MID-FLORIDA PSYCHIATRY CENTER

A TelePsychLive Service Provider

**PATIENT INFORMATION AND CONSENTS**

Name: _____ _____ _____ _____

First Name Middle Last Name Date of Birth

Sex: ********** Marital Status: ********** Social Sec No: _____

Address: _____ _____ _____ _____

Street number and Name City State ZIP

Home Phone: _____ Mobile Phone: _____ Email: _____

Emergency Contact: _____ Relation: _____ Phone No: _____

I agree that I am responsible for the payment of all the bills for services rendered to the patient/myself by the Mid-Florida Psychiatry Center/ physician (s). I understand that as a courtesy and when appropriate, the clinic will bill my third-party payor* on my behalf, and I agree any remaining balance** will become my responsibility. In order for the Mid-Florida Psychiatry Center/ physician (s) to bill correctly, I agree that it is my responsibility to verify that Mid-Florida Psychiatry Center/physician (s) has the correct insurance information for my third-party payor (s). (**Your third-party payor may be your insurance company, your HMO, Medicare and Medicaid as examples. ** Statutes controlling Medicare and Medicaid and Workers Compensation for example, may reduce remaining balance and contracts with insurance companies. We will automatically deduct these amounts from your balance before we bill you*.) Please upload the insurance cards.

_____ Notice of Privacy Practice Acknowledgement:

I have reviewed, agree and consent for Mid-Florida Psychiatry Center's Notice of Privacy Practices.

_____ Email use Policy:

I have reviewed policy, agree and consent to email communication between myself and Mid-Florida Psychiatry Center.

_____ Telepsychiatry Service:

I have reviewed the policy regarding Telepsychiatry at Mid-Florida Psychiatry Center, I further agree and consent to follow the guidelines.

_____ Consent to treatment with medication, including controlled medication.

I have reviewed and consent to medication treatment and therapy as appropriate.

_____ _____

Signature of the patient/ legal guardian Date



P.O Box # 1020, Davenport, FL 33837 <>Phone: (863) 419-7645 <>Fax (863) 419-7655<>Email: contact@telepsychlive.com

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____

I HEREBY Authorize the Mid-Florida Psychiatry Center PL/ Vidyasagar Vangala, MD, to release and/ or obtain any and all the information it possesses relating to my evaluation(s), treatment and illness (es)including the psychiatric and psychological information which may be part of the medical records to/from:

Name: _____

(Name of Physician, psychotherapist, legal representative/ agency, or facility)

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____. Fax: _____

If the information being released and/or obtained contains alcohol and/or drug use, diagnosis, treatment, rehabilitation, or education for prevention, or content related to HIV status, AIDS diagnosis or treatment, you must give further consent as follows:

a) I give my consent for the Mid-Florida Psychiatry Center PL/ Vidyasagar Vangala, MD, to release and/or obtain information from my records concerning my alcohol and/or drug use in conjunction with the above.
b) I give my consent for the Mid- Florida Psychiatry Center PL/ Vidyasagar Vangala, MD, to release and/or obtain information from my records concerning my HIV status, AIDS in conjunction with the above.

_____ _____

Signature of the patient/ legal guardian Date



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## MEDICAL INFORMATION

Primary Care Doctor: _____ Ph: _____

Who Referred you: _____

Reason for visit _____

How long you have this problem: _____

A brief description of your problems: _____

_____

_____

_____

At PRESENT taking any Psychiatric Medication, Treatment, Counseling for this: _____

_____

Have you been in psychiatric treatment in the PAST: _____

In patient ******** or outpatient ****** Any Suicide attempts in the past: Yes ☐ No ☐

