PTC OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

Date: ____/____/_____

Legal First Name: _____ **Legal Middle Name**: _____ **Legal Last Name**: _____

Former legal last name (if applicable): _____ **DOB**: ____/____/_____ **Age**: ____

Gender: □ Male □ Female **SSN#**: _____-_____-_____ **Driver's License #**: _____

Street address: _____ **City**: _____ **State**: _____ **Zip**: _____

Please list two confidential phone numbers we can leave messages at and contact you by:

Home Phone #: (_____) _____ Cell Phone #: (_____) _____

E-Mail: _____ Alternate E-Mail: _____

Referring Physician: _____

Primary Care Physician: _____

Preferred Pharmacy (name and address): _____

INSURANCE INFORMATION

Please provide your insurance card(s) to the receptionist

Primary Insurance: _____ **Patient's Relationship to Subscriber**: □ Self □ Spouse □ Child □ Other: _____

Policy #: _____ **Group #**: _____

Subscriber's Name: _____

Subscriber's SSN#: _____-_____-_____ **DOB:** ____/____/_____

Secondary Insurance: _____ **Patient's Relationship to Subscriber**: □ Self □ Spouse □ Child □ Other: _____

Policy #: _____ **Group #**: _____

Subscriber's Name: _____

Subscriber's SSN#: _____-_____-_____ **DOB:** ____/____/_____

Is this a Worker's Compensation Injury? □ NO □ YES Phone # of your WC adjuster: (_____)_____

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New Patient Packet (Initials:_____ DOB: ____/____/_____)

Is there a possibility that you are pregnant (female patients)? □ NO □ YES

EMERGENCY CONTACT INFORMATION/AUTHORIZED CALLER

List anyone below whom you wish to list as your Emergency Contact and authorize to discuss with us your medical condition and diagnosis (including treatments, payments, appointments, and health concerns). If the name is not listed on this form, we are legally unable to release any information, regardless of the relationship to the patient.

Name: _____ Relationship to patient: _____ Contact Phone #: (_____)_____

Name: _____ Relationship to patient: _____ Contact Phone #: (_____)_____

Name: _____ Relationship to patient: _____ Contact Phone #: (_____)_____

DO NOT RESUSCITATE (DNR)/DO NOT INTUBATE ORDER (DNI)

Do you have a DNR/DNI Order? □ YES □ NO. If YES, provide a copy to the receptionist.

By signing below, you confirm that the information you have provided above is correct and true to the best of your knowledge. It is your responsibility to inform Pain Treatment Centers of Georgia of any changes to any of the information above.

_____/____/_____
Patient's or Authorized Representative's Name and Signature Date

PTC OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

Date: ____/____/_____

Legal First Name: _____ **Legal Middle Name**: _____ **Legal Last Name**: _____

DOB: ____/____/_____ **Age**: ___ **Gender**: □ Male □ Female **Marital Status**: □ S □ M □ D □ W □ Other: ___

Race: □ American Indian □ Asian □ Black/African American □ Hispanic/Latino □ White □ Other: _____

When did the pain start? (please provide date): _____

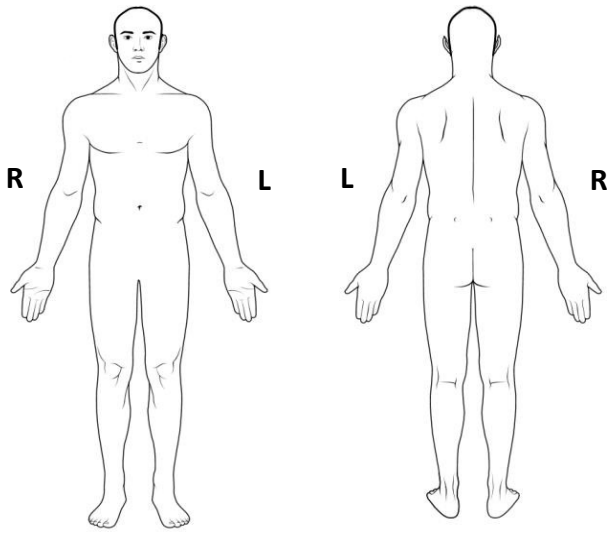
Since your pain began it has: □ Increased □ Decreased □ Remained the same □ Other: _____

Under what circumstances did your pain start?

