PALOUSE PSYCHIATRY & BEHAVIORAL HEALTH

PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

Welcome to our clinic!

Attached are the registration documents that we will need for you to complete and bring with you to your appointment.

**It is required that you show up 15 minutes early for your appointment. If paperwork is not completed, or you are unable to arrive early, your appointment may need to be rescheduled.**

*Our office is located in the Corporate Point Building (on the 2nd floor), across the street from Pullman Regional Hospital and next to Zeppoz.*


Thank you and we look forward to seeing you.
Psychiatry & Behavioral Health
840 SE Bishop Blvd., #203
Pullman, WA 99163
509-339-2394 (Phone)
509-336-7484 (Fax)

PALOUSE PSYCHIATRY & BEHAVIORAL HEALTH

PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

# BEING PREPARED FOR YOUR TESTING DAY(S)*

- If you are coming in for ADHD testing, your exam *could* take 4 or more hours.

- If you are coming in for any type of Neuro Cognitive testing, your exam *could* take 4 hours.

Before you panic, please understand ... this is not just a sit down 1. , 2. , 3. , ... exam. Most people actually enjoy this type of testing while providing some really good information to Dr. Chad Sanders!

However, there are some guidelines we ask you to follow to make the testing day successful for everyone!

- ✓ Get a good night sleep the night before!
- ✓ Be well hydrated leading up to the test (it helps your brain work better!)
- ✓ Eat breakfast that morning before you come in.
- ✓ If you have a bad headache or wake up with a cold, reschedule! You need to be healthy. Just call us ASAP, please!
- ✓ Don't change your medication routine WITH THE EXCEPTION of those taking a stimulant. DO NOT take your stimulant that day you are testing for ADHD.
- ✓ Wear comfortable clothes.
- ✓ Drink coffee in moderation. You don't need a lot of caffeine that day! ☺
- ✓ Feel free to bring food/snack/drinks. The hospital has the Red Sage Café across the street for a quick lunch.
- ✓ Remember ... You just might enjoy this !!

There is a short turn-around time for the testing results and a follow up appointment will be scheduled with you.

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# HEALTH HISTORY

Primary Care Physician: _____ Primary Care Physician Phone #: _____

Who referred you to us? _____ Date of Last Complete Check-Up: _____

What are the primary concerns you are wanting to address?_____ _____

_____

_____

Are you currently taking any medication? ☐ No ☐ Yes

Please list all medications, including herbal supplements/over the counter drugs:

| Name of Medication: | Dose: | Purpose: | Effect: | Prescribing Provider: |
|---|---|---|---|---|
| | | | | |
| | | | | |
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# MEDICAL HISTORY

Have you ever experienced serious illness, injury, or hospitalization, or do you have any physical disabilities?
☐ No ☐ Yes Describe: _____

_____

_____

Have you experienced any of the following?
☐ Head injuries Describe: _____
☐ Seizures Describe: _____
☐ Abnormal motor twitches Describe: _____

Have you had any difficulties with:
Eating? ☐ No ☐ Yes – Describe: _____
Speaking? ☐ No ☐ Yes– Describe: _____
Menstruating? ☐ No ☐ Yes– Describe: _____

**Current Substance Use**

☐ Alcohol: _____ drinks, _____ times per week.
☐ Tobacco: (cigarettes, chewing tobacco, vaporizer), _____ (amount) daily, for _____ years.
☐ Caffeine: _____ cups per day, _____ times per week.
☐ Other Substance use:

## PATIENT/FAMILY HISTORY

| | Patient | Family Member(s) |
|---|---|---|
| Adverse Reaction to Anesthesia | | |
| Allergies (dust, pollen, pets, foods) | | |
| Anemia | | |
| Asthma | | |
| Atherosclerosis | | |
| Autoimmune Disorder | | |
| Cancer of the Breast | | |
| Colon Cancer | | |
| Congenital Anomaly | | |
| Coronary Artery Disease | | |
| Dementia | | |
| Diabetes | | |
| Eczema | | |
| Genetic Disorder | | |
| Glaucoma | | |
| Heart Attack | | |
| High Blood Pressure | | |
| Huntington's Disease | | |
| Hyperlipidemia | | |
| Kidney Disease | | |
| Lung Cancer | | |
| Malignant Hyperthermia | | |
| Migraines | | |
| Mild Cognitive Impairment (MCI) | | |
| Multiple Sclerosis | | |
| Obesity | | |
| Osteoporosis | | |
| Other Blood Disorder | | |
| Other Cancer | | |
| Ovarian Cancer | | |
| Parkinson's Disease | | |
| Prostate Cancer | | |
| Rheumatoid Arthritis | | |
| Seizures | | |
| Skin Cancer | | |
| Strokes | | |
| Thyroid Disease | | |
| Tobacco Abuse | | |
| Tuberculosis | | |

