Patient Forms

Basic Information

Full Name _____
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown

Date of Birth ___ / ___ / ___

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number _____

Email _____

Social Security Number _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ **Zip** _____

Marital Status _____

Maiden Last _____

Driver's License State _____

Driver's License # _____

Demographics

Sexual Orientation _____

Gender Identity _____

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify

Ethnicity _____

Race _____

Language _____

Emergency Contact

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number _____

Email _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ **Zip** _____

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ **Home** ◯ **Mobile** ◯ **Work** **Phone Number** _____

Method of Payment

What will be your method of payment? ◯ Insurance ◯ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company _____ **Policy Number** _____

Insurance Plan _____ **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Relationship to Primary Policy Holder _____

If you are not the primary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** ____ / ____ / ____

Policy ID Number _____ **Social Security Number** _____

Policy Holder Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company **Policy Number**

Insurance Plan **Insurance Phone Number**

Group Number

Insurance Company Address **Address Line 2**

City **State** **Zip**

Relationship to Secondary Policy Holder

If you are not the secondary policy holder, please fill out the following:

Full Name
First Middle Last

Sex ○ Male ○ Female ○ Unknown **Date of Birth** / /

Insurance ID Number **Social Security Number**

Policy Holder Address **Address Line 2**

City **State** **Zip**

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us?

Patient Health History Form

Name: _____ **Date:** _____
SSN: _____ **DOB:** _____

Chief Complaint: What is the reason for your visit today (please describe problem in detail): _____
_____
_____
_____

Past Medical History: Please check all that apply to you:

- ❑ Arthritis
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy/seizures
- ❑ Heart problems
- ❑ Heart surgery
- ❑ High blood pressure
- ❑ Psychiatric disease
- ❑ Stroke
- ❑ Thyroid
- ❑ None

Previous Surgeries: Please list past surgeries with approximate date: _____
_____
_____
_____

Serious Injury: Please describe any serious injuries you have had: _____
_____

Medications: Please list any medications you are taking with dose and frequency:

Drug	***Dose/Frequency***

Allergies: please list any allergies that you have _____
_____

Do you drink alcohol? ❑Yes ❑No If yes, how much/week? _____
Do you smoke? ❑Yes ❑No If yes, how many cigarettes/day? _____
Do you consume caffeine? ❑Yes ❑No If yes, how many cups/week? _____
Do you use recreation drugs? ❑Yes ❑No If yes, what type and frequency? _____
Are you on a special diet? ❑Yes ❑No If yes, please describe? _____

Family History: Do you know of any blood relative who has or had:

- ❑ Asthma
- ❑ Aneurysm
- ❑ Brain Tumor
- ❑ Cancer, Type:
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Headaches
- ❑ Heart Problems
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Lung Disease
- ❑ Migraine
- ❑ Multiple Sclerosis
- ❑ Psychiatric Disease
- ❑ Stroke
- ❑ Thyroid
- ❑ None

Comments:

Patient Health History Form

As you review the following list, please check any problems or conditions, that you are experiencing or have experienced. If you do not have any of the problems listed in the section please check none.

General Health
- ❑ Good general health
- ❑ Recent weight change
- ❑ Loss of appetite
- ❑ Fatigue
- ❑ Fever/chills

Allergy
- ❑ Drug allergies
- ❑ Food allergies
- ❑ Hay fever
- ❑ Other: _____
- ❑ None

Ears, Nose, Mouth, Throat
- ❑ Difficulty swallowing
- ❑ Earaches
- ❑ Loss of hearing/deafness
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Painful chewing
- ❑ Ringing in ears
- ❑ Sinus infection
- ❑ Sores in mouth
- ❑ None
- ❑ Other: _____

Eyes
- ❑ Blind spots
- ❑ Blurred vision
- ❑ Double vision
- ❑ Loss of vision
- ❑ Glaucoma
- ❑ Injury
- ❑ Pain
- ❑ Other: _____
- ❑ None

Gastrointestinal
- ❑ Blood in stools
- ❑ Increasing constipation
- ❑ Nausea
- ❑ Painful bowel movements
- ❑ Persistent diarrhea
- ❑ Stomach or abdominal pain
- ❑ Ulcer
- ❑ Vomiting
- ❑ Other: _____
- ❑ None

