Jeffrey Young, PHD, CBSM (PSY 15577) Tel: 818-905-7121, Fax: 818-453-8961
HIPAA Secure Email: dryoung@drjeffreyyoung.com.

HIPAA Notice

Privacy Practices (Effective Date April 14, 2003)-HIPAA and Confidentiality Limits

The confidentiality of your records is closely safeguarded and protected in accordance with the standards set forth by The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) and general ethical practice principles.
In the majority of cases no one but you or I, or other professionals involved in your care, will have access to your Protected Health Information (PHI).
However, there are some **exceptions** that allow me to release your PHI to concerned parties (e.g., police & other government agencies, hospitals, family members, attorneys/judges) without your prior consent. Conditions meeting these standards include:

**You pose a danger to yourself or others (e.g., suicide, physical harm to identifiable party) _____Initial

**You become gravely disabled (e.g., severely impaired judgment/basic survival impaired)_____Initial

**There is a reasonable suspicion that you are either a victim or perpetrator of Child, Dependent Adult, or Elder abuse (abuse can be physical, severe emotional, or financial). Victim or perpetrator of Domestic Violence. Knowingly with specific intent to view a child (under 18 years of age) in obscene sexual conduct via the internet or possessing/exchanging child pornography. _____Initial

**Valid Subpoenas for records and/or testimony. A request made by a Judge. A request by the Federal Government under Patriot or Freedom Act (if still enacted) _____ Initial

** To Collect a Debt from Patient or other Responsible Party, Appointment Reminders, Parties with whom I have a Business Associates Agreement (e.g., Electronic Records Company) _____Initial

**Health Oversight: If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint. _____ Initial

Additionally

**I understand that I have the right to inspect, amend, and receive copies of my PHI and to be provided with a list of disclosures. _____ Initial

**I understand that I may complain about the use of PHI to either the Department of Health & Human Services and/or California Board of Psychology _____ Initial

**I also acknowledge that once PHI is handed over to you or to another party you authorize that Dr. Young cannot control the extent to which your PHI is safeguarded by that party. _____ Initial

Please note that Dr. Young will always strive to give only the minimum necessary amount of information to any party so as to satisfy the specific needs of that party and I will always attempt to contact you directly before complying with any valid request to ensure that you are aware that a request has been made (contacting you may be prohibited under the patriot/freedom act).

_____

Name (Print) *Signature* *Date*

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HIPAA Secure Email: dryoung@drjeffreyyoung.com.

Patient Copy of HIPAA Notice

HIPAA Notice

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_____

Name (Print) ***Signature*** ***Date***

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Treatment of Sleep Disorders: Information & Acknowledgement

I understand that the cognitive-behavioral treatment of insomnia or other sleep disorders may require me to change my sleep schedule in some way. This change might lead to a period of sleep deprivation which may adversely affect my daytime functioning and may require me to temporarily discontinue any potentially dangerous activities such as driving, operating machinery, or any activity where excessive sleepiness or fatigue could undermine my motor abilities and judgment. This sleep deprivation may come in the form of going to sleep later than usual, getting out of bed during the night during an awakening, or discontinuing naps. This is all in service of creating an environment where your sleep is as deep and as efficient as possible.

I understand that during such treatment I will not be asked to limit my sleep opportunity/window to less than 5.5 hours per night and that the sleep I get may be less than the window of time allowed. As sleep efficiency improves that window of sleep will expand so the 5.5 hour minimum usually does not last more than a week or two. Dr. Young will follow you closely during this process and advise modifications as needed. However, I understand that it is ultimately my responsibility to determine my capability to perform any activity safely. Often, I advise my patients to expect some increase in sleepiness and/or fatigue and to have countermeasures readily available to them such as having rides available to work, or discontinuing certain activities, etc.

When it comes to these interventions, I always preach "safety first". For example, if you know that you must make a long drive (perhaps unexpected), feel free to nap, and/or abandon the "rules" in service of staying safe. A couple of days off the treatment plan will not be problematic.