List medication tried before if you can remember: _____

_____

Substance use history: IF THIS DOES NOT APPLY TO YOU CHECK HERE: ☐

Alcohol: ☐ Yes ☐ No Cigarettes: ☐ Yes ☐ No

Soda/Coffee: Yes ☐ No ☐ Drugs: yes ☐ No ☐

Social/personal History: Marital status: _____ Children: _____

Education: _____ Working/ Retired: _____

Any history of abuse: _____

Any family history of Psychiatric Problems: Yes: ☐ No: ☐

_____



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Medical and Surgical History:

| | | | |
|---|---|---|---|
| ☐ High BP | ☐ CHF | ☐ Asthma/COPD | ☐ GERD |
| ☐ Anemia | ☐ Seizures | ☐ Glaucoma | ☐ Obesity |
| ☐ High Cholesterol | ☐ Prostate Disease | ☐ Sleep Apnea | ☐ COVID |
| ☐ Hypothyroidism | ☐ Headaches | ☐ Diabetes | ☐ Lupus |
| ☐ Urinary problems | ☐ Arthritis | ☐ Chronic Pain | ☐ Hearing loss |
| ☐ Head Injuries | ☐ Fibromyalgia | ☐ Dementia | ☐ Parkinson's |
| ☐ Appendectomy | ☐ Tonsillectomy | ☐ Gallbladder | ☐ Stents in heart |
| ☐ CABG | ☐ Back Surgery | ☐ Hysterectomy | ☐ Lumpectomy |
| ☐ Prostatectomy | ☐ Neck Surgery | ☐ Bariatric Surgery | ☐ C-Sections |

In women: Are you pregnant Yes ☐ No ☐ NA ☐

Breast feeding Yes ☐ No ☐ NA ☐

Allergies to medication: yes ☐ No ☐

List if YES: _____

Last Physical Exam: _____ Last Blood/ Lab work: _____

Are you taking any Narcotic Pain Medication: Yes ☐ No ☐

Are you taking any Steroid treatment for COVID/ Chronic pain and other ☐ Yes ☐ No

Your Pharmacy name: _____ Phone: _____

List of Current Medication: Add a separate sheet if more medication to list.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

10. _____ 11. _____ 12. _____



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# RATING SCALES

## DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

**Name:** _____ **Date:**_____

*If this questionnaire is completed by an informant*, **what is your relationship with the individual?** _____
**In a typical week, approximately how much time do you spend with the individual?**_____ **hours/week**

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

| | During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems? | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
|---|---|---|---|---|---|---|---|
| I. | 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 | 4 | |
| | 2. Feeling down, depressed, or hopeless? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. Feeling more irritated, grouchy, or angry than usual? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. Sleeping less than usual, but still have a lot of energy? | 0 | 1 | 2 | 3 | 4 | |
| | 5. Starting lots more projects than usual or doing more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 6. Feeling nervous, anxious, frightened, worried, or on edge? | 0 | 1 | 2 | 3 | 4 | |
| | 7. Feeling panic or being frightened? | 0 | 1 | 2 | 3 | 4 | |
| | 8. Avoiding situations that make you anxious? | 0 | 1 | 2 | 3 | 4 | |
| V. | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)? | 0 | 1 | 2 | 3 | 4 | |
| | 10. Feeling that your illnesses are not being taken seriously enough? | 0 | 1 | 2 | 3 | 4 | |
| VI. | 11. Thoughts of actually hurting yourself? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 12. Hearing things other people couldn't hear, such as voices even when no one was around? | 0 | 1 | 2 | 3 | 4 | |
| | 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 14. Problems with sleep that affected your sleep quality over all? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind? | 0 | 1 | 2 | 3 | 4 | |
| | 17. Feeling driven to perform certain behaviors or mental acts over and over again? | 0 | 1 | 2 | 3 | 4 | |
| XI. | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? | 0 | 1 | 2 | 3 | 4 | |
| XII. | 19. Not knowing who you really are or what you want out of life? | 0 | 1 | 2 | 3 | 4 | |
| | 20. Not feeling close to other people or enjoying your relationships with them? | 0 | 1 | 2 | 3 | 4 | |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day? | 0 | 1 | 2 | 3 | 4 | |
| | 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco? | 0 | 1 | 2 | 3 | 4 | |
| | 23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0 | 1 | 2 | 3 | 4 | |
| | | | | | | Total | |