***KEY***

M: Mother F: Father
S: Sister B: Brother
Son: Son Dau: Daughter
PGF: Paternal Grandfather
PGM: Paternal Grandmother
MGF: Maternal Grandfather
MGM: Maternal Grandmother
A: Aunt U: Uncle C: Cousin

***Any other health conditions not listed?***

**Sleep**

Have you had any difficulties with sleeping? ☐ No ☐ Yes – Describe:

_____

Do you experience problems falling asleep? ☐ No ☐ Yes – Describe: _____

_____

Do you experience problems staying asleep? ☐ No ☐ Yes – Describe: _____

_____

Any history of parasomnias (e.g. sleepwalking, night terrors, etc.)? ☐ No ☐ Yes – Describe: _____

_____

Have you ever completed a sleep study? ☐ No ☐ Yes – Describe: _____

_____

Do you nap? ☐ No ☐ Yes – Describe: _____

Sleep / Wake Schedule: _____

Average hours of sleep per night: _____

Number of hours that would be ideal: _____

**Suicide Risk Assessment**

Have you ever had feelings or thoughts that you didn't want to live? ☐ No ☐ Yes

➔ *If YES, please answer the following. If NO, please skip to the next section.*

Do you currently feel that you don't want to live? ☐ Yes ☐ No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

_____

On a scale of 1 to 10 (10 being strongest), how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

On a scale from 0 to 100 (100 being full confidence), how confident are you that you will be able to keep yourself safe currently? _____

Have you ever received a mental health diagnosis or treatment previously? ☐ No ☐ Yes

If yes, where? _____

_____

Have you ever completed a psychiatric inpatient stay? ☐ No ☐ Yes

If yes, please describe: _____

_____

_____

Is there any other relevant information you would like to provide us? ☐ No ☐ Yes

If yes, please describe: _____

_____

# PSYCHIATRIC HISTORY

Current Symptoms Checklist: (check once for any symptoms present, circle for major symptoms)

- ☐ Depressed mood
- ☐ Unable to enjoy activities
- ☐ Sleep pattern disturbance
- ☐ Loss of interest
- ☐ Concentration/forgetfulness
- ☐ Change in appetite
- ☐ Excessive guilt
- ☐ Fatigue
- ☐ Decreased libido
- ☐ Racing thoughts
- ☐ Impulsivity
- ☐ Increased risky behavior
- ☐ Increased libido
- ☐ Decreased need for sleep
- ☐ Excessive energy
- ☐ Increased irritability
- ☐ Crying spells
- ☐ Indecisiveness
- ☐ Excessive worry
- ☐ Panic attacks
- ☐ Avoidance
- ☐ Hallucinations
- ☐ Suspiciousness
- ☐ Dissociation
- ☐ _____
- ☐ _____
- ☐ _____

**PATIENT/FAMILY PSYCHIATRIC HISTORY**

| | Patient | Family Member(s) |
|---|---|---|
| Anxiety | | |
| Attention Deficit /Hyperactivity Disorder | | |
| Autism Spectrum Disorder | | |
| Bipolar Disorder | | |
| Depression | | |
| Hoarding Disorder | | |
| Intellectual Disability | | |
| Learning Difficulties/SLD | | |
| Obsessive-Compulsive Disorder | | |
| Personality Disorder | | |
| Post-Traumatic Stress Disorder | | |
| Schizophrenia | | |
| Suicidal Behavior/Ideation | | |
| Violent Behavior/Ideation | | |
| Other: | | |

***KEY***

M: Mother F: Father
S: Sister B: Brother
Son: Son Dau: Daughter
PGF: Paternal Grandfather
PGM: Paternal Grandmother
MGF: Maternal Grandfather
MGM: Maternal Grandmother
A: Aunt U: Uncle C: Cousin

If anyone has been diagnosed with any of the above mental health disorders, please list the diagnosis and whether or not treatment has been received, including medication:

| Diagnosis: | Treatment Received: | Medications: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# DEVELOPMENTAL HISTORY

Were alcohol, drugs or tobacco used during your mother's pregnancy? ☐ No ☐ Yes (If yes, see below.)

a. Which substance(s)? _____
b. Quantity and frequency? _____
c. How long/Still currently using? _____

Did your mother experience any high stress levels or illness during pregnancy? ☐ No ☐ Yes
(If yes, please describe the illness and any treatment, medication or special diet your mother received.)_____
_____

Where were you born? _____
Were you born prematurely? ☐ No ☐ Yes If yes, number of weeks: _____
How long did labor last? _____ Birth Weight: _____