□ Home Accident □ Work Accident □ Auto Accident □ Sports □ Fall □ Surgery □ Other: _____

Do you have a pending lawsuit related to your pain? □ NO □ YES Which areas of your body are included in the lawsuit?: _____. Contact information of your attorney? _____

Where is your pain located? (please mark the diagram below):



Indicate your pain level (please circle one number on each line):

Current pain level: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

Least pain level last week: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

Highest pain level last week: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

Average pain level last week: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

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Your pain is mostly: □ Constant □ Off and On □ Other: _____

Describe your pain briefly in your own words (please include the location and quality of the pain):

_____

Does your pain feel like any of the following?

□ Aching □ Burning □ Throbbing □ Stabbing □ Sharp □ Dull □ Shooting □ Other: _____

Do you experience any of the following?

□ Numbness □ Tingling □ Weakness □ Coldness □ Spasms □ Other: _____ Where? _____

Does your pain interfere with sleep? □ Occasionally □ Frequently □ Doesn't interfere

What makes your pain WORSE? (please list) _____

What makes your pain BETTER? (please list) _____

PREVIOUS IMAGING/DIAGNOSTIC TESTS (related to pain)

Please circle all that apply

X-ray (when/where? _____)	CT Scan (when/where? _____)	MRI (when/where? _____)
Myelogram (when/where? _____)	EMG/NCS (when/where? _____)	Other: _____

PREVIOUS TREATMENTS (related to pain)

Please circle all that apply

Bedrest	TENS unit/braces	Home exercises	Acupuncture
Chiropractor	Muscle relaxants	NSAIDs	Opioid medications
Trigger point injections	Epidural steroid injections	Joint injections	Nerve blocks
Facet joint injections	Radiofrequency ablations (i.e. "Nerve Burning")	Spinal cord stimulator	Pain pump
Physical Therapy: What body area(s): _____, Where done: _____, Dates done: _____			

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New Patient Packet (Initials:_____ DOB: ____/____/_____)

PREVIOUS MEDICATIONS TRIED (at any point in the past)

Please circle all that apply

Tylenol	Ibuprofen	Advil/Aleve	Meloxicam	Celebrex
Naproxen	Diclofenac	BC Powder	Tramadol	Tylenol #3/4
Hydrocodone	Hysingla	Roxicodone	Morphine	Hydromorphone
Nucynta	Methadone	Buprenorphine	Butrans	Fentanyl patch
Belbuca	Oxycodone	Percocet	Fioricet	Celexa/citalopram
Zyprexa/olanzapine	Paxil/paroxetine	Effexor/venlafaxine	Lexapro/escitalopram	Prozac/fluoxetine
Zoloft/Sertraline	Trintellix/vortioxetine	Wellbutrin/bupropion	Remeron/mirtazapine	Luvox/fluvoxamine
Viibryd/vilazodone	Cymbalta/duloxetine	Other: _____	Other: _____	Other: _____

ALLERGIES AND MEDICATIONS

Allergies: List ALL medications (or other drugs) to which you are allergic: □ I am NOT allergic to anything

Medication you are allergic to?	Type of reaction

Medication you are allergic to?	Type of reaction

Please attach an additional sheet of paper if needed

Do you have an allergy to Latex? □ NO □ YES Reaction: _____

Do you have an allergy to Contrast Dye or Iodine? □ NO □ YES Reaction: _____

Are you taking anti-coagulants or "blood thinners"? □ NO □ YES (please check below)

□ Plavix □ Coumadin □ Eliquis □ Xarelto □ Pradaxa □ Aspirin □ Other: _____

Who is prescribing you the blood thinner? Physician's name and phone #: _____

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New Patient Packet (Initials:_____ DOB: ____/____/_____)

If you do take anti-coagulants or "blood thinners," will the prescribing physician allow you to discontinue this medication for any length of time? □ NO □ YES Please note that you must have permission from your prescribing physician to discontinue your anti-coagulants or "blood thinners" for any length of time.

