PATIENT INFORMATION

Name_____ Sex_____

Street Address_____

City _____ State_____ Zip_____

Home Phone _(____)_____Work Phone_(____)_____

Cell Phone_(____)_____Marital Status_____

Age_____ Date of Birth_____ SS#_____

Spouse's Name_____

Emergency Contact Name_____

Relationship to Patient _____

Emergency Phone _(____)_____ _(____)_____

JOSEPH M. SHARPE, M.D.
General Office Guidelines
Tel: 615-284-3850
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Patients are seen by appointment only. As we make every effort to remain on time according to schedule, you are asked to be on time as well. Visits typically last between fifteen minutes and one hour depending on the individual patient's needs. Payment in full is required at the time of service.

Should you arrive **late** for your scheduled appointment, we can meet for the remainder of the scheduled time, but probably not the full time out of respect for the next patient.

Telephones are either answered in person or via service throughout each business day, and Michelle, my assistant, is also happy to communicate via email at michelle.moon@sth.org as many people find that more convenient.

Because we only schedule one patient per time-slot, missed appointments will be charged the full fee and must be paid prior to rescheduling. Should you find that you need to cancel an upcoming appointment, we require a minimum notice of 24-hours. Our answering service is available when the office is closed and messages should be left with them for any cancellation.

Due to the unavailability of patient records, medications will **not** be refilled outside of office hours, including weekends and holidays. We strive to make sure patients have sufficient refills to cover from one appointment until the next. Should you need a refill prior to an appointment, depending on the type of medication, we will only fill enough until your scheduled appointment. Early refills of medication will **not** be approved under any circumstance.

Initial appointments last approximately one hour and the fee is $300. Follow-up visits range from 15-60 minutes depending on patient's preference. Fifteen minute medication management visits are $90, a 30-minute visit is $150, a 45-minute visit is $225, and a one-hour counseling session is $300. Payment of these fees is required at the time of service.

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This information should cover most of the questions that may arise. It is intended to familiarize you with how the office operates so that we may work together with you in a manner of mutual respect.

AGREEMENT: By signing below, I am acknowledging my willingness to participate in the treatment process. I further acknowledge that I have read, understand and agree to all listed office policies. I agree to pay for all charges incurred as a result of my treatment, and understand that a delinquent account is subject to being turned over to a collection agency if not paid in a timely manner. I also understand that I will be charged for cancellations made with less than 24 hours' notice or in the event I fail to keep my scheduled appointment.

_____ _____

Patient Signature Date

Joseph M. Sharpe, M.D.

2010 Church Street, Suite # 513
Nashville, TN 37203
Phone (615) 284-3850 Fax (615) 284-4350

Patient Name_____ Referred by _____

What is your main problem? _____

_____

List difficulties/symptoms/ issues which have prompted you to seek treatment: _____

_____

_____

What, if anything, happened recently to make the problem worse? _____

_____

_____

Please circle each symptom that relates to you:

Depression	Pain	Perfectionistic
Decreased interest	Muscle tension	Addicted to drugs/alcohol
Weight loss/gain	Excessive worry	Feel ugly
Feeling guilty	Racing thoughts	Feel empty
Irritability	Talkative	Flashbacks
Feeling agitated	Excessive energy	Extreme fatigue
Worthlessness	Paranoid	Loud snoring
Hopelessness	Hearing voices	Sleeping too much
Diminished ability to think	Seeing images	Trouble getting to sleep
Poor concentration	Obsessive thoughts	Trouble staying asleep
Easily distracted	Intrusive thoughts	Jerking legs while sleeping
Difficulty staying on task	Suicidal thoughts	Panic attacks

Yes **No**

_____ _____ Have you ever been a patient of a psychiatrist?

If yes, what was your diagnosis and how long were you treated? _____

_____

_____ _____ Have you ever been in talk therapy/psychotherapy?

If yes, when and for how long? _____

Patient Name_____

Yes	No	
_____	_____	Have you ever attempted suicide?
_____	_____	Have you ever been hospitalized for any psychiatric reason?
		If yes, how many times and for what reason? _____
_____	_____	Have you ever taken any psychiatric medication?

Some examples are:

Adderall	Cymbalta	Geodon	Nuvigil	Risperdal	Valium
Ambien	Depakote	Klonopin	Paxil	Ritalin	Viibryd
Ambien CR	Deplin	Lamictal	Paxil Cr	Rozerem	Vyvanse
Ativan	Effexor XR	Effexor XR	Lexapro	Pristiq	Wellbutrin
Brintellix	Emsam	Lithium	Provigil	Savella	Xanax
Celexa	Fanapt	Fanapt	Lunesta	Prozac	Seroqueal XR
Concerta	Fetzima	Luvox CR	Restoril	Trazodone	Zyprexa

Past Psychiatric Medications Taken	**Reason Discontinued**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current treatment providers: (Please include therapists, primary care physicians, etc.)

Name	**Role**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication allergies: _____

Patient Name_____

List all CURRENT medication and dosages:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List all medical illness you now have, or have had in the past: (including high blood pressure, diabetes, heart disease, etc.) _____

_____

_____

Have any of your family members had psychiatric difficulties including depression, bipolar disorder (manic depression), alcohol abuse, anxiety, panic disorder or dementia?

