Stony Brook Medicine

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ADMISSIONS REVIEW OF SYSTEMS

PATIENT NAME: _____ DATE: _____ DOB: _____

PCP: _____ THERAPIST NAME: _____

OB/GYN: _____ PHARMACY / TOWN: _____

MARITAL STATUS: SINGLE □ MARRIED □ DIVORCED □ WIDOW □ OTHER □

HOW MUCH DO YOU SMOKE PER DAY? _____ □ NONE

HOW MUCH ALCOHOL DO YOU DRINK PER WEEK? _____ □ NONE

HOW MANY CUPS OF CAFFEINE A DAY (COFFEE, TEA, SODA W/ CAFFEINE) _____ □ NONE

ALLERGIES TO MEDICATIONS: (STATE DRUGS AND THEIR REACTIONS) □ NONE

_____

OTHER ALLERGIES: (LATEX / FOOD) □ NONE

_____

SURGERIES: (LIST TYPE OF SURGERY, (YEAR PERFORMED OR YOUR AGE AT THE TIME OF SURGERY)
□ NONE

_____

HOSPITALIZATIONS:

_____ □ NONE

_____

CURRENT WEIGHT: _____ HEIGHT: _____

MEDICATIONS OR SUPPLEMENTS YOU TAKE REGULARLY (INCLUDE DOSAGE IF YOU RECALL) □ NONE

_____

FAMILY MEDICAL HISTORY:

	AGE	DISEASES	PSYCHIATRIC HISTORY	IF DECEASED, CAUSE OF DEATH
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
SIBLINGS	_____	_____	_____	_____
	_____	_____	_____	_____
CHILDREN	_____	_____	_____	_____
	_____	_____	_____	_____

PATIENTS NAME _____

OTHER SYMPTOMS OR AREAS OF YOUR BODY THAT ARE BOTHERING YOU:

Neuro	**None ☐**	**Psychiatric**	**None ☐**	**Eyes**	**None ☐**
☐ Headache		☐ Depression		☐ Visual Problems	
☐ Convulsions		☐ Anxiety		☐ Blurry Vision	
☐ Seizures		☐ Stress/Excess Worry		☐ Red Eyes	
☐ Fainting		☐ Drug/Alcohol Issues		☐ Other: _____	
☐ A.D.D.		☐ Other: _____			
☐ Stroke					
☐ Hypertension					
☐ Other: _____					
Nose	**None ☐**	**Throat**	**None ☐**	**Mouth**	**None ☐**
☐ Nasal Allergies		☐ Swallowing Difficulty		☐ Dental Problems	
☐ Nose Bleeds		☐ Frequent Sore Throats		☐ Tongue Problems	
☐ Other: _____		☐ Speech Problems		☐ Canker Sores	
		☐ Other: _____		☐ Other :_____	
Neck	**None ☐**	**Chest**	**None ☐**	**Heart**	**None ☐**
☐ Swollen Glands		☐ Chest Pain		☐ Murmurs	
☐ Thyroid Problems		☐ Asthma		☐ Palpitations	
☐ Other: _____		☐ Shortness of Breath		☐ Valve Problems	
		☐ Cough		☐ Mitral Valve Prolapse	
		☐ T.B.		☐ Angina	
		☐ Other: _____		☐ Other: _____	
Intestinal	**None ☐**	**Urinary**	**None ☐**	**Genital**	**None ☐**
☐ Colitis		☐ Urinary Problems		☐ Infection	
☐ Ulcer Gastritis		☐ Urinary Frequency		☐ Warts	
☐ Barrett's Esophagus		☐ Burning		☐ Herpes	
☐ Polyps		☐ Kidney Stones		☐ Impotence	
☐ Constipation		☐ Other: _____		☐ Sexual Difficulty	
☐ Other: _____				☐ Other: _____	
Upper Extremity	**None ☐**	**Lower Extremity**	**None ☐**	**Spine**	**None ☐**
☐ Pain in Arm		☐ Pain in Legs		☐ Low Back Pain	
☐ Carpal Tunnel		☐ Knee Pain		☐ Neck Pain	
☐ Shoulder Pain		☐ Hip Pain		☐ Mid Back Pain	
☐ Elbow Pain		☐ Ankle Pain		☐ Scoliosis	
☐ Wrist Pain		☐ Tingling		☐ Herniated Disc	
☐ Other: _____		☐ Other: _____		☐ Sciatica	
				☐ Other: _____	
Systemic	**None ☐**				
☐ Weight Loss		☐ Night Sweats		☐ Loss of Energy	
☐ Fever		☐ Trouble Sleeping		☐ Arthritis	
☐ Other: _____					

ANY OTHER HEALTH ISSUES NOT MENTIONED ABOVE?

