Williamsville Psychiatry PLLC

5904 Sheridan Drive, Williamsville, NY 14221 • P (716) 886-5493 • F (716) 886-5835

Patient Name: _____ Date of Birth: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Social Security Number: _____ Gender: ____Male ____Female _____Other

Marital Status: ____Single ____Married ____Divorced ____Widowed ____Other_____

Email address: _____

Employer / School: _____

Name of Parent/Guardian (if applicable): _____

Emergency Contact Name:_____ Phone#: _____

Relationship to Patient: _____

Primary Physician: _____ Phone#: _____

Address: _____

City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone#: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance: _____ ID#: _____

Subscriber: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____

Secondary Insurance: _____ ID#: _____

Subscriber: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____

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Please circle any of the following medications that you have previously tried. If possible, please add at what doses you tried the medication(s) and any side effects or adverse effects.

SSRIs

Zoloft / Sertraline

Prozac / Fluoxetine

Paxil / Paroxetine

Lexapro / Escitalopram

Celexa / Citalopram

Desyrel / Trazodone

Luvox / Fluvoxamine

Remeron / Mirtazapine

Viibryd

Brintellix

SNRIs

Effexor (XR) / Venlafaxine (ER)

Cymbalta / Duloxetine

Pristiq

Fetzima

Strattera

OTHER ANTIDEPRESSANTS

Wellbutrin(XL/SR/IR)/Buroprion

EMSAM / Selegiline

Elavil / Amitriptyline

Anafranil / Clomipramine

Tofranil / Imipramine

Pamelor / Nortriptyline

Norpramin / Desipramine

Sinequan / Doxepine

MOOD STABILIZERS

Lamictal / Lamotrigine

Depakote (ER) / Valproic Acid

Trileptal / Oxcarbazapine

Tegretol / Carbamazepine

Topamax / Topiramate

Zonegran / Zonisamide

Lithium

Abilify / Abilify Maintena

Geodon / Ziprasidone

Risperdal / Risperidone

Seroquel (XR) / Quetiapine

Zyprexa / Olanzapine

Zyprexa Relprevv

Invega

Saphris

Fanapt

Latuda

Rexulti

Clozaril / Clozapine

Thorazine / Chlorpromazine

Haldol / Haloperidol

Prolixin / Fluphenazine

Trilafon / Perphenazine

Mellaril / Thioridazine

Navane / Thiothixene

STIMULANTS

Adderall (XR) / Amphetamine

Dextroamphetamine

Ritalin / Methylphenidate

Concerta

Vyvanse

Focalin (XR)

Evekeo

OTHER

Ambien / Zolpidem

Sonata

Lunesta

Provigil / Modafinil

Nuvigil / Armodafinil

Xanax (XR) / Alprazolam

Ativan / Lorazapam

Valium / Diazepam

Klonopin / Clonazepam

Buspar / Buspirone

Vistaril / Hydroxyzine

Neurontin / Gabepentin

Lyrica

Horizant

Inderal / Propranolol

I acknowledge that the above information is correct and co-relates with my psychiatric history.

_____ _____

Print Name Signature

Patient Name _____

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Main reason for seeking help at this time: _____

_____

_____

CURRENT SYMPTOMS

Describe your current symptoms in your own words:

Please check all that apply:

