Rowan Medicine

NeuroMusculoskeletal Institute—Division of Psychiatry
Rowan Medicine Building
42 E. Laurel Road, Suite 1700
Stratford, New Jersey 08084

856-566-7010

To our new patients:

We welcome you to our practice and look forward to seeing you at the time of your scheduled visit. In order to make the best of your time with the provider, please see the following guidelines:

1. **Medications—**Please bring all current medications, including prescription drugs and over the counter medicines you have purchased.
2. **Assistive Devices**—If you wear eyeglasses, or use a hearing aide, walker or cane, please bring them with you.
3. **Health Status Questionnaire**—Please complete the enclosed questionnaire and bring it with you. It will provide our physicians with important information about your health history and current health status and will expedite your visit. If you are unable to answer all the questions by yourself, ask a family member or your caregiver to assist you.
4. **Medical Records**—Medical records from a referring physician or recent past hospitalization provide important information about your health history and help provide a more complete picture of your health status. Please contact the appropriate physician or facility to obtain a copy of your most recent records to bring with you or have them mailed or faxed to our office prior to your visit. Our address and fax number are on this letter.
5. **Report of Consultation**—If you have been referred by another physician, it is important that you provide us with the physician's complete name and address. After your evaluation has been completed, a letter summarizing the findings and recommendations and a copy of your reports will be sent to the referring physician and any other physicians you have requested.
6. **Insurance**—Please bring all health insurance cards (Medicare, Medicaid, Blue Cross, HMO, etc.) and photo ID, with you at the time of your visit. To avoid improper billing, it is very important that our Billing Office receives accurate insurance information from you. Our physicians accept assignment from Medicare, Medicaid, and participate in most HMOs. Based on the type of health insurance you currently have a copay may be required at the time of your visit.

Incomplete information could result in you, as the patient, having to assume the full responsibility for all charges and/or rescheduling the appointment.

We look forward to seeing you and if you have any questions before our appointment, please call our office at 856-566-7010.

Sincerely,

NeuroMusculoskeletal Institute

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856-566-7010

Please complete this form and bring it with you to your appointment, along with your prescription insurance card.

PATIENT NAME:

DATE OF BIRTH:

Your Preferred Pharmacy

PHARMACY NAME:

ADDRESS:

PHONE:

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PATIENT INFORMATION FORM
NeuroMusculoskeletal Institute—Division of Psychiatry

Patient Name: DOB:

Parent's Name (if minor): Home#:

Work/Cell#:

Emergency Contact: Relation: Phone#:

Pharmacy: Phone#:

Primary Care Physician: Phone#:

Highest Level of Education:

Marital Status: ◉ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Name of Spouse: Spouse DOB:

# of Children: Age(s):

Were you referred by anyone? ○ Yes ○ No If yes, by whom:

Have you ever been treated for a mental health condition? ○ Yes ○ No

If this treatment resulted in hospitalization, please state the facilities name, location and treating physician:

If this is a matter for legal involvement, this must have been arranged prior to your appointment.

Payment and/or copays are due at the time services are rendered.

***Acknowledgement: I have been informed the department of psychiatry has a 24 hour cancellation and no show policy.** The doctor is reserving a time for me and if I should cancel the appointment less than 24 hours before the appointment time or not show, there will be a charge applied to my account. I understand that my insurance will not be billed for these fees and that I will be personally liable for these charges. I also understand I am financially liable for all charges connected with my treatment not covered by my insurance contract.

Signature Date

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PATIENT PAST MEDICAL HISTORY