Other Considerations

Exposure to sunlight: Getting into bright light, such as sunlight, may be advisable as part of your treatment because it helps strengthen your sleep/wake clock. You do not need to be in direct sunlight. Taking a walk with a hat and sunglasses or sitting by a bright window or under shade are all good strategies. Do not sacrifice eye or skin safety to get a higher dose of light. Avoid sun or bright light per your physician's recommendation particularly if you have any vulnerable eye or skin disease, or if you have been prescribed any photosensitizing internal or topical medications where sun exposure or bright light exposure is to be avoided. We will work around any restrictions you may have.

Exercise: Same idea here. You may be asked to include some exercise in your routine. Exercise taken 4-5 hours before your usual bedtime can improve sleep. However, the exercise you choose should be in line with your regular ability and congruent with your physician's advice.

Use of Herbals, Supplements, Natural Compounds, Over the Counter, Marijauna, Light Boxes: I do not directly recommend use of these products. Even though, I might have extensive scientific knowledge in these areas and can educate you accordingly, the formulations and dosing are generally not standardized or controlled. Some, clearly, can be effective but "natural" does not mean without potential harm or potential interaction with existing medical conditions or medications. I am happy to share what I know but direct advice should come from your internist or sleep medicine physician who might be in a better position to evaluate your complete medical status.

Discontinuation of Medications: Do not discontinue medications or alter dosing without the advice of your prescribing physician, other qualified prescriber, or pharmacist.

I acknowledge the above best practices and safety concerns.

Patent Name (print) Signature Date

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THE EPWORTH SLEEPINESS SCALE

Name: _____
Today's Date: _____ Your Age (years): _____
Your sex (male = M; female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in the past week. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation:

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

FLINDERS FATIGUE SCALE

We are interested in the extent that you have felt **fatigued** (tired, weary, exhausted) over the last **two weeks**. We **do not** mean feelings of **sleepiness** (the likelihood of falling asleep). Please circle the appropriate response in accordance with your average feelings over this two-week period.

1. Was fatigue a problem for you?
☐ Not at all ☐ Moderately ☐ Extremely
2. Did fatigue cause problems with your everyday functioning (e.g., work,social, family)?
☐ Not at all ☐ Moderately ☐ Extremely
3. Did fatigue cause you distress?
☐ Not at all ☐ Moderately ☐ Extremely
4. How often did you suffer from fatigue?
☐ 0 days/week ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5-6 days/week ☐ 7 days/week
5. At what time(s) of the day did you typically experience fatigue? (Please tick box(es))
☐ Early morning ☐ Mid morning ☐ Mid afternoon ☐ Late afternoon
☐ Early evening ☐ Midday ☐ Late evening
6. How severe was the fatigue you experienced?
☐ Not at all ☐ Moderate ☐ Extreme
7. How much was your fatigue caused by poor sleep?
☐ Not at all ☐ Moderately ☐ Entirely

Insomnia Severity Index (ISI)

Name: _____ Date: _____

1. Please rate the current (i.e., last week) SEVERITY of your insomnia problem(s).

	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	0	1	2	3	4
Difficulty staying asleep	0	1	2	3	4
Problem waking up too early:	0	1	2	3	4

2. How SATISFIED/dissatisfied are you with your current sleep pattern?

Very Satisfied				Very Dissatisfied
0	1	2	3	4

3. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.).

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

4. How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all Noticeable	Barely	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

5. How WORRIED/distressed are you about your current sleep problem?

Not at all	A Little	Somewhat	Much	Very Much
0	1	2	3	4

Total Score _____

Jeffrey Young, PHD, CBSM (PSY 15577) Tel: 818-905-7121, Fax: 818-453-8961
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Sleep Disorders Screener

Date: _____ **Name**_____

Answer all questions for what has been typical for you for the last 3 months.