Sadness	☐ YES ☐ NO	Lack of Sleep	☐ YES ☐ NO	Anger	☐ YES ☐ NO	Panic	☐ YES ☐ NO
Fatigue	☐ YES ☐ NO	Low Energy	☐ YES ☐ NO	High Energy	☐ YES ☐ NO	Worry	☐ YES ☐ NO
Tearfulness	☐ YES ☐ NO	Slowed Thinking	☐ YES ☐ NO	Fast Thinking	☐ YES ☐ NO	Social Withdrawal	☐ YES ☐ NO
Lack of Interest	☐ YES ☐ NO	Impulsivity	☐ YES ☐ NO	Paranoia	☐ YES ☐ NO	More than Usual Sleep	☐ YES ☐ NO
High Motivation	☐ YES ☐ NO	Forgetfulness	☐ YES ☐ NO	Low Motivation	☐ YES ☐ NO	Helpless	☐ YES ☐ NO
Poor Organization	☐ YES ☐ NO	Short-Temper	☐ YES ☐ NO	Hopeless	☐ YES ☐ NO	Lack of Focus	☐ YES ☐ NO
High Appetite	☐ YES ☐ NO	Low Appetite	☐ YES ☐ NO	Weight Gain	☐ YES ☐ NO	Joint Pains	☐ YES ☐ NO
Increased Urgency	☐ YES ☐ NO	Homicidal Ideations/Plan	☐ YES ☐ NO	Weight Loss	☐ YES ☐ NO	Muscle Aches	☐ YES ☐ NO
Seasonal Mood Changes	☐ YES ☐ NO	Seasonal Energy Change	☐ YES ☐ NO	Obsessions /Compulsions	☐ YES ☐ NO	Hallucinations	☐ YES ☐ NO
Poor Concentration	☐ YES ☐ NO	Fears of having illness	☐ YES ☐ NO	Suicidal Ideations/Plan	☐ YES ☐ NO	Headaches	☐ YES ☐ NO
Urinary Symptoms	☐ YES ☐ NO	Stomach Symptoms	☐ YES ☐ NO	Other Physical Symptoms	☐ YES ☐ NO	Explain Other:	

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PAST HISTORY OF PSYCHIATRIC TREATMENTS			
Have you ever had mental health counseling / psychotherapy?			☐ YES ☐ NO
If Yes, list:			
Name of Therapist	Type of Therapy	Time Period / # of Sessions	Any Comments / Describe Experience

ELECTROCONVULSIVE TREATMENTS (ECT)				
Have you ever had Electroconvulsive Treatment (ECT)?				☐ YES ☐ NO
If Yes, When, Where, inpatient/outpatient and time period				
What was your response to the treatment?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Describe your experience with ECT:				

TRANSCRANIAL MAGNETIC STIMULATION THERAPY (TMS)				
Have you ever had Transcranial Magnetic Stimulation (TMS)?				☐ YES ☐ NO
If Yes, When, Where, and time period				
What was your response to the treatment?	Excellent	Good	Fair	Poor
Describe your experience:				

CURRENT MENTAL HEALTH RELATED QUESTIONS		
Are you currently seeing a mental health counselor or therapist?		☐ YES ☐ NO
Name:	Phone:	Fax:
Address:		
Do you wish to continue counseling with your current counselor / therapist?		☐ YES ☐ NO
If Yes, let the Doctor know. If No, would you like to receive both medication and counseling?		☐ YES ☐ NO

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FAMILY MENTAL HEALTH HISTORY		
	AGE	SIGNIFICANT HEALTH PROBLEMS, CHEMICAL ABUSE, OR MENTAL HEALTH HISTORY
Father		
Mother		
Siblings	M F	
	M F	
	M F	
	M F	
Children	M F	
	M F	
	M F	
	M F	
Grandmother (Maternal)		
Grandfather (Maternal)		
Grandmother (Paternal)		
Grandfather (Paternal)		

List all Physical Health Illnesses since Birth	List all Mental Health Illnesses since Birth

Hospitalizations since birth (Surgical / Medical)		
Year	Reason	Hospital

Hospitalizations since birth (Mental)		
Year	Reason	Hospital

Patient Name _____

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SPECIAL HEALTH QUESTIONS		
Check if you have any of the following:		
☐ Seizure	☐ Brain Surgery	☐ Aneurism Surgery
☐ Epilepsy	☐ Heart Surgery	☐ Dental
☐ Head Trauma	☐ Pace Maker Placement	☐ Gun shot/Metal in the body
Describe:		

Check if you have had metal work done in any of the following areas:				
☐ Mouth	☐ Face	☐ Chest	☐ Head	☐ Neck
Please list and give details of any non-removable metallic objects in or around your head and/or neck:				

