PLEASE CONTACT OUR OFFICE IF YOU ARE INTERESTED IN SCHEDULING YOUR PSYCHOLOGICAL EVALUATION

Algos Behavioral Health Services, Inc.
MONDAY-FRIDAY 8am-4:30pm

Karri Lusk, Psy.D.
Sean Connolly, Ph.D.
Sandy Zamora, LPC-S

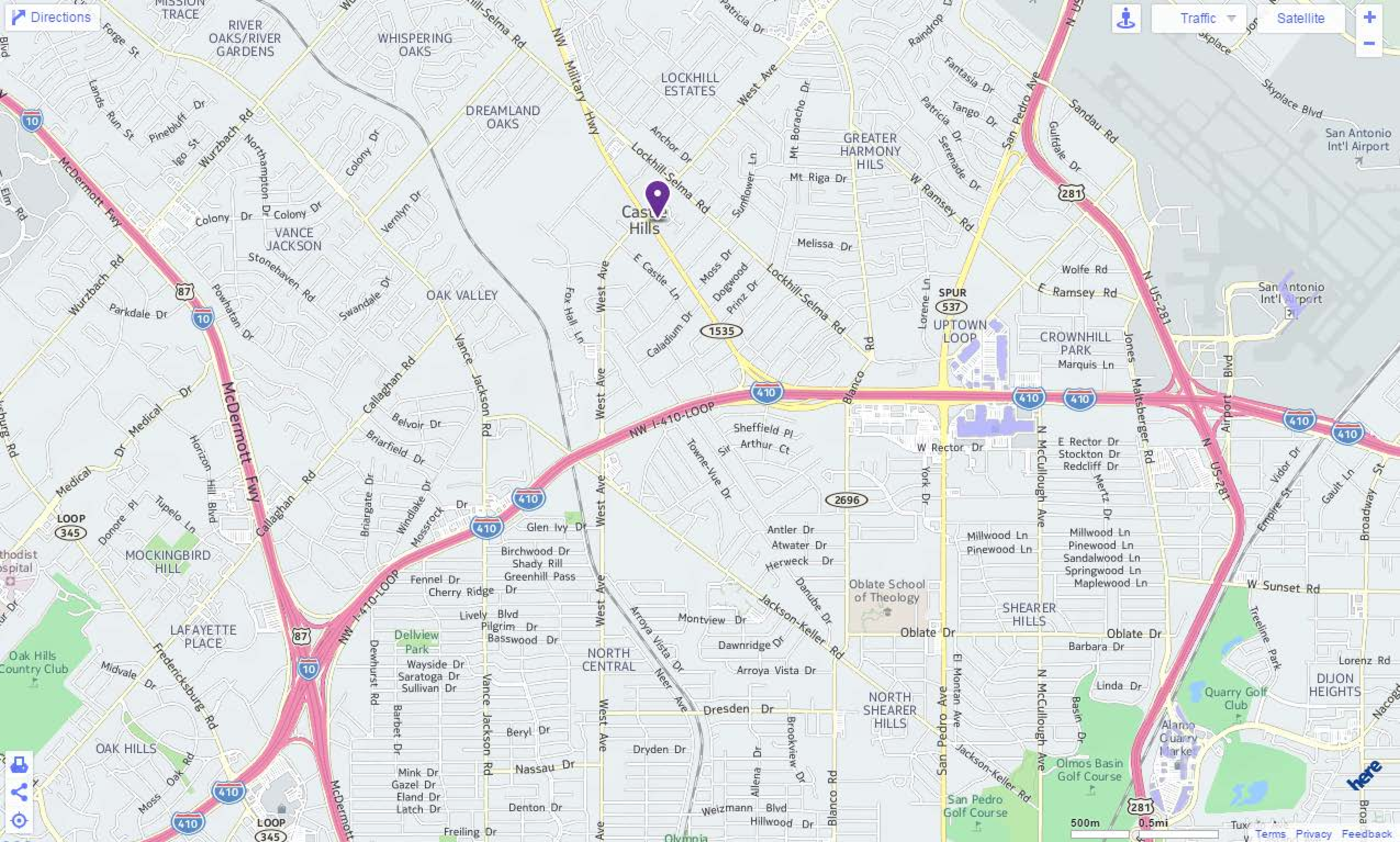
Behavioral Health Consultation for Surgery Candidates