Medications: List ALL your medications (including over-the-counter and herbal medications):

Medication name	Medication dose	Frequency
Example: Lisinopril	*20mg*	*One time daily*

Please attach an additional sheet of paper if needed

PTC OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

PAST MEDICAL & SURGICAL HISTORY

Have you ever been diagnosed with or treated for any of the following health problems?

Cardiac
- □ Aortic regurgitation/stenosis
- □ Coronary artery disease (CAD)
- □ Heart attack (MI)
- □ Heart stent (angioplasty)
- □ Congestive heart failure (CHF)
- □ Irregular pulse (arrhythmia)
- □ Pacemaker/defibrillator (AICD)
- □ High blood pressure
- □ Deep vein thrombosis (DVT)
- □ Other: _____

Respiratory
- □ COPD
- □ Asthma
- □ Sarcoidosis
- □ Pneumonia
- □ Pulmonary embolism (PE)
- □ Sleep apnea
- □ Other: _____

Gastrointestinal
- □ Heartburn (GERD)
- □ Constipation
- □ Peptic ulcer disease
- □ Inflammatory bowel disease
- □ Crohn's disease
- □ Bulimia/anorexia
- □ Other: _____

Musculoskeletal
- □ Osteoporosis
- □ Arthritis (type: _____)
- □ Joint degeneration (DJD)
- □ Gout
- □ Fibromyalgia
- □ Scoliosis
- □ Psoriasis or lupus
- □ Spinal Stenosis
- □ Connective tissue disease
- □ Carpal tunnel syndrome
- □ Other: _____

Neurologic
- □ Headaches or migraines
- □ Diabetic neuropathy
- □ Myasthenia gravis
- □ Seizures or epilepsy
- □ Multiple sclerosis
- □ Alzheimer's/Parkinson's disease
- □ Stroke or TIA ("mini stroke")
- □ Other: _____

Psychiatric
- □ Anxiety or panic attacks
- □ Depression
- □ Bipolar disorder
- □ Schizophrenia
- □ Insomnia
- □ PTSD
- □ ADHD/ADD
- □ Other: _____

Other
- □ Diabetes (type: _____)
- □ Easy bleeding
- □ HIV/AIDS
- □ Hepatitis (type: _____)
- □ Cancer (type: _____)
- □ Kidney or liver disease
- □ Other: _____

Please list all surgeries that you have had:

Surgery type	**Date** (month and year)	**Location** (which hospital)

Please attach an additional sheet of paper if needed

PTC OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

FAMILY & SOCIAL HISTORY

Please list all medical conditions that your immediate family members have:

Is your **mother** still living? □ YES □ NO Cause of death: _____

Is your **father** still living? □ YES □ NO Cause of death: _____

Family member	Conditions

Family member	Conditions

Work status: □ Employed full time □ Employed part time □ Unemployed □ Student □ Disabled □ Retired

Occupation and employer: _____

Do you use street (recreational) drugs? □ NO □ YES Please tell us all street drugs that you have ever used and the last date of use: _____

Have you ever been treated for alcohol/drug dependence or addiction? □ NO □ YES Year? _____

Have you ever abused or taken "not as prescribed" prescription drugs? □ NO □ YES Comment: _____

Do you have a history of physical or sexual abuse? □ NO □ YES Comment: _____

Do you have any thoughts of hurting yourself or someone else? □ NO □ YES Comment: _____

I certify that I have answered all of the above questions truthfully and to the best of my ability:

_____/____/_____

Patient's or Authorized Representative's Name and Signature Date

PTC OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

PRACTICE POLICIES

PATIENT IDENTIFICATION: I understand that at every appointment, we will ask you to present a **picture ID** and your **insurance information** (primary and secondary insurance cards (if applicable)) and verify your personal information. It is the patient's responsibility to inform Pain Treatment Centers of Georgia of any changes to their demographic or insurance information.