How were you born? ☐ Head first ☐ Feet first ☐ Breech (buttocks first) ☐ C-Section ☐ Other_____

Were there any difficulties or peculiarities in your appearance or behavior at birth or during infancy?
☐ No ☐ Yes If yes, describe: _____

Were you given oxygen? ☐ No ☐ Yes -If yes, for how long? _____
Blood transfusions? ☐ No ☐ Yes
Placed in an incubator? ☐ No ☐ Yes -If yes, for how long? _____
Other medical treatment? ☐ No ☐ Yes - Describe: _____

**INFANCY & NEWBORN**
By whom were you raised? _____
Looking back on your early childhood years, and based on what you have been told by others, were you:
(Check any that apply.)

☐ Difficult to Sooth
☐ Easy-Going
☐ Slow to Warm

Please describe: _____
_____

Did you experience any developmental delays or problems? ☐ No ☐ Yes

Describe: _____
_____
_____

At what age did you first smile? _____ Walk alone? _____
Say your first word? _____ Speak in sentences? _____
At what age was bowel training complete? _____ Urinary training? _____
Was there any difficulty in training? ☐ No ☐ Yes - Describe: _____
Any past or present problems in bowel or urinary control? ☐ No ☐ Yes - Describe: _____
_____

**EARLY CHILDHOOD**

Did you experience any difficulties with expressing your emotions in childhood? ☐ No ☐ Yes
Describe: _____

Did it take a long time for you to warm up to new situations or new people? ☐ No ☐ Yes
Describe: _____

Did you react *strongly/not at all* to physical pain? ☐ No ☐ Yes
(circle one, if applicable)
Describe: _____

Did you react strongly to other things? ☐ No ☐ Yes Explain: _____

**EARLY SOCIALIZATION:**

Describe your early socialization skills with others within and outside the home: _____
_____
_____

What parenting strategy/style was implemented at home (i.e. Time-Out, Positive Reinforcement, etc.)
Describe: _____
_____
_____

# EDUCATIONAL AND CULTURAL HISTORY

What is your primary language?: _____

What is your cultural or ethnic background?: _____

What is the highest grade you completed in school?: _____

- ➔ What was your GPA when you graduated from high school?: _____

Have you completed any additional degrees (e.g. A.A., B.S., Master's, PhD, MD, etc.)? ☐ No ☐ Yes
If yes, please describe: _____
_____

- ➔ What was your GPA in college?: _____
- ➔ What was your GPA in graduate school?: _____

Any history of disciplinary action in school?: ☐ No ☐ Yes
If yes, please describe: _____
_____
_____

# CURRENT SOCIAL HISTORY

List all individuals currently living with you. Specify relationship (e.g. spouse, friend, sibling [full, half, step, foster], other)

| First & Last Name | Sex | Age | School Grade / Occupation | Relationship to Patient |
|---|---|---|---|---|
| | | | | |
| | | | | |
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Any significant life transitions within the home or environment? ☐ No ☐ Yes
If yes, please describe: _____

Are you currently involved in any litigation? ☐ No ☐ Yes
If yes, please describe: _____

Do any of the following problems apply to your current living situation?

| | |
|---|---|
| Marital or relationship problems | ☐ No ☐ Yes |
| Problems with other persons living at home | ☐ No ☐ Yes |
| Problems with present living situation/housing | ☐ No ☐ Yes |
| Recent major changes or stressors in the living situation or family | ☐ No ☐ Yes |
| Violence in the home or neighborhood | ☐ No ☐ Yes |
| Alcohol or drug problems in the home or neighborhood | ☐ No ☐ Yes |
| Other problems, such as legal issues, financial strain, etc. | ☐ No ☐ Yes |

If yes to any of the above, please describe:

_____

_____

Please describe your typical day:

_____

_____

What sorts of hobbies do you enjoy? _____

Are there any other factors in your current social/living situation that you would like to discuss?

_____

_____

_____

## ASRS Symptom Checklist

| Name: | 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 |
|---|---|---|---|---|---|
| Part A | | | | | |
| 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 B | | | | | |
| 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? | | | | | |

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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 | 0 | 1 | 2 | 3 |

add columns _____ + _____ + _____

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).* TOTAL: _____

| | |
|---|---|
| **10.** 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 _____<br>Somewhat difficult _____<br>Very difficult _____<br>Extremely difficult _____ |



A2663B 10-04-2005

# Generalized Anxiety Disorder 7-item (GAD-7) scale

| Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all sure | Several days | Over 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's 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 |
| *Add the score for each column* | + | + | + | |
| Total Score *(add your column scores)* = | | | | |

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.