You have been referred by your physician for a **Behavioral Health Assessment (BHA)** as part of evaluating your candidacy for ***Bariatric Surgery***. This is a routine step for candidates for this type of surgery. Surgical treatment for clinically severe obesity is a major invasive procedure and requires a Behavioral Health Assessment. This step will assist your physician in determining your suitability and readiness for the procedure as well as identify personality and behavioral factors that will help assure a positive and desired outcome. The pre-operative assessment can identify possible psychosocial risk factors for surgical outcomes and make recommendations to both the patient and the surgical team that are aimed at facilitating the best possible outcome for the patient.

The underlying factor here is that the surgery will change your body, but it will not change personality, behavior, or your social environment. The purpose of this assessment is to identify and evaluate psychological factors that will need to be addressed if you are to achieve your desired goal of losing weight. This team of behavioral health specialists will be partners with you to assist you before and after the surgery. The surgeon addresses the medical and physical aspects of weight loss, the nutritionist will assist you with foods and dietary precautions, and the behavioral health specialist provides assistance with the emotions, thoughts and behaviors that have brought you to this point. The psychologist's consultation is not to determine whether you can handle the surgery, or because your physician thinks your weight problem is "psychological." The purpose is to evaluate what emotions, behaviors and environmental issues will need to be addressed before and after the surgery to ensure that the surgery will be as successful as possible. Your physician and clinical support team want to make the best clinical judgments for you.

The **BHA** will consist of a clinical interview, including a review of your personal history and past life experiences, a review of your medical record, and completion of some psychological testing instruments and questionnaires. You will have the opportunity to discuss with the psychologist/clinical associate any questions or concerns you may have. This BHA usually takes 3-4 hours to complete. Some of the paperwork can be completed at home prior to the appointment, in order to expedite the process. Some insurance companies require us to do the interview first and then request the testing procedures. If this is so, it may require a follow-up visit to our office.

Standard ethical and professional guidelines to assist with these clinical judgments will be utilized. Every effort will be made to complete the assessment as conveniently and efficiently as possible.



