

INITIAL PACKET

Thank you for considering an evaluation with Dr. Angela Caires, CRNP. I understand that, for some of you, seeking help with a psychiatric or mental health concern can be difficult. You may be struggling with concerns about depression, anxiety, or behavioral symptoms. For others of you, the call to our office was influenced by the need to have your spiritual beliefs and values honored as you seek healing for an illness like depression or anxiety. For others, just finding a competent, capable clinician to listen to your concerns and provide a thorough evaluation is the goal.

The initial visit with me will be about 90 minutes. I will be asking questions to understand your concerns as well as obtaining a medical and psychological history. It would be helpful if you bring with you any available medical records or lab work, and bottles of medication and supplements that you currently take.

Because medical issues can cause emotional symptoms, it will be important to rule out contributing medical disease. For this reason I insist that my patients have a primary care physician to follow them while I am involved with their care. Frequently I also refer to psychologists for psychological testing which can be very helpful in making a diagnosis and treatment plan.

Having said all that, it is your responsibility to present your concerns as honestly as you can. In the next section you will find a health care screening form to complete prior to your first visit. I would ask you to be as open and complete in your responses as you can. Making the proper diagnosis and treatment plan depends on getting the accurate information from the beginning. Please take the time to gather the information needed to complete the form. If there are issues you cannot put on paper please consider discussing these with me during our first visit.

During the first visit you will have a chance to gauge your comfort level with me and I will be able to assess my ability to offer help to you. If I cannot help you, I will do all I can to help you find another provider.

I look forward to meeting with you.

Angela Caires, DNP, CRNP

5151 Research Dr NW Huntsville, AL 35805 Ph 256 722 1999 Fax 256 722 1366

Office Use Only:
DX: _____
Initial Eval Date: _____

Hayden and Associates

DATE: _____ Date of BIRTH _____ AGE _____

PATIENT NAME: _____

HOME ADDRESS: _____ CITY: _____
STATE: _____ ZIP: _____

WORK/CELL #: _____ HOME # _____ (CIRCLE BEST CONTACT #)

WHO REFERRED YOU TO THE OFFICE: _____

FAMILY DOCTOR (PCP) _____ TELEPHONE #: _____

IN CASE OF EMERGENCY NOTIFY: _____ TELEPHONE #: _____

PRIMARY INSURANCE: _____

DO YOU HAVE MEDICARE OR TRICARE INSURANCE? _____

OFFICE POLICY

PLEASE READ AND SIGN THE FOLLOWING INFORMATION CONCERNING THE POLICIES OF THIS OFFICE. YOU WILL BE GIVEN A COPY FOR YOUR RECORDS.

AUTHORIZATION:

I, (your name) _____, hereby authorize Dr. Angela Caires, CRNP as needed and/or requested:

___ To release any applicable mental health information to my primary care physician (PCP) named above.

___ To release any applicable substance abuse information to my PCP named above.

___ Not to release any information to my PCP named above.

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it.

If I do not revoke this authorization, it will expire in one (1) year after I have terminated treatment.

I have read and understand this statement: _____

Signature of patient or guardian

INSURANCE PAYMENT ISSUES

I, (your name) _____ understand that Dr Caires is an out of network provider for Blue Cross of Al, and is not in network for any private insurance providers. The staff of Hayden & Associates does not file insurance . You will be provided with a superbill with codes and diagnosis so that you can bill your insurance directly. Payments should be made at the time of service and cash, check and credit cards are accepted. Checks should be made out to Charles Hayden MD PA. Payments for TMS therapy are applied in a different manner- consult Cindy Duvall RN.

I have read and understand this statement: _____

Signature of patient or guardian

CANCELLATION POLICY:

All cancellations and/or rescheduling of appointments MUST be done at least 24 hours in advance. Patients, who cancel the day of an appointment or do not show, will incur a cancellation/no show fee. If your appointment is on a Monday, and you leave a message on the machine over the weekend, **that does not constitute 24 hour notice**. That appointment would have had to be changed on the Friday prior. Confirmation calls are done as a courtesy to patients; however, there are times we cannot make them. Please do not rely on our reminder call.

I have read and understand this statement: _____

Signature of patient or guardian

MEDICAL AND PSYCHIATRIC HISTORY

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding the health concerns that you may have. Please answer every question to the best of your ability.