_____
_____
_____
_____

THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR'S OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

_____ _____
SIGNATURE OF CLINICIAN DATE

MEDICATION AND CONTROLLED SUBSTANCES AGREEMENT WITH ALL ISLAND BEHAVIORAL HEALTH

I will take my medication(s) at the dose and frequency prescribed. I will not add or decrease the dose of my prescription(s) without discussing this first with my provider.

I will comply with scheduled appointments. If I know in advance that I am unable to keep a scheduled appointment, I will arrange to reschedule in advance.

I understand there is a fee for a missed appointment.

Should I miss a medication management appointment, my provider may decide not to refill my prescription(s) until I can be seen. In some cases, this could mean being without medication until the next visit.

My provider will be the only person prescribing psychotropic medication for me. I agree not to ask for psychotropic medication from another provider without my provider's knowledge.

I will not request controlled substances from another provider that are prescribed to me by my provider.
I am aware that non-prescribed drugs such as illegal drugs, marijuana, or alcohol are not recommended to be used with psychiatric medications.

I will inform my provider if I am prescribed a pain medication or other controlled substance by another physician. I will consent to random drug testing.

Positive tests for illegal substances or misuse of controlled substances (benzodiazepines, opiates, etc.) will result in immediate discharge from the practice and a referral to a more appropriate program or level of care.

Prescriptions will not be filled early if they are lost, stolen, or destroyed. I agree to protect my medication(s).

This agreement will be placed in my medical record.

I have read and understand the above guidelines.

For women of child bearing age, it may not be safe to take the prescribed medication if you become pregnant. If at any time you are considering pregnancy, or become pregnant, please inform us immediately.

It is understandable that emergencies can occur, and in such occurrences, exceptions to the above guidelines may be made on an individual basis.

_____ _____

Signature of Patient Date Signed

_____ _____

Signature of Provider Date Signed

All Island Behavioral Health - Informed Consent for Treatment

I give consent for evaluation and treatment to be provided to me or my dependent child by:

☐ Filomena Buncke, PhD, NP, BC
☐ Kathleen Bowen, PMHNP-BC
☐ Kimberly Buncke, PMHNP-BC
☐ Jill Bruning Hindes, MS, PMHNP-BC

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly,
- Obtain payment from third party payers,
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I am aware that the practice of psychotherapy/psychopharmacology is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment. The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

I understand that I may terminate treatment at any time.

My signature below indicates that I understand and agree with all of the above statements, and that I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

_____ _____
Signature of Patient or Parent/Guardian Date

_____
Printed Name

_____
Relationship to Patient (if applicable)

_____ _____
Witness Signature Date

PATIENT: _____ DATE: _____

LABORATORY & PATHOLOGY SERVICES CONSENT FORM

Please be sure to use an in-network lab or pathologist because using an out-of-network lab or pathologist will result in higher out-of-pocket costs.

You are being asked to sign this consent form because the provider requires lab results for one of the reasons reflected below. The provider will indicate the reason at the time of the visit by placing a check mark next to the reason.

☐ One-time testing

☐ Ongoing monitoring (standard order or custom profile testing; valid for one year from signature date below)

If you are not certain which labs and pathologists are in-network, please call your insurance carrier or visit your insurance carrier's website.

Your insurance carrier requires that you select one of the following choices below by placing a check mark next to the choice:

☐ I will use an **in-network** lab or pathologist

☐ I will use an **out-of-network** lab or pathologist. I am aware that I will be responsible for a higher cost share or the entire cost of the lab or pathology services if I use an out-of-network lab or pathologist. I understand that out-of-network labs and pathologists are usually prohibited from waiving member cost share amounts.

Please sign below where indicated.

_____ _____

PATIENT'S SIGNATURE DATE SIGNED

_____ _____

PROVIDER'S SIGNATURE DATE SIGNED

SR:08/08/16

All Island Behavioral Health

Statements of Member's Rights

Members have the right to be treated with dignity and respect.

Members have the right to fair treatment; regardless of their race, religion, gender, ethnicity, age, disability or source of payment.

Members have the right to have their treatment and other member information kept private. Only where permitted by law, may records be release without member permission.

Members have the right to easily access timely care in a timely fashion.

Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.

Members have the right to share in developing their plan of care.