Directions
Traffic
Satellite
MISSION TRACE
RIVER OAKS/RIVER GARDENS
WHISPERING OAKS
LOCKHILL ESTATES
DREAMLAND OAKS
GREATER HARMONY HILLS
San Antonio Int'l Airport
Castle Hills
VANCE JACKSON
OAK VALLEY
SPUR 537
UPTOWN LOOP
CROWNHILL PARK
San Antonio Int'l Airport
MOCKINGBIRD HILL
LAFAYETTE PLACE
Oak Hills Country Club
OAK HILLS
NORTH CENTRAL
Dellview Park
Oblate School of Theology
SHEARER HILLS
NORTH SHEARER HILLS
DIJON HEIGHTS
Quarry Golf Club
Alamo Quarry Market
Olmos Basin Golf Course
San Pedro Golf Course
LOOP 345
Forge St
Lands Run St
Pinebluff Dr
Igo St
Wurzbach Rd
Northampton Dr
Colony Dr
Vernlyn Dr
McDermott Fwy
Elm Rd
Stonehaven Rd
Swandale Dr
Powhatan Dr
Parkdale Dr
Callaghan Rd
Medical Dr
Horizon Hill Blvd
Tupelo Ln
Donore Pl
Belvoir Dr
Briarfield Dr
Briargate Dr
Windlake Dr
Mossrock Dr
Vance Jackson Rd
Fox Hall Ln
West Ave
NW Military Hwy
Lockhill-Selma Rd
Anchor Dr
Sunflower Ln
Mt Boracho Dr
Mt Riga Dr
Melissa Dr
E Castle Ln
Moss Dr
Dogwood
Prinz Dr
Caladium Dr
1535
NW I-410-LOOP
Sheffield Pl
Sir Arthur Ct
Towne-Vue Dr
2696
Blanco Rd
Lorene Ln
Raindrop
Fantasia Dr
Tango Dr
Patricia Dr
Serenade Dr
W Ramsey Rd
San Pedro Ave
Gulfdale Dr
Sandau Rd
Skyplace Blvd
281
Wolfe Rd
E Ramsey Rd
Marquis Ln
Jones Maltsberger Rd
N US-281
Airport Blvd
W Rector Dr
E Rector Dr
Stockton Dr
Redcliff Dr
Mertz Dr
York Dr
N McCullough Ave
Vidor Dr
Empire St
Gault Ln
Broadway St
Millwood Ln
Pinewood Ln
Sandalwood Ln
Springwood Ln
Maplewood Ln
W Sunset Rd
Glen Ivy Dr
Birchwood Dr
Shady Rill
Greenhill Pass
Fennel Dr
Cherry Ridge Dr
Lively Blvd
Pilgrim Dr
Basswood Dr
Antler Dr
Atwater Dr
Herweck Dr
Danube Dr
Jackson-Keller Rd
Montview Dr
Dawnridge Dr
Arroya Vista Dr
Neer Ave
Oblate Dr
Barbara Dr
Treeline Park
Lorenz Rd
Linda Dr
Basin Dr
El Montan Ave
Midvale Dr
Fredericksburg Rd
Wayside Dr
Saratoga Dr
Sullivan Dr
Dewhurst Rd
Barbet Dr
Dresden Dr
Brookview Dr
Allena Dr
Beryl Dr
Dryden Dr
Nassau Dr
Mink Dr
Gazel Dr
Eland Dr
Latch Dr
Denton Dr
Weizmann Blvd
Hillwood Dr
Freiling Dr
Moss Oak Rd
Olympia
410
10
87
500m
0.5mi
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ALGOS BEHAVIORAL HEALTH SERVICES, INC.

NEW PATIENT INFORMATION RECORD

Today's Date:		Referred By:	
Patient Full Legal Name:			
Date of Birth: / /	Age:	Male / Female	Male
SSN: / /		Marital Status:	Widowed
Address **(physical)**:		Drivers License#:	
City:	State:	Zip Code(9 digits):	
Home Phone: ( )	Cell Phone: ( )	Work: ( )	EXT#
Can confidential messages (i.e., appointment reminders) be left on your answering machine or voicemail?			
◯ **YES** ◯ **NO**	**If yes, which is best:**	Work	
Email Address**:**			
Employer's Name:		Occupation:	
Address:	City:	State:	Zip:

PRIMARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Primary Insurance:	Phone # *(Located on the back of card)*	
Subscriber ID#:	Group # :	
Name of Policy Holder:	**DOB**:	
Insured's Address:	☐ **same as patient**	
City:	**State:**	**Zip Code(9 digits):**
Policy Holder's Employer:		
Patient Relationship to Policy Holder:	Partner	

SECONDARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Secondary Insurance:	Phone # (*Located on the back of your card*):	
Subscriber ID#:	Group # :	
Name of Policy Holder:	**DOB**:	
Insured's Address:	☐ **same as patient**	
City:	**State:**	**Zip Code(9 digits):**
Policy Holder's Employer:		
Patient Relationship To Insured: SEL	Partner	

EMERGENCY CONTACT PERSON

Name:	Relationship:	Other
Home Phone: ( )	Work Phone: ( )	EXT:

ALGOS BEHAVIORAL HEALTH SERVICES, INC.
Financial Policy

Thank you for choosing Algos Behavioral Health Services, Inc. as your mental health care provider. The following is a summary of our financial policies. Please read the information carefully and sign or initial where noted below. We must obtain a copy of your driver's license and a current, valid insurance card. Failure to provide a current, valid insurance card and/ or information prior to your visit will result in payment due in full at the time of visit.

Initial below please:

_____ 1. **PAYMENTS**. **All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment**.
Initial We accept cash or credit card (Visa, MasterCard, or Discover). Unpaid accounts may be referred to an outside collection agency.