NeuroMusculoskeletal Institute—Division of Psychiatry

Patient Name: _____ Age: _____ Date: _____

Do you or have you had:	Past	Present	No	Do you or have you had:	Past	Present	No
EYE				**GASTROINTESTINAL**			
Wear Eyeglasses/contact lenses	☐	☐	☐	Frequent nausea/vomiting	☐	☐	☐
Cataracts	☐	☐	☐	Peptic ulcer disease	☐	☐	☐
Glaucoma	☐	☐	☐	Reflux	☐	☐	☐
ENT				Abdominal pain	☐	☐	☐
Seasonal Allergies	☐	☐	☐	Gall bladder	☐	☐	☐
Frequent sinus infections	☐	☐	☐	Liver problems	☐	☐	☐
Sore gums	☐	☐	☐	Constipation	☐	☐	☐
Dental problems	☐	☐	☐	Blood in stool	☐	☐	☐
Hearing loss	☐	☐	☐	Hemorrhoids	☐	☐	☐
Frequent ear infections	☐	☐	☐	Hernia	☐	☐	☐
Frequent sore throats	☐	☐	☐	Frequent diarrhea	☐	☐	☐
Thyroid condition	☐	☐	☐	**GENITOURINARY**			
Difficulty swallowing	☐	☐	☐	Painful or frequent urination	☐	☐	☐
HEAD				Prostate condition	☐	☐	☐
Head injuries	☐	☐	☐	Blood in urine	☐	☐	☐
Frequent headaches	☐	☐	☐	Sexually transmitted disease	☐	☐	☐
Dizziness	☐	☐	☐	**EXTREMITIES AND BACK**			
Fainting episodes	☐	☐	☐	Pain or swelling in joints	☐	☐	☐
Convulsions or Epilepsy	☐	☐	☐	Arthritis	☐	☐	☐
Meningitis	☐	☐	☐	Lyme disease	☐	☐	☐
SKIN				Leg cramping ___◯___ night ___◯___ anytime	☐	☐	☐
Frequent rashes	☐	☐	☐	Varicose veins	☐	☐	☐
Lesions (Site: _____)	☐	☐	☐	Back pain ___◯___chronic ___◯___ occasional	☐	☐	☐
Boils	☐	☐	☐	**FEMALE**			
Allergies	☐	☐	☐	Painful menstruation	☐	☐	☐
MENTAL HEALTH				Irregular cycle	☐	☐	☐
Anxiety	☐	☐	☐	# of pregnancies _____ # of births _____	☐	☐	☐
Depression	☐	☐	☐	Date of last pregnancy:			
Memory loss	☐	☐	☐	**OTHER MEDICATION PROBLEMS**			
Sleep disturbances	☐	☐	☐	Diabetes ___☐___ Type 1 ___☐___ Type II	☐	☐	☐
Attempted suicides	☐	☐	☐	Anemia	☐	☐	☐
RESPIRATORY				Cancer (Site: _____)	☐	☐	☐
Asthma	☐	☐	☐	Rheumatic fever	☐	☐	☐
Chronic cough	☐	☐	☐	Tuberculosis	☐	☐	☐
Shortness of breath	☐	☐	☐	**SOCIAL HISTORY**			
CARDIOVASCULAR				Do you smoke cigarettes	☐	☐	☐
High blood pressure	☐	☐	☐	If yes, how many per day?			
Stroke	☐	☐	☐	Do you use alcohol?	☐	☐	☐
☐ chest pain ☐ tightness ☐ palpations	☐	☐	☐	If yes, how many drinks per week?			
Swelling of feet or ankles	☐	☐	☐				

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PATIENT PAST MEDICAL HISTORY
NeuroMusculoskeletal Institute—Division of Psychiatry

LIST ALL DRUG ALLERGIES

LIST YOUR **CURRENT MEDICAITONS** INCLUDING STRENGTH AND DIRECTIONS AS WELL AS ALL OVER THE COUNTER MEDICATIONS.

MEDICATION	STRENGTH	DOSES PER DAY

PAST SURGERY

SURGICAL PROCEDURE	DATE	HOSPITAL

Patient Signature Date

Physician Signature Date

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HISTORY OF PREVIOUS TREATMENTS
NeuroMusculoskeletal Institute—Division of Psychiatry

Name: Date:

Check any of the following medications or treatment that you have tried in the past:

ANTIDEPRESSANTS		**Mood Stabilizers/Anticonvulsants**	
SSRI's		☐	Depakote (divalproex sodium)
☐	Celexa (citalopram)	☐	Depakene (valproic acid)
☐	Lexapro (escitalopram)	☐	Lamictal (lamotrigine)
☐	Luvox (fluvoxamine)	☐	Lithium
☐	Paxil (paroxetine)	☐	Tegretol (carbamazepine)
☐	Prozac (fluoxetine)	☐	Trileptal (oxcarbazepine)
☐	Zoloft (sertraline)		
SNRI's		**TCA's**	
☐	Cymbalta (duloxetime)	☐	Anafranil (clomipramine)
☐	Effexor (venlafaxine)	☐	Asendin (amoxapine)
☐	Pristiq (desmethylven)	☐	Elavil (amitriptyline)
		☐	Ludiomil (maprotiline)
		☐	Noripramin (desipramine)
OTHER	**ANTIDEPRESSANTS**	☐	Pamelor (nortryptiline)
☐	Desyrel (trazadone)	☐	Sinequan (doxepin)
☐	Remeron (mirtazapine)	☐	Surmontil (trimipramine)
☐	Serzone (nefazondone)	☐	Tofranil (imipramine)
☐	Wellbutrin (bupropion)	☐	Vivactil (protryptiline)
☐	Reboxetine		
MAOI's		**ATYPICALS**	
☐	Emsam patch (selegiline)	☐	Abilify (aripiprazole)
☐	Marplan (isocarboxazid)	☐	Clozaril (clozapine)
☐	Mannerix (moclobemide)	☐	Geodon (ziprasidone)
☐	Nardil (phenelzine)	☐	Risperdal (risperdone)
☐	Pamate (tranylcypromine)	☐	Seroquel (quetiapine)
		☐	Zyprexa (olanzapine)
TYPICALS			
☐	Haldol (haloperidol)	**STIMULANTS**	
☐	Mellaril (thioridiazine)	☐	Adderal (mixed amphetamine salts)
☐	Thorazine (chlorpromazine)	☐	Dexedrine (dexamphetamine)
☐	Trilafon (perphenazine)	☐	Focalin (dexmethylphenidate)
		☐	Provigal (modafanil)
		☐	Ritalin, Concerta (methylphenidate)
		☐	Strattera (Atomoxetine)