Genitourinary
- ❑ Blood in urine
- ❑ Female: irregular periods
- ❑ Female: #pregnancies_____ #miscarriages_____
- ❑ Female: vaginal discharge
- ❑ Kidney stones
- ❑ Male: prostate disease
- ❑ Male: testicle pain
- ❑ Painful or burning urination
- ❑ Sexual difficulty
- ❑ Sexually transmitted disease
- ❑ Urgency with urination
- ❑ Urine retention/ incontinence
- ❑ Other: _____
- ❑ None

Heart and Lungs
- ❑ Pain in chest
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart beat
- ❑ Other: _____
- ❑ None

Muscles/Joints/Bones
- ❑ Back pain
- ❑ Difficulty walking
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Muscle pain or tenderness
- ❑ Neck pain
- ❑ None

Neurological
- ❑ Balance trouble
- ❑ Black outs/loss of consciousness
- ❑ Difficulty speaking
- ❑ Difficulty walking
- ❑ Facial drooping
- ❑ Headaches
- ❑ Injury to the brain or spine
- ❑ Light-headed or dizziness
- ❑ Memory loss
- ❑ Mental Confusion
- ❑ Migraines
- ❑ Mini stroke
- ❑ Neuropathy
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Stroke
- ❑ Tremors
- ❑ Weakness
- ❑ Other: _____
- ❑ None

Are you? ❑ right handed
❑ left handed
❑ Both

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Eating disorder
- ❑ Other: _____
- ❑ None

Pulmonary
- ❑ Asthma
- ❑ Blood in cough
- ❑ Cancer
- ❑ Chronic or frequent cough
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Other: _____
- ❑ None

Skin
- ❑ Rash or itching
- ❑ Sun sensitivity
- ❑ Hair loss
- ❑ Color changes
- ❑ Other: _____
- ❑ None

Sleep
- ❑ Snoring
- ❑ Sleepwalking
- ❑ Nightmares

Do you sleep well? ❑Yes ❑No
Do you feel rested when you wake? ❑Yes ❑No
Do you fall asleep during the day? ❑Yes ❑No

Building New Horizons Office Policies

PLEASE NOTIFY THIS OFFICE IMMEDIATELY IF THERE ARE ANY CHANGES IN YOUR ADDRESS, TELEPHONE NUMBER, INSURANCE COVERAGE OR EMPLOYMENT, SO WE CAN UPDATE OUR RECORDS.

NEW PATIENTS: PLEASE SHOW UP 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME TO ENSURE ALL PROPER PAPERWORK AND QUESTIONNAIRES ARE COMPLETED. IF YOU WILL BE MORE THAN 10 MINUTES LATE FROM YOUR SCHEDULED TIME, PLEASE CALL THE OFFICE IN ORDER TO BE RESCHEUDLED.

PREVIOUS PSYCHIATRIC RECORDS: IT WOULD BE BENIFICIAL TO THE PROVIDERS TO HAVE A COPY OF YOUR PREVIOUS RECORDS AND LABS BEFORE THE FIRST APPOINTMENT. THEY CAN BE FAXED TO 727-330-7551 OR EMAILED TO MARKETING@BUILDINGNEWHORIZONS.COM

RETURNING PATIENTS: IF YOU WILL BE MORE THAN 5 MINUTES LATE FOR YOUR APPOINTMENT, PLEASE CALL THE OFFICE TO BE RESCHEDULE TO ANOTHER DAY/TIME.

CANCELLATIONS: OTHER THAN THE OBVIOUS EMERGENCIES, TWENTY-FOUR HOURS NOTICE IS REQUIRED TO CANCEL AN APPOINTMENT. YOU WILL BE ASSESSED A FEE OF $100 FOR A CANCELLATION OF LESS THAN TWENTY-FOUR HOURS NOTICE. THIS FEE WILL BE PAID BEFORE ANOTHER APPOINTMENT CAN BE MADE. YOUR INSURANCE COMPANY WILL NOT PAY FOR A MISSED APPOINTMENT.

PAYMENT: ALL PATIENTS WILL BE REQUIRED TO PAY THEIR CO-PAY AT TIME OF CHECK-IN. IF YOU BELONG TO AN INSURANCE COMPANY, IN WHICH WE PARTICIPATE, YOUR CLAIMS WILL BE FILED FOR YOU. WE WILL ALLOW 60 DAYS FOR YOUR INSURANCE TO SUBMIT PAYMENT TO US. IF WE DO NOT RECEIVE PAYMENT WITHIN THAT TIME, THEN YOU WILL BE BILLED AND EXPECTED TO PAY THE BALANCE. THERE WILL BE A MINIMAL FEE FOR ANY REPORT OR MEDICAL RECORDS REQUESTED FROM THIS OFFICE.