_____ 2. **CANCELLATIONS**. To reserve the hour of the clinician's time, we request a credit card to assure you of the availability of the
Initial doctor. There is a fee of **$50.00** for a missed appointment or late cancellation. You can avoid this charge if you cancel 24 or more hours prior to the appointment. Your insurance carrier will not cover this fee.
____ ** When applicable, for individuals scheduled for a testing appointment – you will be charged **$50.00** for every hour of testing that is missed or not cancelled within 24 hours. For example, if you are scheduled for 3 hours of testing, and you cancel or do not show for that appointment time, you will be charged $150.

_____ 3. **CHANGE OF INFORMATION**. You are responsible to provide us with any change regarding your address, phone number or
Initial insurance information as soon as possible.

_____ 4. **PRIVATE INSURANCE AUTHORIZATION AND INFORMATION RELEASE.**
Initial I, the undersigned, authorize payment of mental health benefits to Algos Behavioral Health Services, Inc for any services rendered. **I understand that I am financially responsible for any amount not covered by my insurance policy including but not limited to co-payments, co-insurance and deductibles.** Any payments denied by the insurance company will be forwarded to the undersigned, and the undersigned will be held responsible for payment. I also authorize Algos Behavioral Health Services, Inc to release to my insurance company any information concerning health care, diagnosis or treatment provided to me. This information will be used only for the purpose of evaluating and administering claims of benefits.

_____5. **POTENTIAL NON COVERAGE**
Initial Although other medical services may be covered by your insurance, this psychological service may not be covered and, in that case, you will be fully responsible for the entire amount**.** If the clinician is *out-of-network* with your insurance policy, you will be required to pay the full amount of the service rendered. We will NOT file claims for out-of-network services.

_____ 6. **NON-COMPLIANCE.** We reserve the right to discontinue care with you for non-compliance with any of the above
Initial policies.

_____ 7. The undersigned agrees that in the event of **default in payment** or if the account is placed with a collection agency for
Initial collection, he/she is responsible for reasonable attorney's fees, miscellaneous costs of collection, collection agency fees, and court costs, at the interest rate of 18% per annum.

For all services rendered to minor patients, the adult accompanying the patient, or the policy holder, is responsible for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

X _____ **Date:** _____
Signature of Patient OR Responsible Party if a Minor

_____
Printed Patient Name

I WILL NOT BE USING INSURANCE FOR THIS SERVICE AND WILL PROVIDE ANOTHER FORM OF PAYMENT.

SIGNED: _____ **DATE:** _____

Form E

Algos Behavioral Health Services, Inc.

Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., Sandy Zamora, LPC-S

CONSENT TO TREATMENT AND CLINICAL ASSESSMENT SERVICES

This is to certify that I give permission to Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., or Sandy Zamora, LPC-S at Algos Behavioral Health Services, Inc. to provide psychological and behavioral health services for myself and/or child(ren), or for an adult child for whom I am the legal guardian.

I have reviewed the **Statement of Office Policies for Clinical Practice** and the specific assessment and/or treatment procedures have been explained to me.

Service:

___ Psychological Evaluation
___ Psychoeducational Evaluation
___ Neuropsychological Evaluation
___ Behavioral Health Assessment
___ Biofeedback Therapy
___ Other: _____

___ Couple Psychotherapy
___ Group Psychotherapy
___ Family Psychotherapy
___ Individual Psychotherapy
___Group Behavior and Health Intervention

The specific treatment has been described in the written **Statement of Office Policies for Clinical Practice** and/or explained by the clinician. If applicable, alternatives to treatment have been explained to me. Due to the complex nature of psychotherapy and other behavioral health services, including discussing past and present emotional pain and the stresses in life, it is quite common for persons entering this type of treatment to have periods of time when they experience their feelings as more intense, and perceive their condition as possibly worse. This should be discussed as part of the treatment, and is usually temporary. Please note that it is impossible to guarantee any specific results regarding psychological treatment. However, every effort will be made to achieve the best possible results for you. Maximum benefits occur with regular attendance and your active emotional investment in the process.