Initials: _____

REFERRALS/AUTHORIZATIONS: I understand that depending on my insurance, I may need a referral from my provider to see a specialist. My insurance may also require preapproval for procedures and imaging. If so, and my provider decides it is medically necessary, I will allow 7-10 working days for this process. I understand that if I choose to access services without prior authorization from my provider, I may be financially responsible for the services rendered.

Initials: _____

CO-PAYS/DEDUCTABLES: I understand that **all copays and deductibles** must be paid at the time of service; this is an insurance requirement and a part of your contract with the insurance company.

Initials: _____

FEES FOR PATIENT'S HEALTH INFORMATION: I understand that I may be charged a cost-based fee when requesting copies of my health information, including copying (supplies and labor) and postage (if information is to be mailed).

Initials: _____

FEE FOR FORMS: I understand that if I request to have any forms completed by my physician that are not directly related to patient care, I will be required to pay a fee. Examples of the forms include but are not limited to jury duty excuses, Family Leave Act applications, accident reports, and school and camp forms. There may be other forms with associated fees. Any request to complete such documentation will require a prepaid fee of **$50** and **7-10 days** for completion.

Initials: _____

ON-TIME ARRIVAL POLICY: **I understand that I must arrive on time for my appointment to check in**. If I arrive late for my scheduled appointment, it may be necessary to reschedule the appointment or wait until my physician is available. Our physicians attempt to maintain an "on-time" schedule, but I understand that urgent or complex needs for patients with prior appointments may cause my physician to be late for my appointment. If you are habitually late for scheduled appointments, you could be subject to dismissal from our practice.

Initials: _____

APPOINTMENT RESCHEDULING: I understand that if I need to reschedule my appointment, we ask that you do so within **24 hours** of your scheduled appointment time.

Initials: _____

NO-SHOW POLICY: I understand that if I miss an appointment or cancel with less than 24 hours prior notice, I will be charged a $50.00 fee for a missed office visit and a **$100.00** fee for a missed procedure visit. If there are two or more scheduled appointments that you miss in a short period of time, you could be subject to dismissal from our practice.

Initials: _____

P|T|C
OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

RETURNED CHECKS: I understand that a **$25** fee will be charged for any returned check, and we will no longer accept your checks.

Initials: _____

SELF-PAY POLICY: Patients without insurance coverage and patients covered by insurance plans in which our practice does not participate are considered self-pay. The NEW PATIENT visit appointment fee is **$350**, and the FOLLOW-UP patient visit appointment fee is **$250**. Any additional testing, interventions, procedures, etc., are assessed separately and must be paid at the time of service. It is always the patient's responsibility to know if our office is participating in their health plan.

Initials: _____

EXCLUSIONS: **We do not provide disability evaluations or disability approvals**.

Initials: _____

PAYMENT METHODS: We accept all major credit cards, checks (under $200), money orders, and cash.

Initials: _____

MEDICATION REFILLS: I understand that to receive a refill, I must have a current opiate prescribing agreement with Pain Treatment Centers of Georgia, recent toxicology screening as mandated by law, and must be seen monthly and/or have an agreement with the physician to be seen regularly for my refills to be provided to me. I understand that refills may take 24-48 hours to complete. I acknowledge that the best way to ensure my medications are filled in a timely manner is to come in for re-evaluation by my physician monthly. I agree to allow staff 24 to 48 hours to complete prior authorization for medications (if needed) and that my insurance has 3 days to review after that. I further understand that prior authorization for my insurance is a courtesy that the office is providing me and that once this is completed, the provider's office does not control the time frame of the insurance review. I also agree and understand that refills of NARCOTICS ARE NOT REFILLED ON FRIDAYS AND AFTER HOURS. If refills are needed, a call is to be made to the pharmacy so a fax can be sent to our office, and a decision will be made during normal business hours. Medication refills are NOT AN EMERGENCY.

