Acct#_____

STEVEN MACHLIN M.D., LLC
6820 Porto Fino Circle, Ste 1
Fort Myers, Florida 33912

Please complete all lines or put N/A-Thank you. How did you hear about us?_____

Last Name_____ First Name_____ Middle_____

Social Security_____DOB_____Age_____

Phone #'s Cell_____ Home _____ Work_____
(Appointment Reminder Text Messages may be sent-though you are responsible to know your next appt)

Email _____**CHECK (No)__ if NOT okay to use email for clinical exchanges.**

Your Address_____
City_____ State_____ Zip_____
*(If applicable) Alternate Address*_____ *City*_____ *State*_____
*Zip*_____ *When will you be at this address?*_____ *Phone#* _____

Employer/Occupation_____ Marital Status:_____ Spouses Name _____

If applicable-WEB TPA INSURANCE:
Last name of card holder (if not yourself)_____ First_____
Relationship to you _____ SS#_____ DOB: _____

EMERGENCY CONTACT INFORMATION-Mandatory

Name_____ Cell #_____ Alternate#_____

Their email address if known_____ Relationship to you_____

MEDICAL INFORMATION

Pharmacy (Local) Pharmacy name _____ Pharmacy#_____
90 day Mail Order? Y_____ N_____ Pharmacy _____ ID#_____
Primary Care Physician_____ Phone#_____ Last Visit_____
Therapist(if applicable)_____ Phone#_____ Last Visit_____
Medication Allergies_____ Physical Problems _____
Current Medication List_____

Payment for office visits is expected at the time of service. I understand that I am, and remain financially responsible for these charges. I give permission for text appointment reminders and office exchanges on treatment concerns via email between appointments as needed (unless I've checked NO above).
I HAVE READ THIS SECTION AND AGREE TO CONTENT.
SIGNED_____ **DATE**_____ 2/2023

Dr. Steven Machlin, MD. LLC
Health Questionnaire

Name_____ Date_____

Allergies – Also list your response to this substance: _____

_____

_____

Current medication and dosages:

_____

_____

_____

_____

_____

_____

_____

_____

Current Health Problems:

_____

_____

_____

_____

_____

_____

_____

_____

Past Psychiatric Treatments- List Types of Therapies, ECT, etc..

_____

_____

_____

_____

_____

_____

_____

Please list medications that you have tried before.
List Good Effects and Bad effects of each:

_____
_____
_____
_____
_____
_____
_____

Hospitalizations and past surgeries - Please give dates if possible

_____
_____
_____
_____
_____
_____
_____

Describe Alcohol Use:
Kind of beverage_____, # of Glasses _____
# of days per week_____; Total glasses per week _____
Social only_____

Recreational Drugs: Substance of choice and frequency:

_____
_____
_____

Describe your sleep: # of hours, trouble falling asleep, early wakening, is it restful?, do you awake refreshed?

_____
_____
_____
_____
_____

Your goals for seeking treatment in our office:

Reviewed by_____ Date _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total 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**
☐	☐	☐	☐

GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than 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 is 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

(For office coding: Total Score T____ = ____ + ____ + ____)

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

STEVEN R. MACHLIN, M.D., LLC
6820 Porto Fino Circle, Ste 1
Fort Myers, Florida 33912

PHONE: (239)225-1364 FAX: (239)225-7337

Authorization to Release/Obtain Protected Health Information

(Pursuant to the Health Insurance Portability and Accountability Act (HIPAA)

PATIENT:_____ **DOB:**_____
(Print)

This information should only be ( )**released to** and/or ( )**obtained from**: Check appropriate boxes.

PERSON/ENTITY:_____ **FAX#**_____

ADDRESS:-_____ **PHONE#**_____

CITY/STATE/ZIP_____

This form, when completed and signed by you, provides authorization to Dr. Machlin (or his staff) to Release and/or obtain protected health information from the person/entity you've designated above.

To **Release: Check applicable boxes:**
( ) Initial Evaluation
( ) Office Visit Notes
( ) All records
( ) Verbal Exchange of treatment issues
( ) Other_____

To **Obtain: Check applicable boxes**:
( ) Discharge summary
( ) H & P/Initial Evaluation
( ) Office Notes
( ) MRI/Cat Scans
( ) EKG/Labs(specify)_____
( ) Neuropsych testing
( ) Verbal clinical exchange
( ) Other_____

This information is to be used for:
( ) Coordination of Treatment ( ) Legal purposes ( ) Other_____

This authorization remains in effect for:
( ) Duration of treatment between Dr. Machlin and above named party.
( ) Single disclosure.
( ) Ninety days from this date.
( ) Other_____

I understand that I may revoke this authorization in writing, except to the extent that Dr. Machlin has taken action or has relied on the authorization. It will go into effect, at any time of this office receiving the written revocation. Once the uses and disclosures have been made pursuant to this authorization, they may be subject to redisclosure by any recipient and no longer protected. Dr. Machlin, and his employees are hereby released from any legal liability for the disclosures of the above information to the extent indicated and authorized herein.
I fully understand and accept terms of this authorization.