The issues of confidentiality have been reviewed, and I have been assured that all communications between a professional and a client are held in strict confidence. However, I also understand that there are exceptions to those laws and regulations. I understand it is the clinician's legal responsibility to disclose certain issues for my protection and that of others, and these situations have been clarified to me. Every reasonable effort will be made to resolve issues through discussion and planning within the clinical setting, and I will be notified of any anticipated compromise of the client-therapist relationship.

I have the right to terminate the therapeutic relationship at any time that I desire, without fault, and I have the right to seek and obtain a second opinion on the procedures and/or treatment process.

I understand that I am fully financially responsible for my treatment provided by the clinician, and for any balance that is not covered by my insurance company. A billing service may be used for the

collection of insurance reimbursement and co-pay fees. Psychologists have the right to seek the services of a collection agency to obtain payment of past due balances.

My signature certifies that I have read and understand all the information provided by Algos Behavioral Health Services Inc., about the clinicians, the treatment to be provided, and the expense to be incurred. I hereby voluntarily give my informed consent for treatment. A copy of this authorization shall be considered valid. I understand that I will be informed of any changes concerning what is in this document and my consent will be obtained regarding these changes.

You are assured that the services will be provided in a professional manner, consistent with the rules and regulations of the Texas State Board of Examiners of Psychologists and the ethical principles of the American Psychological Association. Every effort will be made to provide services in a caring, supportive and trustworthy environment.

In addition to the specified procedure checked above, the initial goals of treatment will be established after the first or second session.

My signature certifies that I have been provided the opportunity to read/review the following relevant documents:

- **Notice of Privacy Practices**
- **Statement of Office Policies for Clinical Practice: Psychotherapy, Psychological or Neuropsychological Testing and Behavioral Health Assessments**

My signature certifies that I voluntarily give my informed consent to the clinical services offered by this psychological practice.

X_____ _____

Signature of Client/Patient Date

_____ _____

Signature of Responsible Party (if client is a minor) Date

Form A

Algos Behavioral Health Services, Inc.

Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., Sandy Zamora, LPC-S

Health Insurance Portability and Accountability Act (HIPAA) Consent

General Notice
When seeking psychological consultation and/or treatment in this practice, **P**rotected **H**ealth **I**nformation **(PHI)** will be gathered about you. This information may include a clinical history, medical history, personal information, and possibly performance/responses on psychological testing instruments.

Notice to Protect the Privacy of Your Health Information

A complete description of how your **PHI** may be used and disclosed is available for your review in the **"HIPAA Notice of Privacy Practices."** A copy of this document is available at the reception desk. You may request a copy for your records.

Individual Rights

You have the right to restrict the uses and disclosures of your **P**rotected **H**ealth **I**nformation **(PHI)** for the purpose of treatment and health care. A signed consent form is usually required. This practice is not required to agree to requested restrictions, but is bound by any restrictions to which it agrees.
You have the right to revoke this consent in writing, except to the extent that our practice has taken action on the reliance on this consent. You have the right to refuse to sign this consent. This practice has the right to refuse to provide the clinical services requested, if you refuse to sign the consent or if you revoke this consent at any time.

Your signature below acknowledges:

- You have read and understand this consent;
- You have agreed to have your **P**rotected **H**ealth **I**nformation **(PHI)** used by this practice for the purposes of your consultation and treatment, to secure payment for your treatment, and for this practice's psychological care operations;
- Prior to signing this consent, you were given the opportunity to review the practice's **"HIPAA Notice of Privacy Practices;"**
- You are aware that you may now, or at any time in the future, request restrictions to the use and disclosure of your **P**rotected **H**ealth **I**nformation **(PHI)**;
- This consent may be terminated at any time, with written request, except to the extent that this practice has taken action in reliance of the consent.

X_____ _____
Signature of Client/Patient or Representative Date

Form C

Authorization Form to Release Protected Health Information (PHI)

This form when completed and signed by you authorizes this psychological clinic to release Protected Health Information (PHI) from your clinical record to the person(s) you designate.