Initials: _____

_____/____/_____

Patient's or Authorized Representative's Name and Signature Date

PTC OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

HIPPA AGREEMENT

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

Our practice is dedicated to maintaining the privacy of your health information as required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The following circumstances may require us to use your health information:

1. To coordinate your care with your physical therapists, pharmacist, suppliers of medical equipment, referring/primary treating physician, or in the event of an emergency.
2. To file claims with your insurance carrier for the purpose of billing and payment.
3. To comply with Worker's Compensation regulations.
4. At the request of public health oversight agencies that are authorized to collect information.
5. At the request of a law enforcement official.
6. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of others.
7. As legally required in the case of lawsuits or similar proceedings.

Your rights regarding your health information:

1. Except as described in this notice, we will use and disclose your health information only with your written consent. You may revoke your consent to disclose at any time.
2. You can request a restriction in our use or disclosure of your health information. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Pain Treatment Centers of Georgia.
4. You may ask us to amend your health information if you believe it is incomplete or incorrect, and as long as the information is kept by or for our practice. You must submit an amendment in writing to Pain Treatment Centers of Georgia. You must provide us with a legitimate reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy by asking the front desk.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing to Pain Treatment Centers of Georgia. You will not be penalized for filing a complaint.

I acknowledge that I have been provided a Privacy Notice and understand my rights as a patient.

_____/____/_____

Patient's or Authorized Representative's Name and Signature Date

P|T|C OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

PAYMENT POLICIES

Please review the following payment policies and ask us any questions you may have. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please get in touch with your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us uphold the law by paying your co-payment and deductible at each visit.
3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.
4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. Missed appointments. Our policy is to charge for missed appointments not canceled within a 24-hour period prior to an appointment. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointments.

I have read and understand the payment policy and agree to abide by its guidelines:

_____/____/_____

Patient's or Authorized Representative's Name and Signature Date

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend this consent to continue in nature even after a specific diagnosis has been made and treatment recommended, and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at Pain Treatment Centers of Georgia. I understand that if additional testing and invasive/interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____/____/_____

Patient's or Authorized Representative's Name and Signature Date

PTC OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ **DOB**: ____/____/_____ **SSN#**: _____-_____-_____

Street address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone #: (_____)_____ **Alternate Phone #**: (_____)_____

I (the patient) **authorize Pain Treatment Centers of Georgia to**:

- Obtain medical records from another doctor or medical facility: _____ (please initial)
- Release medical records to another doctor or mental facility: _____ (please initial)
- Share medical information/records with the persons(s) indicated below: _____ (please initial)

Doctor/facility: _____ **Phone #**: (_____)_____ **Fax**: (_____)_____

Street address: _____ **City**: _____ **State**: _____ **Zip**: _____

RELEASE THESE RECORDS (check one): □ All Medical Records □ Specific Records: _____

I authorize the release of the above information with the <u>exception of</u> (check all that apply):
□ Substance abuse (if any)
□ AIDS/HIV (if any)
□ Psychological/psychiatric records (if any)

This authorization will remain in effect indefinitely or until revoked in writing.

Photocopy: I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that the healthcare organization may deny the release of protected health information if it has reason to believe (1) the authorization has been altered or (2) is not a true and accurate authorization initiated by the patient or (3) is dated prior to the treatment dates for which the records are being requested.