HEALTH HABITS AND PERSONAL SAFETY				
CAFFINE	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			

ALCOHOL	Do you drink alcohol?	☐ Yes	☐ No
	Have you ever felt you should cut down on your drinking?	☐ Yes	☐ No
	Have people annoyed you by criticizing your drinking?	☐ Yes	☐ No
	Have you felt bad or guilty about your drinking?	☐ Yes	☐ No
	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes	☐ No
	Do you drive after drinking?	☐ Yes	☐ No

TOBACCO	Do you use tobacco		☐ Yes	☐ No
	☐ Cigarettes- pks/day	☐ Chew- #/day	☐ Pipe- #/day	☐ Cigars- #/day
	☐ # of years		☐ Or year quit	

DRUGS	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever used recreational or street drugs?	☐ Yes	☐ No

Patient Name _____

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	Have you ever given yourself recreational or street drugs with a needle?	☐ Yes	☐ No
	Have you ever felt you should cut down on your drug use?	☐ Yes	☐ No
	Have people annoyed you by criticizing your drug use?	☐ Yes	☐ No
	Have you ever felt bad or guilty about using drugs?	☐ Yes	☐ No
	Have you ever used drugs first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes	☐ No
	Do you drive after using drugs?	☐ Yes	☐ No

CHEMICAL USE	Do you have a problem with chemical use?	☐ Yes	☐ No
	If yes, are you in treatment?	☐ Yes	☐ No
	If not in treatment, do you wish to pursue treatment?	☐ Yes	☐ No

SEX	Are you trying for a pregnancy?	☐ Yes	☐ No
	Are you taking any female hormones irrespective of reasons?	☐ Yes	☐ No
	Are you using any birth control measures?	☐ Yes	☐ No
	Do you have sex related issues / concerns or medical side effects?	☐ Yes	☐ No

EDUCATION / WORK HISTORY		
WORK HISTORY	Current Employer:	Date of employment From _____ To _____
EDUCATION HISTORY		

DISABILIY HISTORY			
Are you currently disabled to work?	☐ Yes	☐ No	☐ Maybe
If you are disabled?	☐ Officially		☐ Unofficially
If YES, then answer the following question on the type of disability			

Social Security ☐ Yes ☐ No Comment:	Social Service ☐ Yes ☐ No Comment:	No Fault ☐ Yes ☐ No Comment:
Workers Compensation: ☐ Yes ☐ No	Comments:	
Have you been disabled in the past	☐ Yes ☐ No	

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Any specific issues you would like to discuss with the doctor?

_____

_____

_____

Patient Name _____

Patient Name: DOB: Date of screening:

Generalized Anxiety Disorder (GAD-7) Screening Questions

During the last 2 weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

2. Not being able to stop or control worrying
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

3. Worrying too much about different things
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

4. Trouble relaxing
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

5. Being so restless that it is hard to sit still
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

6. Becoming easily annoyed or irritable
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

7. Feeling afraid as if something awful might happen
- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Add Columns: + + +
GAD-7 Score:

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
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Name: **Date:**
Start Time:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

2. Feeling down, depressed, or hopeless
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

3. Trouble falling or staying asleep, or sleeping too much
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

4. Feeling tired or having little energy
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

5. Poor appetite or overeating
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

8. 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
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

9. Thoughts that you would be better off dead, or of hurt yourself in some way
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

(Healthcare professional: For interpretation of TOTAL,
Please refer to accompanying scoring card.) **PHQ9 Score:**

10. If you choose 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
☐ Somewhat difficult
☐ Very difficult
☐ Extremely difficult

Permission to Verbally Discuss Protected Health Information with Family and Friends

NAME:

DOB:

MR#: HCL# :

LABEL

—Completion of this form is optional—

Patient name	Date of birth	Medical record number, if known	
Patient street address	City	State	ZIP
Home phone	Work phone		

I give permission for the HealthPartners Family of Care to VERBALLY share the information I have checked with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. *(check all boxes that apply)* This form does not authorize releasing copies of my records.