I hereby authorize my psychologist and/or clinical associate, Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., or Sandy Zamora, LPC-S and their practice management company, Algos Behavioral Health Services, Inc. and/or their administrative and clinical staff to release *the following specific clinical record and/or administrative/payment information*: (please list which information you want released)
_____results of the psychological evaluation_____

**This information should be released to only the person(s) below:
_____
_____
_____

I am requesting the release of this information for the following reasons:
☐ at the request of the individual ☐ for continuing care ☐ for public agency use
☐ legal purposes ☐ other:_____

This authorization shall remain in effect until _____ (date),
or until _____
(specific purpose).

You have the right to revoke this authorization in writing at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist or clinical associate generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

X_____ _____
Signature of Patient Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

CLINICAL HISTORY: Bariatric Surgery Candidates

All information provided is treated in strict confidence, according to HIPAA regulations.
Provide as much information as you can. The clinician will go over the details with you.

NAME _____ TODAY'S DATE _____

AGE _____

REFERRED BY: _____, M.D., Your Bariatric Surgeon

HISTORY OF WEIGHT DIFFICULTIES:

How long have you had a weight problem? _____
What do you think led to your weight problems? _____
In reflecting on your eating behaviors, have you had a pattern of
☐ overeating ☐ emotional eating ☐ night eating ☐ grazing
☐ undereating ☐ impulsive eating ☐ excessive snacking ☐ poor portion control
☐ other eating patterns? Describe _____
What have you done to lose weight? --- Various diets ☐ ; Consult nutritionist ☐; Exercise ☐;
Weight Watchers? ☐; Medications? ☐; Consult Counselor/Therapist? ☐; Consult a Physician? ☐;
Other Programs? _____
What has seemed to help you in losing weight? _____
What has made it difficult for you to lose or maintain weight loss? _____

How long have you been thinking about the surgery? _____
What are your reasons for seeking surgery? _____

Do you have a history of an eating disorder? --- Anorexia? ☐ ; Bulimia? ☐ ; Binge eating? ☐; Purging? ☐;
Other eating disorder? _____

BEHAVIOR ISSUES:

Do you see yourself as prone to addictive/compulsive behaviors? ◯ ◯; What and how? _____
_____

How much and how often do you use the following:
tobacco/nicotine _____ alcohol _____
coffee _____ tea _____
sodas _____ carbonated/sparkling water _____
energy drinks _____ straws _____

How dependent do you believe you are on the items listed above? _____
_____

Do you experience cravings for certain foods? _____ If so, do you satisfy cravings or eat something else?
_____
What will be your greatest behavior challenge after surgery? _____

*If you have any **history of alcohol or drug abuse/addiction,** please complete the following; if not, skip*

Any **abuse of alcohol** in your lifetime? _____; How long (did) have you abused alcohol? _____; Are you still drinking? _____ OR When did you stop? _____ If you have been in treatment for alcoholism, where & when?

_____

Any **abuse of street drugs or medication** in your lifetime? _____ ; Which drugs? _____
Have you been in chemical dependency treatment?_____; Where, when, for how long? _____

_____

Have you had any **legal problems** (arrests, lawsuits)? _____What type, when? _____

_____

INFORMED CONSENT AND READINESS FOR COMPLIANCE

Do you understand the details of the surgery? _____; Any concerns you have **not** discussed with your physician? _____; How do you think the surgery will help you? _____

_____

Are you aware that noncompliance can put you at risk for complications? _____

Have you made changes in eating behaviors since you made the decision to have surgery? _____ What changes?

_____

* Some of the necessary changes include: reducing portion size_____; no liquids with meals_____;
eating slowly and chewing _____; no snacking _____; water consumption _____; exercise _____;
monitoring protein intake _____; lifelong vitamins _____

What family patterns and customs will you have to change? _____
Have you informed your family of your decision? _____; If not, why? _____

_____

Do you have a family support system during surgery and afterwards? _____; How does your spouse/partner/family member(s) feel about your decision to have surgery? _____

_____

How do you expect spouse/partner/family relationships might be changed? _____

_____

What stresses/issues do you anticipate with your children? _____

Describe any changes in eating behaviors or habits that you have ALREADY made as you prepare for this surgery:

_____

_____

RATINGS

How would you rate the following?

