INITIAL PACKET

Thank you for considering an evaluation with Dr. Charles Hayden. In taking this step, I assume that you have one or more concerns that you would like to address and that you have concluded that you need the expertise of a psychiatrist. For some, the call to our office was influenced by the need to have their spiritual beliefs and values honored while they seek healing for an illness like depression or anxiety. For others, just finding a competent, capable clinician to evaluate and treat them would be the goal.

This initial visit with me will be about 90 minutes. I will be asking questions to understand your concerns and get a medical and psychological history. It would be helpful if you bring 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 and 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.

Charles Hayden MD

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

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

CHARLES HAYDEN MD
For patients considering TMS Therapy

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 Charles Hayden 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 Hayden is an out of network provider for Blue Cross of Al, and is not in network for any private insurance providers. Dr Hayden's staff 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	

*Do you have any physical disease or condition not listed above that you think the doctor should know? Yes No If so, please explain:*_____

Circle each medication that you have ever taken:

Antidepressants	
Brand Name	**Generic**
Strattera	Atomoxetine
Remeron	Mirtazapine
Trintellix	Vortioxetine
Wellbutrin	Bupropion
Viibryd	Vilazodone
Luvox	Fluvoxamine
Prozac	Fluoxetine
Zoloft	Sertraline
Celexa	Citalopram
Lexapro	Escitalopram
Effexor	Venlafaxine
Cymbalta	Duloxetine
Pristiq	Desvenlafaxine
Savella	Milnacipram
Fetzima	Levomilnacipram
Paxil	Paroxetine

Tricyclic	
Brand Name	**Generic**
Anafranil	Clomipramine
Asendin	Amoxapine
Elavil	Amitriptyline
Ludiomil	Maprotiline
Norpramin	Desipramine
Pamelor	Nortriptyline
Sinequin	Doxepin
Surmontil	Trimipramine
Tofranil	Imipramine

MAOI's	
Brand Name	**Generic**
Marplan	Isocarboxazid
Nardil	Phenelzine
Parnate	Tranylcypromine
Emsam	Selefiline Patch

Mood Stabilizer	
Brand Name	**Generic**
Lithium	Lithium
Tegretol	Carbamazepine
Depakote	Divalproex
Neurontin	Gabapentin
Lamictal	Lamotrigine
Trileptal	Oxacarbazepine
Depakote	Valproate

Sedatives & Sleeping Agents	
Brand Name	**Generic**
Klonopin	Clonazepam
Xanax	Alprazolam
Valium	Diazepam
Benadryl	Diphenhydramine
Lunesta	Eszopiclone
Ativan	Lorazepam
Serax	Oxazepam
Restoril	Temazepam
	Trazodone
Halicon	Triazolam
Sonata	Zaleplon
Silenor	Doxepin
Vistaril	Hydroxyzine
Belsomra	Suvorexant
Ambien	Zolpidem

Stimulants	
Brand Name	**Generic**
Nuvigil	Armodafinil
Adderal	Amphetamine
Vyvanase	Lisdexamphetamine
Ritalin	Methylphenidate
Provigil	Modafinil
Focalin	Dexmethylphen.
Concerta	Methylphen.
Intuniv	Guanfacine

Antipsychotics	
Brand Name	**Generic**
Abilify	Aripiprazole
Saphris	Asenapine
Vraylar	Cariprazine
Rexulti	Brexpiprazole
Fanapt	Iloperidone
Latuda	Lurasidone
Zyprexa	Olanzapine
Seroquel	Quetiapine
Risperdal	Risperidone
Geodon	Ziprasidone

Augmenting Agents	
Brand Name	**Generic**
Buspar	Buspirone
Cytomel	LioThyronine
Fish Oil	Omega-3
Deplin	L-Methylfolate
Enlyte	L-Methylfolate

Other	
Brand Name	**Generic**

For each drug you circled on the previous page, record here and give as much detail as possible:

Drug	Year drug was taken	Highest dose taken	# Weeks drug was taken	Was it helpful (Y/N)?	Describe side effects	Stopped due to side-effects (Y/N)?

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/PROFESSI*	*TREATMENT (THERAPY, MED*	*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. <u>Over the last two (2) weeks, have you been bothered by any of the following problems?</u>

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. <u>Questions about anxiety:</u>

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. <u>Think about your last bad anxiety attack:</u>

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. <u>Over the last four (4) weeks, have you been bothered by the following problems?</u>

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. <u>Questions about eating</u>

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

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. <u>Do you ever drink alcohol, including beer and wine?</u>..... *Yes No*
if you answered no, go to question 11

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

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. <u>Do you presently use recreational drugs?</u>..... *Yes No*

If yes, please give details: _____
_____
_____

12. <u>Have you ever used alcohol or drugs more than you do now?</u> ..... *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. <u>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?</u> ..... *Yes No*

15. <u>What is the most stressful thing in your life right now?</u>

_____
_____
_____

16. <u>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?</u>

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

FOR WOMEN ONLY:

17. <u>Which best describes your menstrual periods?</u>

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

19. <u>Pregnancy:</u>

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?*_____
_____
_____