_____
(Signature of Patient or Legal Representative) **(Date)**

Payment Information
Steve Machlin, LLC.

Credit Card Authorization: I, _____ (printed name) authorize the maintenance of a valid credit card. Charges will appear on your credit card statement as "Steve Machlin, LLC ".

Cardholder Name: _____

Circle Card Type: Visa MC Discover

Billing Address: _____ **City:** _____ **Zip:**_____

Credit Card # _____ **3 digit CVV code:** _____

Expiration date: ___/__/____ **Email Address:** _____

Cardholder/Patient Signature: _____ **Date:** __/__/___

Please read payment procedures and initial:

_____ Payment in full is expected at the time services are rendered via check, cash, or credit card. All phone, virtual, and missed appointments will be processed via the credit card on file.

____ I understand that I am individually responsible for all incurred charges.

____ I understand there is **a 24-hour cancellation policy** and that **without providing 24 hours advance** notice to cancel or reschedule a session **I will be charged the *full fee* for the missed appointment**.

____ I consent to text message appointment reminders. I understand that text message appointment reminders are a curtesy, but failure to receive a message does not waive the missed appointment fee. Please call the office to cancel or change an appointment.

_____ I consent to telehealth appointments via HIPAA compliant Business Zoom.

_____ I consent to communication via email. I understand email communication cannot be guaranteed secure. Please be aware that email is never an appropriate way to communicate in an emergency. My email is _____.

Insurance Receipts: Superbills can be requested at the time of each visit. Patients are responsible for submitting all claims to their insurance provider.

I have read, understand and agree to the information authorization and guarantee stated above.

Signature: _____ **Date:** _____

Printed Name: _____

NAME_____

Check the medications that you have taken in the past (Updated 8/21/23)

Antidepressants

- Anafranil (Clomipramine)
- Auvelity (dextromethphan HBr/buproprion)
- Celexa (Citalopram)
- Cymbalta (Duloxetine)
- Effexor (Venlafaxine)
- Fetzima (Levomilnacipran)
- Lexapro (Escitalopram)
- Luvox (Fluvoxamine)
- Nortriptyline (Pamelor)
- Paxil (Paroxetine)
- Pristiq (Desvenlafaxine)
- Prozac (Fluoxetine)
- Remeron (Mirtazapine)
- Trintellix (Vortioxetine)
- Viibryd (Vilazodone)
- Wellbutrin (Bupropion)
- Zoloft (Sertraline)

Stimulants

- Adderall (Amphetamine) IR and XR
- Adzenys XR-ODT (amphetamine XR)
- Azstaryz (serdexmethylphenidate and dexmethylphenidate)
- Clonidine
- Dyanavel XR (amphetamine XR)
- Focalin (Dexmethylphenidate) IR and XR
- Jornay PM (methylphenidate)
- Mydayis (longer acting Adderall xR)
- Ritalin, Concerta (Methylphenidate)
- Strattera (Atomoxetine)
- Sunosi (solriamfetol)
- Vyvanse (Lisdexamfetamine)

Mood stabilizers

- Depakote (Divalproex)
- Lamictal (Lamotrigine)
- Lithium
- Neurontin (Gabapentin)
- Tegretol (Carbazepine)
- Topamax (Topiramate)
- Trileptal (Oxcarbazepine)
- Verapramil

Antipsychotics

- Abilify (Aripiprazole)
- Caplyta (Lumateperon)
- Clozaril (Clozapine)
- Geodon (Ziprasidone)
- Haldol (Haloperidol)
- Invega (Paliperidone)
- Latuda (Lurasidone)
- Rexulti (Brexpiprazole)
- Risperdal (Risperidone)
- Saphris (Asenapine)
- Seroquel (Quetiapine fumarate)
- Stelazine (Perphenazine)
- Vraylar (Cariprazine)
- Zyprexa (Olanzapine)

Anxiolitics/Hypnotics/

- Ambien(Zolpidem)
- Ativan (Lorazepam)
- Belsomra (suvorexant)
- Buspar (Buspirone)
- Dalmane (Flurazepam)
- Doxepin (Elavil)
- Halcion (Triazolam)
- Klonopin (Clonazepam)
- Lunesta (eszopiclone)
- Restoril (Temazepam)
- Rozerem (Ramenlteon)
- Sonata (Zaleplon)
- Trazodone
- Valium (Diazepam)
- Vistaril (hydroxyzine)
- Xanax (Alprazolam)

Other

- Deplin
- Electroconvulsive Therapy
- Ketamine or Spravato or Trans Cranial Stim
- Nuvigil (Armodafinil)
- Phentermine
- Pramipexole (Mirapex)
- Provigil (Modafinil)
- Ropinerole (Requip)
- Synthroid or Cytomel