Your emotional readiness for the surgery:	Poor	Poor	Very Good
Readiness for behavior changes:	Poor	Poor	Very Good
Capability of making behavior change:	Poor	Poor	Very Good

Are you physically active? _____ What plans do you have for exercising regularly? _____

_____

What will you have to change in your lifestyle to accomplish this? _____

_____

MEDICAL HISTORY:

List any medical conditions/diagnoses _____
_____
Any injury, accident, or *major surgery* in your life? _____
_____
Ever had a *head injury, concussion* or other brain trauma? _____

PERSONAL AND SOCIAL INFORMATION:

Current living situation*:* With whom are you living? _____
Single ☐ or Married ☐, For how long? _____ OR Divorced ☐ or Widowed ☐
Common law marriage(s)/Partner _____**;** Currently separated? _____ For how long? _____
Married in the past? _____, # of times _____ ; Have children? _____, Ages _____
Any family stresses/conflicts that will cause you concern after surgery and could distract you from achieving your goal of weight loss? _____

Growing up experiences: Where were you born? _____
Where have you lived most of your life? _____
How many children in your family growing up? _____; What was your position (e.g. #l, #4) in the family? _____
Who raised you? _____; If you were raised by someone other than parents, why was this? _____
_____
Were your parents divorced? _____; Did you have regular contact with each parent during childhood? _____
How was family life while growing up? _____
Any history of abuse as a child? Physical _____ by whom?_____
emotional/verbal/ mental _____ by whom? _____
sexual _____ by whom? _____
Any neglect? _____ by whom? _____
Other trauma (significant death/fire/scare/or any other major life event)? _____
How long did the abuse/trauma go on, and how did it affect you? _____

Have you experienced: the death or loss of – a spouse? _____a child? _____ a parent as a child? _____
a sibling? _____ another significant person in your life? _____

Have you experienced: a major loss of – a home? _____ career? _____family? _____
support system? _____ OR experienced losses through a – flood? _____hurricane? _____ tornado? _____fire? _____

Have you experienced a – sexual assault? _____ date rape? _____ kidnapping? _____ physical assault? _____
been victim of a crime? _____ home invasion? _____ assault or harassment at work? _____ burglary? _____

On a scale of 1 to 10, with 1 being limited, and 10 meaning extensive, how would you rate the following?
A. The emotional trauma of the event *then*: 10
B. The emotional trauma of the event *now*: 10
- Your efforts to heal the trauma since : _____

EDUCATION AND WORK HISTORY:

Education: How far did you go in formal school? _____ **OR** GED? _____
Any learning difficulties? _____
Any vocational or technical programs (where, when, certificates)? _____
College experience (degree, name of college, when)? _____
_____

Employment History: Are you employed now? _____ What kind of work do you do? _____
What kind of jobs have you had in the past? _____
_____
Have you had any difficulty keeping jobs? _____ Have you been able to maintain stable employment? _____
Has your weight affected your work and/or career in any way? _____

EMOTIONAL HEALTH/PSYCHOLOGICAL INFORMATION:

Current Moods: How would you describe your emotional health in the **last few months**? _____
If you have had emotional struggles in your life, have they been – Mild _____Moderate _____ Severe _____
Frequent moods: Depression _____ Anxiety and stress _____Excessive anger _____ Panic attacks _____
What is the history of these experiences? _____
_____

What symptoms have you experienced **most days for the last month**?

