PATIENT CONSENT FOR COORDINATION OF CARE

Please let us know if you have more than one provider and will need an extra form.

Patient Name: _____

Physician's Name: _____ Phone: _____

Address: _____

We hope that the following information will be helpful in the coordinating of this patient's care.

Date of initial consultation: _____ Referred by: _____

Diagnosis and/or presenting problems: _____

_____

_____

Treatment Recommendations: _____

_____

_____

Medications: _____

_____

_____ _____

Provider Signature Date

Patient Authorization

I, _____ , hereby authorize AIM Behavioral Health Specialists to communicate the following information with my above named provider.

Please check one of the following:

☐ To release any applicable mental health information to the provider named above.

☐ To release any applicable mental health information to the provider named above.

☐ To release any applicable substance abuse information to the provider named above.

☐ To release ONLY medication information to the prover named above.

☐ NOT to release any information to the provider 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 one (1) year after I have terminated treatment.

_____ _____

Print Name of Patient/Guardian Patient Date of Birth

_____ _____

Signature of Patient/Guardian Date

AIM Behavioral Health Specialists

CLIENT BACKGROUP INFORMATION

Client: _____ Date: _____

What are your goals for treatment? _____

_____

What medicines or supplements do you routinely take? _____

Allergies _____ Medication allergies _____

Do you enjoy work/school? _____ Comments _____

_____

If married, how long? _____ Children/Step children, sexes and ages _____

_____

Do you use tobacco? _____ How much? _____ Caffeine? _____ How much? _____

Do you use alcohol? _____ How much? _____ Do you use drugs? (other than

prescribed) _____ How much? _____

What are your hobbies or interest? _____

What do you see as your strengths? _____

What are the things that you feel need to change about yourself? _____

_____

In your opinion how can I best help you? _____

_____

_____

You may use the back of this form to provide additional information that you;think might be helpful to your case.

Signed: _____

Client or Parent/Guardian

AIM Behavioral Health Specialists

REVIEW OF SYSTEMS

Please list any illnesses, injuries, accidents, hospitalizations or conditions pertaining to the organ systems listed below.

Skin _____

Head, Eyes, Ears, Nose and Throat _____

Allergies or Immune System _____

Lungs or Respiratory _____

Heart or Circulatory System _____

Esophagus, Stomach or Intestines _____

Liver, Spleen, Pancreas or Gallbladder _____

Breasts _____

Reproductive Organs _____

Bladder, Kidneys and Prostate _____

Endocrine System (Glandular) _____

Bones and Muscles _____

Nerves, Brain or Mental System _____

Do you exercise regularly? _____ Alcohol, Cigarettes or Drug Abuse (if yes, describe) _____

_____

Significant Family History _____

_____

Primary Care Provider Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Any additional comments that you may wish to express regarding your state of health _____

_____

Signed _____ Date _____

Client or Parent/Guardian

BRIEF PATIENT HEALTH QUESTIONNAIRE (Brief PHQ)

Name _____ Age _____ Sex: ❑ Female ❑ Male Today's Date _____

1. 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
a. Little interest or pleasure in doing things	❑	❑	❑	❑
b. Feeling down, depressed, or hopeless	❑	❑	❑	❑
c. Trouble falling or staying asleep, or sleeping too much	❑	❑	❑	❑
d. Feeling tired or having little energy	❑	❑	❑	❑
e. Poor appetite or overeating	❑	❑	❑	❑
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	❑	❑	❑	❑
g. Trouble concentrating on things, such as reading the newspaper or watching television	❑	❑	❑	❑
h. 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.	❑	❑	❑	❑
i. Thoughts that you would be better off dead, or of hurting yourself in some way	❑	❑	❑	❑

2. Questions about anxiety.

	No	Yes
a. In the last 4 weeks, have you had an anxiety attack – suddenly feeling fear or panic?	❑	❑
If you checked "NO", go to question 3.		
b. Has this ever happened before?	❑	❑
c. Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?	❑	❑
d. Do these attacks bother you a lot or are you worried about having another attack?	❑	❑
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	❑	❑

3. If you checked off any 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?

❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

Instructions: Indicate how much you have been bothered by each symptom during the past week, including today. Circle the number in the column that most closely corresponds to how you have been feeling.