Relationship of Family Member **Type of Psychiatric Problem**

_____ _____

_____ _____

_____ _____

Where were you born? _____ Where did you grow up? _____

Yes **No**

_____ _____ Are your parents living?

_____ _____ Are they married?

_____ _____ Do you have any brothers/sisters? If so, how many? _____

_____ _____ Are you married?

_____ _____ Have you been divorced? If yes, how many times? _____

What do you like most about your spouse? _____

What do you like least about your spouse? _____

_____ _____ Do you have children? If yes, how many? _____

How far in school did you go? _____

Patient Name_____

Yes	No	
_____	_____	Are you employed? If yes, what is your job? _____
_____	_____	Have you ever been in the military?
		If yes, what branch and for how long? _____
_____	_____	Do you have any history of childhood abuse/trauma?

Whom do you currently live with? _____

What would you say is the most stressful thing in your life currently? _____

_____

_____	_____	Do you attend church or a religious service?
_____	_____	Do you drink alcohol?

If yes, how much do you drink? _____ Rarely _____ Occasionally _____ Frequently

_____	_____	Have you ever tried to cut back your drinking unsuccessfully?
_____	_____	Do you get annoyed at friends/family telling you that you need to drink less?
_____	_____	Do you ever feel guilty about your drinking?
_____	_____	Do you ever use alcohol first thing in the morning?
_____	_____	Do you use tobacco? If yes, how much? _____
_____	_____	Do you use cocaine/ marijuana or other illegal drugs?
_____	_____	Have you ever been arrested?
_____	_____	Have you ever been through detox or rehab?

I understand that this is part of my initial psychiatric evaluation and I have filled it out to the best of my ability.

_____ _____

Patient Signature Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

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
	add columns:	+	+	

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

10. 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** _____

ZT242043

Generalized Anxiety Disorder 7-item (GAD-7) scale

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.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

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?	○	○

JOSEPH M. SHARPE, M.D.
Patient Medication Agreement

Tennessee is one of the top states in the nation for prescription fraud and misuse. Efforts are being made at state and federal levels to try and help this serious problem. These measures, while important, have resulted in some clinics refusing to write certain controlled medications. We feel that omitting medications would not allow us to provide the care that we would want for ourselves and our families. You will notice changes that are designed to satisfy the monitoring requirements. These include prescription database monitoring, as well as drug testing as appropriate.

I understand I have been, or may be, prescribed medications which are controlled substances. I understand that these medications are regulated by state and federal law. I also understand that it is a FELONY to obtain these medications by fraudulent means, to possess these medications without a legitimate prescription, sell or give these medications to others.

If a prescription or the medication is lost, stolen, or damaged, the prescription will **NOT** be re-written before the 30-day renewal period. I understand it is my responsibility to protect both my written prescription and my medication from being lost, stolen, or misused.

If appointments are not kept or scheduled as required, it is not possible to refill medications. Once the dose of medication is stabilized I may be allowed to stretch my visits to every 3 months, depending on the medication I am prescribed. At these appointments, I will be given sufficient prescriptions to last until my next visit. It is my responsibility to safeguard my medication and prescription. Lost or stolen prescriptions cannot be renewed.

If I am prescribed stimulants, I will be given three separate prescriptions, each to be filled at 30-day intervals allowing me sufficient medication to last 90 days. I understand that it is my responsibility to safeguard my medication and prescriptions. Lost, stolen, or damaged prescriptions will not be renewed earlier than 30 days from the previous prescription date – **NO EXCEPTIONS**. I also understand that if I fail to schedule an appointment within the time frame requested, or if I miss an appointment that I have made, my medications will not be renewed until I am seen for an appointment. I also understand that I will not be allowed to fill my prescriptions earlier than the required 30 days.

We regret any unintended negative impact. Together with you as our partner, we will do all in our power to continue to be able to provide the level of care that we would want for ourselves.

Patient Signature: _____

Printed Name: _____

Date: _____

Authorization to Release Information

I hereby authorize (name/facility): **JOSEPH M. SHARPE, M.D.**
2010 Church Street, Ste 513
Nashville, Tennessee 37203
TEL 615-284-3850 FAX 615-284-4350

To Release to: _____

_____

(fax)_____(phone)_____

All of my medical records, including any specially protected records, such as those relating to the psychological or psychiatric impairments, drug abuse, and alcoholism, sickle cell anemia, or HIV infection for the purpose of medical treatment.

Specific Instructions:
(Specific information requested)

This authorization will expire one year from the date signed

- I understand that I may revoke the authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by Nashville Wellness Center or employees before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the address shown above.
- I understand that I am not required to sign this Authorization. Nashville Wellness Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.
- I understand that my record may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations
- I understand that this Authorization does not limit Nashville Wellness Center or its employees or agent's ability to use or disclose my information for treatment, payment or health care operations, or as otherwise permitted by law.

Printed Name: _____ SSN#:_____

Date of Birth: _____ Signature: _____

Parent/Guardian (if patient is under legal age of 18)_____

Witness: _____ Date: _____