	NEVER 0	ONCE A MONTH 1	1-3 TIMES A WEEK 2	3-5 TIMES / WEEK 3	>5 TIMES / WEEK 4
1. My work or other activities prevent me from getting at least 7hrs of sleep					
2. My bedtime or waketime varies by more than 3 hours					
3. It takes me 30 minutes or more to fall asleep					
4. I am awake for 30 minutes or more during the night					
5. I wake up 30 or more minutes before I have to and can't fall back asleep					
6. I am tired, fatigued, or sleepy during the day					
7. I sleep better if I go to bed before 9pm and wakeup up before 430am					
8. I sleep better if I go to bed late (after 1am) and wakeup late (after 9am)					
9. I am prone to fall asleep at inappropriate times or places					
10. I snore					
11. I wake up with a dry mouth in the morning (cotton mouth)					
12. My snoring is so loud, that my bed partner complains					
13. I have been told that that I stop breathing in my sleep					
14. I wake up choking or gasping for air					
15. I feel uncomfortable sensations in my legs, especially when sitting or lying down, that are relieved by moving them					
16. I have an urge to move my legs that is worse in the evenings and nights					
17. I wake up frequently during the night for no reason					
18. When angered, humored, frightened, I experience sudden muscle weakness					
19. When falling asleep or waking up, I experience scary dream like images					
20. When I am first awakening, I feel like I can't move					
21. I have nightmares					
22. For no reason, I awaken suddenly, startled, and feeling afraid					
23. I have been told that I walk, talk, eat, act strangely or violently when I sleep					
24. I grind my teeth or clench your jaw during your sleep					
25. My sleep difficulties interfere with my daily activities					

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Patient Name _____ **Date** _____

PHQ-9-Depression Screener

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you 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 being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. **If you checked off any problem on this questionnaire so far, 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
0	1	2	3

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Name_____ Date_____

GAD-7 – Anxiety Screener

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score _____

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Name _____ **Date** _____

Medical & Psychiatric Conditions (Current and Relevant Past)

Begin by listing any current medical and/or psychiatric conditions you currently have and include when you were first diagnosed.
Then, list any past medical and/or psychiatric conditions and include when it began and when it ended. Feel free to identify any condition that you think might have contributed to any problem you are having now, and any condition or concern not yet formally evaluated.

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Name _____ **Date** _____

List of Current Medications, Herbals, Over-the Counter.

List here all current Medications even if you use it just as needed or very rarely. Use as much space or lines as you need for a given medication and provide information in the following order and skip a line between medications for clarity. Use the following format and include as much information as you can. Feel free to identify any medication that you think might be contributing to any problem you are having now.

Medication Name, Dosage, Time(s) of Dose, Disorder Treated, Start Date, Side Effects/Problems, Effectiveness, Who Prescribed by and Specialty

Effectiveness: **A**) You can rate effectiveness numerically from 1 to 5 with 5 being highest,

B) indicate if the effectiveness has varied over time.

Example: Xanax, .5mg, .5 in am .5 in pm, anxiety, 4/2015, .5 unless having a rare panic attack then only effective if I take a double dose of 1.0mg- tends not to be as effective as when first prescribed, Dr. John Doe, PCP Internal Medicine.

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Past Relevant Medications

List of *Past Relevant* Medications, Herbals, Over-the Counter

Relevant here means that you do not have to list every medication. However, it is helpful to know if you have been on certain medications for depression, anxiety, or sleep and why those were discontinued. Feel free to identify any medication that you think might have contributed to any problem you are having now or any that were particularly helpful at that time.

Medication Name, Dosage, Time(s) of Dose, Disorder Treated, Start Date, Side Effects/Problems, Effectiveness, Prescribed by and Specialty

Effectiveness: **A**) You can rate it numerically from 1 to 5 with 5 being highest, **B**) indicate if effectiveness has varied over time.

Add in the **Stop Date and Reason for Stopping** and if a **replacement** medication was prescribed.

Example: Xanax, .5mg, .5 in am .5 in pm, anxiety, 4/2015, 5 unless having a rare panic attack then only effective if I take a double dose of 1.0mg- tends not to be as effective as when first prescribed, **Stopped 6/2016** due to **reduced effectiveness** – started **Prozac** to replace, Dr. Alan Jones, PCP Internal Medicine.

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Surgical Procedures and Dates

Allergies: Medication, Food, and Environment Induced

Let me know if these are managed by avoiding the trigger or by medication