_____ loss of sleep/insomnia _____ low self-esteem/self-confidence
_____ excessive sleep _____ irritability/getting upset with people easily
_____ overeating behaviors _____ loss of enjoyment in life
_____ loss of appetite _____ fatigue/always tired
_____excessive appetite _____ loss of sexual interest or desire
_____ crying episodes _____ concentration problems
_____ social withdrawal/wanting to be alone _____ forgetfulness/memory problems
_____ loss of energy and motivation to do things _____ manic behavior
_____ loss of interest in enjoyable activities _____ sad feelings
_____ mood swings/rapid changes in mood _____ excessive feelings of guilt
_____ agitation/restlessness _____ weight loss/gain
_____ negative/pessimistic thoughts _____ indecisiveness/difficulty making decisions
_____ sense of worthlessness _____ inability/difficulty in thinking clearly
_____ sense of hopelessness _____ thoughts of dying
_____ lack of friends/friendships _____ dissatisfaction with life
_____ a sense of helplessness _____ frequent sense of discouragement

_____ other symptoms *(please explain)* _____
_____ thoughts of suicide; if so, how frequently _____
_____ any suicide attempts in your lifetime? If so, when & how many times? _____

How did you attempt suicide? _____
What was the outcome? _____

How recent was the **last suicide thought or attempt**? _____

If you have panic attacks, how often do you have them? _____
Which symptoms?

_____ racing heart	_____ fear of dying	_____ dizziness or lightheadedness
_____ sweating	_____ sense of terror/panic	_____ chills
_____ trembling or shaking	_____ chest pain or discomfort	_____ fear of losing control
_____ shortness of breath	_____ agitation	_____ hot flashes
_____ sense of choking	_____ nausea	_____ avoidance of people

How do you manage/get over these attacks? _____

Have you ever been diagnosed with any mental health condition? _____ If so, when? _____
What is/was the diagnosis? _____
How do you feel your weight struggles have affected you emotionally, and/or how much are your struggles with depression and/or anxiety related to your weight problems?
_____

Treatment for emotional problems

Have you ever seen a mental health professional (psychiatrist/psychologist/counselor/therapist)? _____
When, and how often? _____
Have you ever been hospitalized for psychiatric treatment? _____ If yes – where, when, length(s) of stay:
_____
How recent was the last psychiatric hospitalization? _____
Medications for emotional problems in the past? _____
Current medications for emotional problems? _____
Is your treatment effective now? _____ How is it helping you? _____

Psychosocial stressors in your life…what causes/contributes to your stress and any emotional problems?

___Weight concerns	___Health concerns	___Work stress/environment
___ Marriage difficulties	___ Relationship problems	___Recent divorce
___Financial problems	___Disabling condition	___Lack of family support
___Children/family problems	___Single parenting	___ Living alone
___Job loss	___Transportation problems	___ Past trauma
___Social isolation	___Unable to be productive	___ Inactivity
___Loss of career	___Slow/No medical progress	___ Change in quality of life
___Physical restrictions	___Recent death(s) – (Who? _____)	

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Karri (Zumwalt) Lusk, Psy.D.
Sean Connolly, Ph.D.
Sandy Zamora, LPC-S

PATIENT NAME: _____

MEDICATION LIST

* Please list all prescribed meds, over-the-counter meds, herbals, supplements, vitamins

Medication Name	Dosage	Frequency	Route of Administration (oral, topical, injection)

NAME: _____ DATE: _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	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 ___ = Add Columns ___ + ___ + ___

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
☐	☐	☐	☐

NAME: _____
DATE: _____
DOB: _____

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**
☐	☐	☐	☐

NAME: _____
DATE: _____
DOB: _____

ELDER ABUSE SUSPICION INDEX © (EASI)			
EASI Questions **Q.1-Q.5 asked of patient; Q.6 answered by doctor** **Within the last 12 months:**			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES ◯	NO ◯	Did not answer ◯
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES ◯	NO ◯	Did not answer ◯
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES ◯	NO ◯	Did not answer ◯
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES ◯	NO ◯	Did not answer ◯
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES ◯	NO ◯	Did not answer ◯
6) Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES ◯	NO ◯	Not sure ◯

Submit Form

The EASI was developed* to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern. The EASI was validated* for asking by family practitioners of cognitively intact seniors seen in ambulatory settings.

*Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) ©. Journal of Elder Abuse and Neglect 2008; 20(3) 000-000. In Press. Haworth Press Inc: http: //www.HaworthPress.com

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