1. Are you in good physical health? Yes No

2. Has there been any change in your general physical health in the last year?..... Yes No

3. Date of your last physical examination (on or about) _____

4. Have you ever had any serious illness or operation?..... Yes No

If so, please list:

5. Are you currently under the care of a physician for any physical condition? Yes No

6. Are you taking any prescription drugs or medications at present time? Yes No

If so, please list:

NAME OF MEDICATION	STRENGTH IN MG	DATE BEGAN/ DATE ENDED	REASON FOR TAKING

Have you ever been hospitalized? Yes No

If yes, please list and explain:

REASON	DATE OF HOSPITALIZATION	LOCATION	REASON TREATMENT RECEIVED

Do you, or have you ever had, any of the following problems?

a. Rheumatic Heart Disease Yes No	t. Anemia..... Yes No
b. Jaundice..... Yes No	u. Arteriosclerosis Yes No
c. Rheumatic Fever Yes No	v. Blood Clotting Problems Yes No
d. Arthritis or Rheumatism Yes No	w. Asthma Yes No
e. Congenital Heart Disease..... Yes No	x. Venereal Disease/STD..... Yes No
f. Stomach Ulcer Yes No	y. Hay Fever Yes No
g. Cardiovascular Disease..... Yes No	z. Bladder problems..... Yes No
h. Kidney Disease Yes No	Aa. Hives Yes No
i. Heart Trouble Yes No	Bb. Cancer..... Yes No
j. Tuberculosis Yes No	Cc. Skin Rash..... Yes No
k. Heart Attack..... Yes No	Dd. Tick Bite..... Yes No
l. Under active Thyroid..... Yes No	Ee. Fainting Spells Yes No
m. Coronary Insufficiency Yes No	Ff. Lyme Disease Yes No
n. Overactive Thyroid Yes No	Gg. Seizures..... Yes No
o. Coronary Occlusion..... Yes No	Hh. Diabetes..... Yes No
p. Glaucoma..... Yes No	Ii. Liver Disease Yes No
q. High Blood Pressure..... Yes No	Jj. Hepatitis Yes No
r. Blood Disorder..... Yes No	Kk. Other (explain) Yes No
s. Low Blood Sugar..... Yes No	

Are you taking any **non prescription** drugs, including **natural remedies and vitamins**? Yes No If so, please list and explain:

NAME OF MEDICATION	STRENGTH IN MG	DATE BEGAN	REASON TAKING

Are you aware of or has a physician ever told you of any **allergies/adverse reactions** to any medications or drugs? Yes No

If so, please list and explain:

NAME OF MEDICATION	REACTION

MENTAL HEALTH QUESTIONNAIRE

1. In chronological order, please list all psychiatrists and/or psychotherapists, (psychologists, nurse practitioners, certified social workers, counselors, etc) who have attended you beginning with the present:

NAME	TITLE/PROFESSION	TREATMENT (THERAPY, MEDS, ETC.)	DATE STARTED	DATE ENDED	REASON DISCONTINUED

2. During the last four (4) weeks, have you been bothered by any of the following problems?

- a. Stomach pain? Yes No
- b. Back pain?..... Yes No
- c. Pain in your arms, legs, or joints..... Yes No
- d. Menstrual cramps, or problems with your period? Yes No

- e. Pain or problems with your periods? Yes No
- f. Headaches? Yes No
- g. Chest pain? Yes No
- h. Dizziness? Yes No
- i. Fainting Spells? Yes No
- j. Feeling your heart pound or race? Yes No
- k. Shortness of breath? Yes No
- l. Constipation? Yes No
- m. Loose bowel or diarrhea? Yes No
- n. Nausea, gas, or indigestion? Yes No

3. Over the last two (2) weeks, have you been bothered by any of the following problems?

- a. Little to no interest or pleasure in doing things? Yes No
- b. Feeling down, depressed, or hopeless? Yes No
- c. Trouble falling asleep or staying asleep? Yes No
- d. Sleeping too much? Yes No
- e. Feeling tired or having little energy? Yes No
- f. Poor appetite or overeating? Yes No
- g. Feeling bad about yourself? Yes No
- h. Feeling that you are a failure, or have let others down? Yes No
- i. Trouble concentrating on things such as reading, watching TV? Yes No
- j. Moving or speaking slowly that other people have noticed? Yes No
- k. Being so fidgety or restless that other people have noticed? Yes No
- l. Thoughts that you would be better off dead or hurting yourself in any way? Yes No
- m. Persistently elevated, expansive mood? Yes No
- n. Inflated self esteem? Yes No
- o. Pressured to keep talking? Yes No
- p. Racing thoughts? Yes No
- q. Distractibility? Yes No
- r. Impulsiveness (buying sprees, sexual indiscretions, foolish business investments?) Yes No
- s. Hallucinations (hearing or seeing things that others don't) Yes No

4. Questions about anxiety:

- a. In the last four (4) weeks have you had an anxiety attack? (suddenly feeling fear or panic) Yes No
- If you checked no, go to question 6**
- b. Has this ever happened before? Yes No
 - c. Do some of these attacks come suddenly out of the blue, or in situations where you don't expect to be nervous or uncomfortable? Yes No
 - d. Do these attacks bother you a lot or are you worried about having another attack? Yes No