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HISTORY OF PREVIOUS TREATMENTS
NeuroMusculoskeletal Institute—Division of Psychiatry

SOMATIC TREATMENTS		HYPNOTICS	
☐	ECT	☐	Ambien (Zoipidem)
☐	Light Therapy	☐	Chloral hydrate
☐	TMS	☐	Lunesta (Eszopiclone)
☐	VNS	☐	Restoril (Temazepam)
		☐	Rozerem (Ramelteon)
BENZODIAZEPINES		**OTHER**	**AGENTS**
☐	Ativan (lorazepam)	☐	Androgel (testosterone)
☐	Klonopin (cloriazepam)	☐	Buspar (buspirone)
☐	Librium (chlordiazepoxide)	☐	Cytomel (T3)
☐	Serax (oxazepam)	☐	Deplin (Methylfolate)
☐	Tranxene (chlorazepate)	☐	Folic Acid (folate)
☐	Valium (diazepam)	☐	Fish Oil (omega 3s)
☐	Xanax (alprazolam)	☐	Inositol
		☐	Mirapex (premepexole)
		☐	Neurontin (gabapentin)
		☐	Opiates
		☐	Requip (roprinole)
		☐	SAME
		☐	Synthyroid (I-thyroxine)
		☐	Topamax (topiramate)

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PATIENT'S CONSENT TO TREATMENT

NeuroMusculoskeletal Institute—Division of Psychiatry

I, , hereby give my permission to the staff of RowanSOM, NeuroMusculoskeletal Institue to conduct such treatment services as are deemed necessary to diagnose, measure and alleviate the psychological, social and/or physical conditions associated with my mental health problems. I realize that written and computerized records will be kept about me and that evaluative data will be requested from me periodically to ascertain my progress. Such data will be kept confidential and in compliance with federal HIPPA standards as outlined in the Notification of Patient Privacy I received from RowanSOM. I authorize the release of medical or other information about me necessary toprocess claims filed with my insurance company(ies).

Furthermore, I understand that I have the right to refuse any recommended treatments and to discuss any forms of potential treatment and possible ill effects with the medical staff of the NeuroMusculoskeletal Institute.

In the event any medication or procedure is prescribed, I understand that I am entitled to a full explanation of the potential risks associated with such medication or participation and that the medical staff of the NeuroMusculoskeletal Institute is obligated to discuss with me, and gain my approval, on all established plans before such plans may be instituted.

If I cancel the appointment less than 24 hours before the appointment time, or if I do not show up to the appointment, I understand that I will be subject to a $25.00 fee that is not reimbursed by my insurance carrier.

Patient Signature: Date:

Witness:

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INFORMED CONSENT FOR PSYCHIATRIC MEDICATION

NeuroMusculoskeletal Institute—Division of Psychiatry

Medications:

1.

2.

3.

Statement:

I have been advised that the above psychotherapeutic medication(s) have been recommended as part of my treatment. I have been informed of the expectations associated with these drugs including benefits, side effects, drug interactions, risks caused by use of alcohol or illicit drugs and its side effects on driving. I have been given-- instructions on when and how much of the medication(s) to take. The advantages of taking this medication as well as the alternative forms of treatment and the probability that it will helphave been discussed with me.

I am aware that I may get follow-up questions regarding this medication answered by my psychiatrist. I am aware that I have the right to refuse this medication(s) at any time and that I may discontinue its use at any time. I am responsible for telling my doctor if I discontinue taking this medication(s), and taking other new medication, become pregnant or develop other medical conditions or side effects.

Patient's Signature Date

Parent, Spouse, Guardian Signature Relationship

Physician's Signature

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GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE
NeuroMusculoskeletal Institute—Division of Psychiatry

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column		+	+	+

Total Score *(add your column scores)* =

If you checked off any problems, how difficult have these 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

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

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