Members have the right to have a clear explanation of their condition and treatment options.

Members have the right to information about their insurance company, its practitioners, services and role in the treatment process.

Members have the right to information about clinical guidelines used in providing and managing their care.

Members have the right to ask their provider about their work history and training.

Members have the right to give input on the Member's Rights and Responsibilities policy.

Members have the right to know about advocacy and community groups and prevention services.

Members have a right to freely file a complaint or appeal and to learn how to do so.

Members have the right to know of their rights and responsibilities in the treatment process.

Members have the right to receive services that will not jeopardize their employment.

Members have the right to list certain preferences in a provider.

Statement of Member's Responsibilities

Members have the responsibility to treat those giving them care with dignity and respect.

Members have the responsibility to give providers information they need. This is so providers can deliver the best possible case.

Members have the responsibilities to ask questions about their care. This is to help them understand their care.

Members have the responsibility to follow the treatment plan. The plan of care is to be agreed upon by the member and provider.

Members have the responsibility to follow the agreed upon medication plan.

Members have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others.

Members have the responsibility to keep their appointments. Members should call the providers as soon as they know they need to cancel visits.

Members have the responsibility to let their providers know when the treatment plan isn't working for them.

Members have the responsibility to let their provider know about any problems with paying fees.

Members have the responsibility to report abuse and fraud.

Members have the responsibility to openly report concerns about the quality of care they receive.

Patient Name: _____

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Member Signature Date:

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

Clinician Signature Date:

Revised 10/29/2019

PATIENT:_____ DATE:_____

SCREENING | Drug Abuse Screening Test (DAST-10)

Using drugs can affect your health and some medications you may take. ***Please help us provide you with the best medical care by answering the questions below.***

Drugs include marijuana, solvents like paint thinners, tranquilizers like Valium, barbiturates, cocaine, stimulants like speed, hallucinogens such as LSD, or narcotics like heroin. Drug use also includes using prescription or over-the-counter medications more than directed.

In the past 12 months….	**YES**	**NO**
DA1. Have you used drugs other than those required for medical reasons?		
DA2. Do you abuse more than one drug at a time?		
DA3. Are you unable to stop using drugs when you want to?		
DA4. Have you ever had blackouts or flashbacks as a result of drug use?		
DA5. Do you ever feel bad or guilty about your drug use?		
DA6. Does your spouse (or parents) ever complain about your involvement with drugs?		
DA7. Have you neglected your family because of your use of drugs?		
DA8. Have you engaged in illegal activities in order to obtain drugs?		
DA9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
DA10. Have you had medical problems as a result of your drug use (such as: memory loss, hepatitis, convulsions, or bleeding)?		
Score 1 point for each question answered “Yes”. **TOTAL**		

DAST-10 SCORES AND ZONES

SCORE	RISK LEVEL	INTERVENTION
0	Zone 1: **No Risk**	Simple advice: Congratulations this means you are abstaining from excessive use of prescribed or over-the-counter medications, illegal or non-medical drugs.
1 - 2	Zone 2: At Risk Use - "low level" of problem drug use	Brief Intervention (BI). You are at risk. Even though you may not be currently suffering or causing harm to yourself or others, you are at risk of chronic health or behavior problems because of using drugs or medications in excess.
3 - 5	Zone 3: "intermediate level"	Extended BI (EBI) and RT – your score indicates you are at an "intermediate level" of problem drug use. Talk with a professional and find out what services are available to help you to decide what approach is best to help you to effectively change this pattern of behavior.
6 - 10	Zone 4: Very High Risk, Probable Substance Use Disorder	EBI/RT – considered to be at a "substantial to severe level" of problem drug use. Refer to specialist for diagnostic evaluation and treatment.

SR:7/19/16

PATIENT: _____ DATE: _____

Responses**:** From 0 (normal) to 6 (severe depression); statements are provided for 0, 2, 4, 6; 1, 3, 5 are scored as in-between values.

[1] APPARENT SADNESS: Despondency, gloom, and despair that is more than just ordinary transient low spirits

Response	**Points**
No Sadness.	0
Looks dispirited but does brighten up without difficulty.	2
Appears sad and unhappy most of the time.	4
Looks miserable all the time; extremely despondent.	6

[2] REPORTED SADNESS: Reports of depressed mood regardless of whether it is reflected in appearance. This includes low spirits, despondency, or the feeling of being beyond help and without hope. Rate according to intensity, duration, and the extent to which the mood is reported to be influenced by events.