5. Think about your last bad anxiety attack:

- a. Were you short of breath? Yes No
- b. Did your heart race, pound, or skip? Yes No
- c. Did you have chest pain or pressure? Yes No
- d. Did you sweat? Yes No
- e. Did you feel as if you were choking? Yes No
- f. Did you have hot flashes or chills? Yes No
- g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea? Yes No
- h. Did you feel dizzy, unsteady, or faint? Yes No
- i. Did you tremble or shake? Yes No
- j. Were you afraid you were dying? Yes No

6. Over the last four (4) weeks, have you been bothered by the following problems?

- a. Feeling nervous, on edge, or worried a lot about different things?..... Yes No
- If you checked no, go to question 7**
- b. Feeling restless so that it is hard to sit still? Yes No
- c. Getting tired very easily?..... Yes No
- d. Muscle tension, aches, or soreness?..... Yes No
- e. Trouble falling asleep or staying asleep? Yes No
- f. Trouble concentrating on things, such as reading, watching TV? Yes No
- g. Obsessions (fear of contaminations, intrusive thoughts of harm, need for order or symmetry)? .. Yes No
- h. Becoming easily annoyed or irritated?..... Yes No
- i. Compulsions (checking doors, oven, washing hands)? Yes No
- j. Social anxiety (center of attention, avoiding social situations)? Yes No

7. Questions about eating

- a. Do you often feel that you can't control what or how much you eat? Yes No
- b. Do you often eat, within any 2 hour period what most people would regard as an unusually large amount of food?..... Yes No
- If you checked no to either a or b, please go to question 9**
- c. Has this been as often as twice a week for the last three (3) months? Yes No

8. In the last three (3) months, have you often done any of the following in order to avoid gaining weight?

- a. Made yourself vomit? Yes No
- b. Taken more than twice the recommended doses of laxatives?..... Yes No
- c. Fasted (not eaten anything at all for at least 24 hours)?..... Yes No
- d. Exercised for more than an hour, specifically to avoid gaining weight after binge eating? Yes No
- e. If you checked YES to any one of these ways of avoiding gaining weight, were any as often or average, as twice a week? Yes No

9. Do you ever drink alcohol, including beer and wine?..... Yes No
if you answered no, go to question 11

10. Have any of the following happened to you more than once in the last six (6) months?

- a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health?..... Yes No
- b. You drank alcohol, were high from alcohol, or were hung over while you were working, going to school, or taking care of someone else's children, or other responsibilities?..... Yes No
- c. You missed or were late for work, school, or other activities because you were drinking or hung over?..... Yes No
- d. You had problems getting along with others while drinking? Yes No
- e. You drove a car after having several drinks or after drinking too much alcohol? Yes No

11. Do you presently use recreational drugs?..... Yes No

If yes, please give details: _____

12. Have you ever used alcohol or drugs more than you do now?..... Yes No

If yes, please explain to what extent: _____

13. In the last four (4) weeks have you been bothered by any of the following problems?

- a. Worrying about your health?..... Yes No
- b. Your weight or how you look? Yes No
- c. Little or no sexual desire or pleasure during sex?..... Yes No
- d. Difficulties with your husband/wife or significant other? Yes No
- e. The stress of taking care of children, parents, or family?..... Yes No
- f. Stress at work, outside of the home, or school?..... Yes No
- g. Financial problems or worries? Yes No
- h. Having no one to turn to when you have a problem? Yes No
- i. Something bad that happened recently?..... Yes No
- j. Thinking or dreaming about something terrible that happened to you in the past? (like your house being destroyed, a severe accident, being physically, mentally or sexually abused..) Yes No
- k. Learning disability (Dyslexia, ADHD, Math Disability)? Yes No

14. In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have unwanted sexual acts? Yes No

15. What is the most stressful thing in your life right now?

16. If you checked off any of the problems 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?

- a. Not difficult at all
- b. Somewhat difficult
- c. Very difficult
- d. Extremely difficult

FOR WOMEN ONLY:

17. Which best describes your menstrual periods?

- a. Periods are unchanged?
- b. Painful menses that have required medication or interfered with functioning?
- c. Periods have become irregular or changed in frequency, duration, or amount?
- d. No periods for at least one (1) year?

e. Having no periods because taking hormone replacement or contraceptives?

18. During the week before your period starts, do you have a serious problem with your mood?
Like depression, anxiety, irritability, anger, or mood swings?..... Yes No

19. Pregnancy:

- a. Have you given birth within the last six (6) months?..... Yes No
- b. Have you had a miscarriage within the last nine (9) months?.....Yes No
- c. Are you having difficulty getting pregnant..... Yes No

SPIRITUAL

- a. Do you have a faith or belief in God – if so what role does that play in your life? _____

- b. Are you connected in a faith community or church- or have you been in the past? _____

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