I understand that I have the right to:

- Revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and send my written revocation to Pain Treatment Centers of Georgia. I understand that the revocation will not apply to the information that has already been released in response to this authorization. I understand it does not apply to Pain Treatment Centers of Georgia when the law provides it the right to contest a claim under my policy.
- I understand that I do not have to sign this authorization and that Pain Treatment Centers of Georgia may not condition treatment, payment, enrollment in health plan, or eligibility for benefits on whether I sign this authorization.
- I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient, and the information may not be protected by Federal Policy Regulations.
- Right to Copy/Voluntary Disclosure: I know I have the right to receive a copy of this authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

_____/____/_____
Patient's or Authorized Representative's Name and Signature Date

If signed by a legal representative, please provide the representative's documentation as required by state law (i.e., Power of Attorney, Health Care Surrogate, Living Will, or Guardianship papers)

PTC OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

OPIOID RISK TOOL (ORT)

Please mark each question as either "Yes" or "No" depending on if the question applies to you. Use *"✓"* to indicate your answer.

	Yes	No
Has there been a family history of alcohol abuse?		
Has there been a family history of illegal drug use?		
Has there been a family history of prescription drug use?		
Has there been a personal history of alcohol abuse?		
Has there been a personal history of illegal drug abuse?		
Has there been a personal history of prescription drug abuse?		
Aged between 16 - 45 years?		
Has there been a history of preadolescent sexual abuse?		
Has there been a personal history of Attention Deficit Disorder (ADD or ADHD), bipolar or schizophrenia?		
Has there been a personal history of depression?		

Clinic use (score): _____

PTC OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

PATIENT HEALTH QUESTIONNAIRE – 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please use *"✓"* to indicate your answer.

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things?				
Feeling down, depressed, or hopeless?				
Trouble falling or staying asleep, or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down?				
Trouble concentrating on things, such as reading the newspaper or watching TV?				
Moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?				
Thoughts that you would be better off dead, or thoughts of hurting yourself in some way?				

Clinic use (score): _____

New Patient Packet (Initials:_____ DOB: ____/____/_____)

Alcohol (Audit-C)

How often did you have a drink containing alcohol in the past year?

Frequency	Response (use "✓" to indicate your answer)
Never	
Monthly or less	
2 to 4 times a month	
2 to 3 times a week	
4 or more times a week	

If "Consuming Alcohol": How many drinks did you have on a typical day when you were drinking in the past year?

Frequency	Response (use "✓" to indicate your answer)
1 to 2 drinks	
3 to 4 drinks	
5 to 6 drinks	
7 to 9 drinks	
10 or more drinks	

If "Consuming Alcohol": How often did you have 6 or more drinks on one occasion in the past year?

Frequency	Response (use "✓" to indicate your answer)
Never	
Less than a month	
Monthly	
Weekly	
Daily or almost daily	

PTC OF GEORGIA

New Patient Packet (Initials:_____ DOB: ____/____/_____)

Tobacco use (including e-cigarettes and vapes)

Indicate current status	Response (use "✓" to indicate your answer)
Currently smoke	
Used to smoke	
Never smoked	
2 to 3 times a week	
4 or more times a week	

If "current smoker": When did you start smoking? _____

If "current smoker": How often do you smoke?

Indicate current status	Response (use "✓" to indicate your answer)
Every day	
Some days, but not every day	

If "current smoker": How many cigarettes a day do you smoke?

Indicate current status	Response (use "✓" to indicate your answer)
5 or less	
6-10	
11-20	
21-30	
31 or more	

If "current smoker": How soon after you wake up do you smoke your first cigarette?

Indicate current status	Response (use "✓" to indicate your answer)
Within 5 minutes	
6-30 minutes	
31-60 minutes	
After 60 minutes	

If "current smoker": Are you interested in quitting?

Indicate current status	Response (use "✓" to indicate your answer)
Ready to quit	
Thinking about quitting	
Not ready to quit	