East End Neuropsychiatry Associates

Please fill out both sides prior to seeing your provider today

Name: **Date:** **Completed By:**

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

TOTAL SCORE______ CLINICIAN SIG_______________

Please note that it is the policy of this office that no controlled substance will be provided without a monthly face to face appointment with your provider NO EXEPTIONS

You will be asked to fill this form out at each visit

East End Neuropsychiatry Associates

Please fill out both sides prior to seeing your provider today

Since your last visit has your insurance changed? **YES NO**

Have you changed Primary Care Providers since your last visit, if so to whom? **YES NO**

NEW PROVIDER NAME AND PHONE NUMBER

Have you been hospitalized or in the emergency room since your last visit to this office?

WHY? **YES NO**

Have your gained or lost more than 5lbs since your last visit to this office? **YES NO**

Current smoking status: ***Current Smoker / Quit More Than 1 Year Ago / Non Smoker / Occasional Smoker***

Would you like to speak to your provider about Alcohol or Drug use today? **YES NO**

Do you currently drive a vehicle? **YES NO**

Would you like to talk to your provider today about your sleep? **YES NO**

Would you like to talk to your provider today about diet management? **YES NO**

Have you been consistently taking your medication as prescribed by your provider? **YES NO**

Would you like to talk to your provider today about your plan of care? **YES NO**

Are you concerned about the cost of your medications at this time? **YES NO**

Do you feel safe and well cared for in your home? **YES NO**

Do you have concerns about abuse or maltreatment? **YES NO**

Are our facilities clean, neat, organized and accessible to you? **YES NO**

Would you like to talk about end of life care, DNR or Power of Attorney today? **YES NO**

COMMENTS OR CONCERNS YOU WOULD LIKE YOUR PROVIDER TO KNOW TODAY:

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