Response	**Points**
Occasional sadness in keeping with the circumstances.	0
Sad or low but brightens up without difficulty.	2
Pervasive feelings of sadness or gloominess. The mood is still influenced by external circumstances.	4
Continuous or unvarying sadness, misery, or despondency.	6

[3] INNER TENSION: Feelings of ill-defined discomfort, edginess, inner turmoil, or mental tension mounting to panic, dread, or anguish. Rate according to intensity, frequency, duration, and the extent of reassurance called for.

Response	**Points**
Placid with only fleeting inner tension.	0
Occasional feelings of edginess and ill-defined discomfort.	2
Continuous feelings of inner tension or intermittent panic that the patient can only master with some difficulty.	4
Unrelenting dread or anguish; overwhelming panic.	6

[4] REDUCED SLEEP: Reduced duration or depth of sleep compared with the subject's own normal pattern when well.

Response	**Points**
Sleeps as usual.	0
Slight difficulty dropping off to sleep; slightly reduced, light, or fitful sleep.	2
Sleep reduced or broken by at least 2 hours.	4
Less than 2 – 3 hours of sleep.	6

[5] REDUCED APPETITE: Loss of appetite compared with when well. There may be a loss of desire for food or the need to force oneself to eat.

Response	**Points**
Normal or increased appetite.	0
Slightly reduced appetite.	2
No appetite and food is tasteless.	4
Needs persuasion to eat at all.	6

PATIENT: _____ DATE: _____

[6] CONCENTRATION DIFFICULTIES: Difficulties in collecting one's thoughts, mounting to an incapacitating lack of concentration. This is rated according to the intensity, frequency, and degree of incapacity produced.

Response	Points
No difficulties in concentrating.	0
Occasional difficulties in collecting one's thoughts.	2
Difficulties in concentrating and sustaining thought, which reduces the ability to read or hold a conversation.	4
Unable to read or converse without great difficulty.	6

[7] LASSITUDE: Difficulty in getting started; slowness in initiating and performing everyday activities.

Response	Points
Hardly any difficulty in getting started; no sluggishness.	0
Difficulties in starting activities.	2
Difficulties in starting simple routine activities, which are carried out with effort.	4
Complete lassitude; unable to do anything without help.	6

[8] INABILITY TO FEEL: Reduced interest in surroundings or in activities that normally give pleasure. The ability to react with adequate emotion to circumstances is reduced.

Response	Points
Normal interest in surroundings and other people.	0
Reduced ability to enjoy usual interests.	2
Loss of interest in surroundings; loss of feelings for friends and acquaintances.	4
Emotionally paralyzed; unable to feel anger, grief, or pleasure; complete or even painful failure to feel for close relatives and friends.	6

[9] PESSIMISTIC THOUGHTS: Feelings of guilt, inferiority, self-reproach, sinfulness, remorse, or ruin.

Response	Points
None	0
Fluctuating ideas of failure, self-reproach, or self-depreciation.	2
Persistent self-accusation or definite but still rational ideas of guilt or sin; increasingly pessimistic about the future.	4
Delusions of ruin, remorse, or unredeemable sin; self-accusations that are absurd and unshakable.	6

[10] SUICIDAL THOUGHTS: Feeling that life is not worth living and/or that a natural death would be welcome; presence of suicidal thoughts and the making for preparations for suicide.

Response	Points
Enjoys life or takes it as it comes.	0
Weary of life; only fleeting suicidal thoughts.	2
Probably better off dead; suicidal thoughts common and suicide is considered as a possible solution but without specific plans or intentions.	4
Explicit plans for suicide when there is an opportunity; active preparations for suicide.	6

TOTAL SCORE ____ 0-6: Absence of symptoms;7-19: Mild Depression;20-34: Moderate depression;35-60: Severe depression.

PATIENT:_____ DATE:_____

FAGERSTROM TEST FOR NICOTINE DEPENDENCE

1. How soon after you wake up do you smoke your first cigarette?

☐ After 60 minutes (0)

☐ 31-60 minutes (1)

☐ 6-30 minutes (2)

☐ Within 5 minutes (3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden?

☐ No (0)

☐ Yes (1)

3. Which cigarette would you hate most to give up?

☐ The first in the morning (1)

☐ Any other (0)

4. How many cigarettes per day do you smoke?

☐ 10 or less (0)

☐ 11-20 (1)

☐ 21-30 (2)

☐ 31 or more (3)

5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?