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
  - ☐ Substance use disorder
  - ☐ Developmental disability
- ☐ Lab/test results (☐ Check here to include HIV results)
- ☐ Billing and payment information
- ☐ Other (describe):_____

The HealthPartners Family of Care has my permission to discuss the above information with the following family member, friend or other person. List only 1 person on each form. This information is directly relevant to their involvement in my health care (or payment for that care).

Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone _____

I understand that in certain situations the HealthPartners Family of Care may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke my permission at any time except where HealthPartners has already made disclosures in reliance upon this request. **I understand this permission remains in effect until the time I revoke it in writing.** If an updated PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION WITH FAMILY AND FRIENDS form is received and it has an identical family member/friend/other person listed with updated permissions (different checkboxes), the new version will automatically revoke the previous version on file.

Signature of Patient/Authorized Representative **X** _____ Date _____

If other than patient, state relationship and authority to sign _____

NOTE: For copies of medical records, contact Health Information Management at 952-993-7600 or www.healthpartners.com.

Williamsville Psychiatry PLLC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____
Home Phone: _____ Work or Cell Phone: _____
Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone: _____
Facility Address: _____ Facility Fax: _____
City/State/Zip: _____
Dates and Type of information to disclose:

☐ 2 years prior from last date seen ☐ Dates Other: _____ ☐ Specific Information Requested

The purpose of this disclosure is:

☐ Change of Insurance or Physician ☐ Continuation of Care ☐ Referral ☐ Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The information may be disclosed and used by the following individual or organization:

Williamsville Psychiatry, Pllc (including any and all of its providers)
5904 Sheridan Drive
Williamsville, NY 14221
P 716-886-5493 F 716-886-5835
PLEASE FAX RECORDS

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, or condition: _____.**
If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ Date: _____
Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status)

_____ _____
Printed name of Authorized Representative Relationship/Capacity to patient

_____
Address and phone number of Authorized Representative

Williamsville Psychiatry PLLC

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_____
Address and phone number of Authorized Representative

Junaid Hashim MD DBA Williamsville Psychiatry PLLC

NO SHOW FEE POLICY

Williamsville Psychiatry does its best to schedule patients and see patients as timely as possible. Each provider maintains a schedule and appointments that are missed or cancelled same day without 24 hour notice are subject to a fee of $75.00. Your clinician allows time on their respective schedule for you to be seen and when you miss an appointment this takes away time that the clinician may use to otherwise assist another patient in need and must be valued. It is also important for your mental health to keep scheduled appointments.

If I am unable to attend to an appointment and do not provide 24 hours' notice of this I am subject to a fee of $75.00 and am expected to pay this fee in full to Williamsville Psychiatry PLLC. This fee is not covered by my insurance carrier and I understand that I am fully responsible for this fee should I miss an appointment or cancel without providing less than 24 hours' notice.

_____

Print Name of Client/Patient or Parent/Legal Representative

_____ _____

Signature of Client/Patient or Parent/Legal Representative Date Effective

5904 Sheridan Drive
Williamsville NY 14221
Phone 716-886-5493
Fax: 716-886-5835
www.williamsvillepsych.com

Junaid Hashim MD DBA Williamsville Psychiatry PLLC

CONSENT FOR TELHEALTH

(REQUIREMENT FOR TELEHEALTH SERVICES)

Telehealth Technology is currently being used by Williamsville Psychiatry PLLC to provide healthcare services throughout New York. Telehealth technology enables real-time communication between clients/patients and healthcare providers using live video conference.

☐ I **authorize** Williamsville Psychiatry PLLC to perform health care services via Telehealth, including must not limited to psychiatric medication management, psychotherapy/counseling, and other services.

OR

☐ (Initial) As of the effective date below, I **withdraw my authorization** for Williamsville Psychiatry PLLC to conduct services via telehealth, including but not limited to psychiatric medication management, psychotherapy/counseling, and other services.

_____
Print Name of Client/Patient or Parent/Legal Representative

_____ _____
Signature of Client/Patient or Parent/Legal Representative Date Effective

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