	Not At All	Mildly It did not bother me much.	Moderately It was very unpleasant but I could stand it.	Severely I could barely stand it.
❑ Numbness or tingling	0	1	2	3
❑ Feeling hot	0	1	2	3
❑ Wobbliness in legs	0	1	2	3
❑ Unable to relax	0	1	2	3
❑ Fear of the worst happening	0	1	2	3
❑ Dizzy or light headed	0	1	2	3
❑ Heart pounding or racing	0	1	2	3
❑ Unsteady	0	1	2	3
❑ Terrified	0	1	2	3
❑ Nervous	0	1	2	3
❑ Feelings of choking	0	1	2	3
❑ Hands Trembling	0	1	2	3
❑ Shaky	0	1	2	3
❑ Fear of losing control	0	1	2	3
❑ Difficulty breathing	0	1	2	3
❑ Fear of dying	0	1	2	3
❑ Scared	0	1	2	3
❑ Indigestion or discomfort in abdomen	0	1	2	3
❑ Faint	0	1	2	3
❑ Face flushed	0	1	2	3
❑ Sweating (not due to heat)	0	1	2	3
			Total Score	_____

Fatigue Severity Scale (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.

- It is important that you circle a number (1 to 7) for every question.

FSS Questionnaire							
During the past week, I have found that:	**Disagree <--------> Agree**						
My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
Exercise brings on my fatigue.	1	2	3	4	5	6	7
I am easily fatigued.	1	2	3	4	5	6	7
Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7
	Total Score:						

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your level of fatigue. It's simple: Add all the numbers you circled to get your total score.

The Fatigue Severity Scale Key

A total score of less than 36 suggests that you may not be suffering from fatigue.

A total score of 36 or more suggests that you may need further evaluation by a physician.

Your next steps

This scale should not be used to make your own diagnosis.

If your score is 36 or more, please share this information with your physician. Be sure to describe all your symptoms as clearly as possible to aid in your diagnosis and treatment.

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing
It is important that you circle a number (0 to 3) on each of the questions.

Situation	Chance of dozing (0-3)
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place–for example, a theater or meeting	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3
	Total Score:

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your own level of daytime sleepiness. It's simple. Just add up the numbers you put in each box to get your total score.

The Epworth Sleepiness Scale key

A total score of less than 10 suggests that you may not be suffering from excessive daytime sleepiness.

A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Your next steps

This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all your symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

Liebowitz Social Anxiety Scale (LSAS-SR)

Name _____ Date _____

Fill out the following questionnaire with the most suitable answer listed below. Base your answers on your experience in the past week and, if you have completed the scale previously, be as consistent as possible in your perception of the situation described. Be sure to answer all items.

Fear or Anxiety	Avoidance
0 = None	0 = Never (0%)
1 = Mild	1 = Occasionally (1%-33% of the time)
2 = Moderate	2 = Often (33%-67% of the time)
3 = Severe	3 = Usually (67%-100% of the time)

Understanding the situations:	FEAR OR ANXIETY	AVOIDANCE
1. **Telephoning in public** - speaking on the telephone in a public place		
2. **Participating in small groups** - having a discussion with a few others		
3. **Eating in public places** - do you tremble or feel awkward handling food		
4. **Drinking with others in public places** - refers to any beverage including alcohol		
5. **Talking to people in authority** - for example, a boss or teacher		
6. **Acting, performing or giving a talk in front of an audience** - refers to a large audience		
7. **Going to a party** - an average party to which you may be invited; assume you know some but not all people at the party		
8. **Working while being observed** - any type of work you might do including school work or housework		
9. **Writing while being observed** - for example, signing a check in a bank		
10. **Calling someone you don't know very well**		
11. **Talking with people you don't know very well**		
12. **Meeting strangers** - assume others are of average importance to you		
13. **Urinating in a public bathroom** - assume that others are sometimes present, as might normally be expected		
14. **Entering a room when others are already seated** - refers to a small group, and nobody has to move seats for you		
15. **Being the center of attention** - telling a story to a group of people		
16. **Speaking up at a meeting** - speaking from your seat in a small meeting or standing up in place in a large meeting		
17. **Taking a written test**		
18. **Expressing appropriate disagreement or disapproval to people you don't know very well**		
19. **Looking at people you don't know very well in the eyes** - refers to appropriate eye contact		
20. **Giving a report to a group** - refers to an oral report to a small group		
21. **Trying to pick up someone** - refers to a single person attempting to initiate a relationship with a stranger		
22. **Returning goods to a store where returns are normally accepted**		
23. **Giving an average party**		
24. **Resisting a high pressure salesperson** - avoidance refers to listening to the salesperson for too long		