☐ No (0)

☐ Yes (1)

6. Do you smoke even if you are so ill that you are in bed most of the day?

☐ No (0)

☐ Yes (1)

SCORING

0-2 Very low dependence
3-4 Low dependence
6-7 High dependence
8-10 Very high dependence

My Score is: _____

My level of dependence on nicotine is: _____

SR: 7/2016

PATIENT:_____ DATE:_____

The AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each of the following questions.

QUESTIONS	0	1	2	3	4	*SCORE*
1. How often do you have a drink containing alcohol?	*(Never)*	*(Monthly or less)*	*(2-4 times a month)*	*(2-3 times a week)*	*(4 or more times a week)*	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	*(1 or 2)*	*(3 or 4)*	*(5 or 6)*	*(7 or 9)*	*(10 or more)*	
3. How often do you have 5 or more drinks on one occasion?	*(Never)*	*(Less than monthly)*	*(Monthly)*	*(Weekly)*	*(Daily or almost daily)*	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	*(Never)*	*(Less than monthly)*	*(Monthly)*	*(Weekly)*	*(Daily or almost daily)*	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	*(Never)*	*(Less than monthly)*	*(Monthly)*	*(Weekly)*	*(Daily or almost daily)*	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	*(Never)*	*(Less than monthly)*	*(Monthly)*	*(Weekly)*	*(Daily or almost daily)*	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	*(Never)*	*(Less than monthly)*	*(Monthly)*	*(Weekly)*	*(Daily or almost daily)*	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	*(Never)*	*(Less than monthly)*	*(Monthly)*	*(Weekly)*	*(Daily or almost daily)*	
9. Have you or someone else been injured because of your drinking?	*(No)*		*(Yes, but not in last year)*		*(Yes, during the last year)*	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	*(No)*		*(Yes, but not in last year)*		*(Yes, during the last year)*	
					TOTAL	

AUDIT SCORES AND ZONES

SCORE	RISK	INTERVENTION
0 - 7	Zone 1: Low Risk Use	Alcohol education to support low-risk use - provide brief advice
8 - 15	Zone 2: At Risk Use	Brief Intervention (BI), provide advice focused on reducing hazardous drinking
16 - 19	Zone 3: High Risk Use	**BI/EDI** - Brief Intervention and/or Extended Brief Intervention with possible referral to treatment
20 - 40	Zone 4: Very High Risk, Probable Substance Use Disorder	Refer to specialist for diagnostic evaluation and treatment

SR:7/19/16

Zung Self-rating Anxiety Scale

Name: _____ Date: _____

Listed below are 20 statements. Please read each one carefully and decide how much the statement describes how you have been feeling **during the past week**. Circle the appropriate number for each statement.

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. I feel more nervous and anxious than usual.	1	2	3	4
2. I feel afraid for no reason at all.	1	2	3	4
3. I get upset easily or feel panicky.	1	2	3	4
4. I feel like I'm falling apart and going to pieces.	1	2	3	4
5. I feel that everything is all right and nothing bad will happen.	4	3	2	1
6. My arms and legs shake and tremble.	1	2	3	4
7. I am bothered by headaches, neck and back pains.	1	2	3	4
8. I feel weak and get tired easily.	1	2	3	4
9. I feel calm and can sit still easily.	4	3	2	1
10. I can feel my heart beating fast.	1	2	3	4
11. I am bothered by dizzy spells.	1	2	3	4
12. I have fainting spells or feel faint.	1	2	3	4
13. I can breathe in and out easily.	4	3	2	1
14. I get feelings of numbness and tingling in my fingers and toes.	1	2	3	4
15. I am bothered by stomachaches or indigestion.	1	2	3	4
16. I have to empty my bladder often.	1	2	3	4
17. My hands are usually dry and warm.	4	3	2	1
18. My face gets hot and blushes.	1	2	3	4
19. I fall asleep easily and get a good night's rest.	4	3	2	1
20. I have nightmares.	1	2	3	4

Score Total*: _____

*Score is for healthcare provider interpretation.

Adapted from Zung WWK. A rating instrument for anxiety. *Psychosomatics*. 1971;XII:371-379.

This instrument is designed for screening purposes only and is not to be used as a diagnostic tool.

How to Use

Patients will circle 1 of the 4 numbers in response to the questions. The healthcare provider, nurse, or medical staff assistant then scores the completed questionnaire and interprets the score using the information found in the box at right.

How to Score

Check that all statements have been answered. Add up the values for each response to get the Score Total.

Interpreting the Score
A Score Total of 36 and over suggests the need for further medical assessment of GAD.