SIGNATURE ON FILE: I HEREBY AUTHORIZE THE NURSE PRACTITIONER ABOVE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE COMPANY. I UNDERSTAND IT IS MY RESPONSIBILITY TO PAY ANY OUTSTANDING BALANCE IN FULL WITH TWENTY-FIVE DAYS OF RECEIVING THE FINAL STATEMENT.

RETURNED CHECKS: THERE WILL BE A $30.00 FEE FOR ANY RETURNED CHECK FROM THE BANK. IF THIS SHOULD OCCUR, WE WILL NO LONGER BE ABLE TO ACCEPT CHECKS FROM YOU.

ABUSE OF OFFICE STAFF WILL NOT BE TOLERATED UNDER ANY CIRCUMSTANCES AND YOU WILL BE DISMISSED FROM THE PRACTICE. THIS INCLUDES: REPEATED PHONE CALLS, YELLING, CURSING, PHYSICAL HARM OR THE THREAT OF PHYSICAL HARM.

PLEASE BE ADVISED THAT THE FOLLOWING ARE TURNAROUND TIMES AND COSTS FOR SERVICES BY OUR STAFF. IF YOU NEED A RETURN SOONER THAN THIS, AN ADDITIONAL RUSH FEE WILL BE APPLIED.
PAYMENT IS DUE WHEN SERVICES ARE PROVIDED.

- FORMS ($25 PER PAGE): 1 WEEK
- LETTERS ($25): 1 WEEK
- RETURN MESSAGE (MON-THURS): 24 BUSINESS HOURS
- PRIOR AUTHORIZATIONS ($10-20): 1 WEEK
- MEDICATION REFILLS (MON-THURS): 24 BUSINESS HOURS
- RECORD REQUESTS ($0.50 PER PRINTED PAGE): 21 BUSINESS DAYS
- PHONE CONFERENCE FEE: $100
- **FIRST** MISSED APPOINTMENT: $100
- FOLLOWING MISSED APPOINTMENTS: $150

Signature: _____

Date: _____

Confidentiality and Consent to Treat

I Hereby Give Sharon M. Krieger, MS, APRN; Jeanne Botz MSN, APRN, PMHNP-BC; Jessica Gordon PhD, APRN, PMHNP-BC

Permission to:

1. To evaluate and treat my psychiatric disorders through psychotherapy and/or psychopharmacology (medication).
2. To release any information requested to my insurance company acquired in the course of my examination and treatment, as may be necessary, including HIV status, drug/alcohol abuse, and psychiatric notes for my treatment/healthcare.
3. To disclose my health information, including HIV status, drug/alcohol abuse, and psychiatric notes for my treatment/healthcare.
4. To request from other healthcare entities, including doctors, dentists, hospitals, and imaging agencies, specific healthcare information.
5. To discuss my health information (only as necessary) with family members or other persons who are or may be involved with your healthcare treatment or payments.

I hereby assign all medical benefits to which I am entitled, to the above-named providers.

Signature: _____ Date:_____

I UNDERSTAND THE ABOVE AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THIS OFFICE OF ANY CHANGES TO THIS INFORMATION.

Signature: _____ Date: _____

Building New Horizons

Sharon Krieger MS, APRN, BC
Jeanne R Botz MSN, APRN, PMHNP-BC
Jessica Gordon PhD, APRN, PMHNP-BC
PHONE (727) 781-1000 FAX (727) 330-7551
33920 US HWY 19 N, Suite 170

Controlled Substance Agreement with Patient Receiving Controlled Substances
Between Patient and the Psychiatric Nurse Practitioners at Building New Horizons.
I agree to comply with all of the Laws of the State of Florida relating to Controlled Substances and agree to the following:

1 I will need to be seen every 30 days for all Stimulant Medications (they are Schedule Il).
2 I will need to be seen every 3 months for all Benzodiazepines. (they are Schedule IV)
3 I cannot be prescribed Benzodiazepines if I am taking or test positive for opiates and agree to wean off the Benzodiazepine, I am currently taking over the next few months (if applicable) and any drug testing that may be deemed necessary. I will fill the Narcan prescription as long as I am on opiates and Benzodiazepines.
4 I will not obtain or use Controlled Substances for Psychiatry from any source other than the Psychiatric Nurse Practitioners at Building New Horizons as long as I am in their care.
5 These scheduled drugs cannot be refilled other than at an appointment as outlined above.
6 These medications cannot be replaced under any circumstances, NO EXCEPTIONS.
7 I will not call the office if I lose my medications or prescriptions as they will not be refilled & I will go to the nearest Emergency Room If I lose my medication or prescription.
9 I will obtain drug screens as directed by the Psychiatric Nurse Practitioners, which is twice a year if I am low risk.
10 If I become a high-risk patient, not taking medication as prescribed, I understand I will be dismissed from the practice. This includes any aggression towards Psychiatric Nurse Practitioners or their staff at any time, either by phone or in person. This includes if I consistently miss appointments.
1l I acknowledge that it is a crime(felony) to obtain any medication, specifically Controlled Medications under false pretenses.
12 I may be dismissed if my drug screen is abnormal, such as it shows I am not taking the prescribed medicines, or that I am taking medications the Psychiatric Nurse Practitioners are not made aware of by me.
13 I acknowledge that if I abuse these medications in any way, such as take more than prescribed, share them with others, sell the medications prescribed or get medications from more than one doctor that I waive my right to confidentiality and the authorities will be given full access to my records.

I hold the Psychiatric Nurse Practitioners and Building New Horizons harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement. I have read and understand the policy above:

Print Name_____ Date of Birth: _____

Patient Signature/Parent/Guardian_____ Date: _____

Information Release

Informed Consent an Authorization for Release or Receipt of Information
The undersigned patient, or legal representative of the patient, hereby authorizes the receipt and/or release of the information specified below to the following Physician, Attorney, or Mental Health Professional, pursuant to Florida Statutes 90.42, 420.32, 90.503.458.16, 458.21 and 394.459(b), 381.609 (2) (f), 936.112, 397.053, and Federal Law 42. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose contained within this authorization.

Please give information below for your Primary Care Provider.
If you do not have a PCP, but plan to get one in the near future, please write "Currently unknown"
in the required fields.
Release Information Between Sharon Krieger/Jeanne Botz/Jessica Gordon and:

_____
Primary Care Phone Number:

_____
Primary Care Fax Number:

_____
Please give information below for your therapist.
If you do not have a therapist, but plan to get one in the near future, please write "Currently unknown" in the required fields.
If you do not plan on getting a therapist in the future, please write "None" in the required fields.
Release Information Between Sharon Krieger/Jeanne Botz/Jessica Gordon and:

_____
Therapist Phone Number

_____
Therapist Fax Number

_____
Please give information below for a family member.
If you do not have a family member that you wish to give access to your information, please put "None" in the required fields.
Release Information Sharon Krieger/Jeanne Botz/Jessica Gordon and:

_____
Family Member Phone Number

_____
Specific Information to be Released or Received:
- Medical/Pharmacological
- Psychiatric Evaluation
- Consult Reports
- Drug/Alcohol Treatment
- Psychosocial History
- Personality Assessment
- Treatment Plan/Summary

- Narrative Summary
- Psychological Testing
- Mental Status Exam

Information concerning AIDS, HIV, ARC, AIDS-Related complex and the performance of any test, counseling and the results and treatment thereof is authorized. General Medication authorization of Subpoena Duces Tecum with a specific "AUTHORIZATION TO RELEASE PSYCHIATRIC INFORMATION" must have this waiver from the patient or legal representative. PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Regulation (42 CFR Part 2) and any further redisclosure from the receiving party is strictly prohibited. This consent is subject to revocation at any time upon the receipt of written notification but will have no effect on action already taken. This authorization is valid for a continuing disclosure. I further understand I have the right to refuse to sign this authorization and that the physician or Mental Health Professional named herein is released from all legal liability that may arise from the release of the information requested.

Signature:

Date: _____

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

Name_____ Date_____

DEPRESSION SCALE

INSTRUCTIONS

This questionnaire includes questions about symptoms of depression. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

RATING GUIDELINES

0=not at all true (0 days)
1=rarely true (1-2 days)
2=sometimes true (3-4 days)
3=often true (5-6 days)
4=almost always true (every day)

During the PAST WEEK, INCLUDING TODAY....

1.	I felt sad or depressed	0	1	2	3	4
2.	I was not as interested in my usual activities	0	1	2	3	4
3.	My appetite was poor and I didn't feel like eating	0	1	2	3	4
4.	My appetite was much greater than usual	0	1	2	3	4
5.	I had difficulty sleeping	0	1	2	3	4
6.	I was sleeping too much	0	1	2	3	4
7.	I felt very fidgety, making it difficult to sit still	0	1	2	3	4
8.	I felt physically slowed down, like my body was stuck in mud	0	1	2	3	4
9.	My energy level was low	0	1	2	3	4
10.	I felt guilty	0	1	2	3	4
11.	I thought I was a failure	0	1	2	3	4
12.	I had problems concentrating	0	1	2	3	4
13.	I had more difficulties making decisions than usual	0	1	2	3	4
14.	I wished I was dead	0	1	2	3	4
15.	I thought about killing myself	0	1	2	3	4
16.	I thought that the future looked hopeless	0	1	2	3	4

17. Overall, how much have symptoms of depression interfered with or caused difficulties in your life during the past week?
    0) not at all
    1) a little bit
    2) a moderate amount
    3) quite a bit
    4) extremely

18. How would you rate your overall quality of life during the past week?
    0) very good, my life could hardly be better
    1) pretty good, most things are going well
    2) the good and bad parts are about equal
    3) pretty bad, most things are going poorly
    4) very bad, my life could hardly be worse

Name:_____ Date:_____

ANXIETY SCALE

INSTRUCTIONS: This scale includes questions about the symptoms of anxiety. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

0=not at all true 1=rarely true 2=sometimes true 3=often true 4=almost always true

During the PAST WEEK, INCLUDING TODAY....

1. I felt nervous or anxious 0 1 2 3 4
2. I worried a lot that something bad might happen 0 1 2 3 4
3. I worried too much about things 0 1 2 3 4
4. I was jumpy and easily startled by noises 0 1 2 3 4
5. I felt "keyed up" or "on edge" 0 1 2 3 4
6. I felt scared 0 1 2 3 4
7. I had muscle tension or muscle aches 0 1 2 3 4
8. I felt jittery 0 1 2 3 4
9. I was short of breath 0 1 2 3 4
10. My heart was pounding or racing 0 1 2 3 4
11. I had cold, clammy hands 0 1 2 3 4
12. I had a dry mouth 0 1 2 3 4
13. I was dizzy or lightheaded 0 1 2 3 4
14. I felt sick to my stomach (nauseated) 0 1 2 3 4
15. I had diarrhea 0 1 2 3 4
16. I had hot flashes or chills 0 1 2 3 4
17. I urinated frequently 0 1 2 3 4
18. I felt a lump in my throat 0 1 2 3 4
19. I was sweating 0 1 2 3 4
20. I had tingling feelings in my fingers or feet 0 1 2 3 4

COVID-19 SCREENING

Name: _____ DOB: _____

TODAY'S DATE: _____

PLEASE READ EACH QUESTION CAREFULLY

Have you experienced any of the following symptoms in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**YES/SPECIFY**	**NO**
Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with: • Anyone who is known to have laboratory-confirmed COVID-19? OR • Anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
Are you currently waiting on the results of a COVID-19 test?	**YES**	**NO**

PTSD Checklist (PCL)

Patient Name: _____ **Date:** _____

If an event listed on the Life Events Checklist **happened to you** or you **witnessed it,** please complete the items below. If more than one event happened, please choose the one that is **most troublesome to you now.**

The event you experienced was _____ (EVENT) on _____ (DATE) .

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then **circle** one of the numbers to the right to indicate how much you have been **bothered** by the problem **in the past month.**

BOTHERED BY	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Repeated disturbing memories, thoughts, or images of the stressful experience?	1	2	3	4	5
2. Repeated, disturbing dreams of the stressful experience?	1	2	3	4	5
3. Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling very upset when something reminded you of the stressful experience?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of the stressful experience?	1	2	3	4	5
6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it?	1	2	3	4	5
7. Avoiding activities or situations because they remind you of the stressful experience?	1	2	3	4	5
8. Trouble remembering important parts of the stressful experience?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being “super alert” or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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
☐	☐	☐	☐