LIDIA ZYLOWSKA M.D.
400 Carlton Ave, Suite 7 740 Front St., Suite 130
Los Gatos, CA 95060 Santa Cruz, CA 95060
Phone 408 416 4400 & Fax 408 843 1707

Dear New Patient,

Welcome to my office! In preparation for our first meeting, please review and fill out the following forms which explain our office policies and help you summarize your medical and mental health history.

Please bring the filled out forms to our first appointment. In addition, please bring:

-Any **labwork results** from the past six months
-If taking dietary or herbal supplements, bring the actual **bottles of your supplements**

FOR ADHD EVALUATIONS ONLY:
-If available, please bring copies of any prior **psychological or educational testing**

Please call my office if you have any questions. I look forward to meeting you at our first appointment.

Best Regards,

Lidia Zylowska M.D.

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400 Carlton Ave, Suite 7 — Los Gatos, CA 95060
740 Front St., Suite 130 — Santa Cruz, CA 95060
Phone 408 416 4400 & Fax 408 843 1707

CONSENTS AND OFFICE POLICY

Name:____

Authorization for Evaluation and/or Treatment
I authorize Dr. Lidia Zylowska M.D. to carry out psychiatric exams, treatment and/or diagnostic procedures during the course of my treatment. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that that while the course of my treatment is designed to be helpful, Lidia Zylowska M.D. can make no guarantees about the outcome of my treatment. Further, the evaluation process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger.

Cancellation and Missed Appointment Policy
Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 business hours notice, you will be billed according to the scheduled fee.

Payment and Billing
Payment for services is due when services are rendered.
1) Patients will receive a monthly statement itemizing previous balance, current charges, payments and balance due.
2) Accounts with balance due over 90 days, and no current payment history are subject to be referred to a collections agency. Patients will be given notice of delinquent account with an opportunity to make payment and arrange a payment schedule prior to collections agency action.

Your Record and Confidentiality
A federal regulation called HIPAA requires that you be given information about how your personal health information is kept confidential or handled. For the detailed version of HIPAA, please visit www.hhs.gov/ocr/privacy/index.html. Our notice of privacy practices is also available online at www.lidiazylowska.com

Limits of Confidentiality
1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patient presents as a physical danger to self (Johnson v County of Los Angeles, 1983).
4. The patient presents as a danger to others (Tarasoff v. Regents of University of California, 1967).
5. Child or Elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes).

Emergencies:
Lidia Zylowska M.D. or another covering psychiatrist is available after hours to handle urgent calls or emergencies. By calling 408 416 4400 during or after hours, you will be instructed on how to handle emergencies.

Release of Information
I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information including diagnosis for pharmacy prior certification, claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

Signature:____ Date__________________

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Acknowledgment of Notice of Privacy Practices (HIPPA)

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Receipt and Acknowledgment of Notice

NAME:____

DOB:______________________

I have been provided information regarding the Notice of Privacy Practices for Lidia Zylowska M.D. with an effective date of 11/1/13
If I have any questions regarding the Notice or my privacy rights, I can contact Lidia Zylowska M.D. 400 Carlton Ave, Suite 7, Los Gatos, CA 95060.

____

Signature of Patient, Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

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Patient Information and Optional Consent for Email Communication

Email communication is a form of communication using Internet web email platforms or other email applications.

******Please note that email should never be used for clinical, sensitive emergency or other time-sensitive communication. These should occur via the regular office telephone or the urgent phone line such as pager.**

Potential Benefits

- Patient convenience

Potential Risks

- Common email applications such as Google or Yahoo **are not** considered secure. If you use such email communication, you should understand that the privacy of your information is not protected and can be forwarded, intercepted or even changed without your knowledge. Accordingly, if you choose to use email communication, you accept the risks associated with such online communication.

My Rights and Responsibilities

- I have the right to withhold or withdraw my consent to the use of email communication during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment. I also understand that Dr. Zylowska has the right to withhold or withdraw his consent for the use of email communication during the course of my care at any time.
- I understand that email communication should not be used to communicate sensitive medical information such as treatment for or information related to HIV/AIDS, sexually transmitted diseases or addiction treatment.
- I will keep my passwords and email communication confidential. Dr. Zylowska will also do the same.
- I understand that email communication becomes part of my medical record.

Patient Consent To Use Email Communication
I have read and understand the information provided above and I give my informed consent for the use of email communication in the course of my medical care with Lidia Zylowska, MD.

Your name and your email address to be used:

____

Signature of Patient or Authorized signer (If authorized signer, please state your relationship to Patient):

____

Date:______________________

LIDIA ZYLOWSKA, M.D.

Patient Information

Name: ______________________________________ **Date:** ________________________

Referred By: ____

Date of Birth: _____/______/_____ **Social Security Number:** __________________________

Driver's License Number: _________________ **State of Issue:** _________________________

Are You a Medicare Beneficiary **Yes**____ **No**____

Home Address: ____

____

Billing Address: (If different from above) ____

____

Home Phone: ________________________ ☐ Okay to leave messages here?

Work Phone: ________________________ ☐ Okay to leave messages here?

Other Phone: ________________________ ☐ Okay to leave messages here?

Marital Status: ________________**Spouse's / S.O. Name:** _______________________________

Primary Care Doctor's Name and Phone: ____

Therapist's Name and Phone: ____

Emergency Contact: ____

NAME PHONE

____

ADDRESS CITY STATE ZIP CODE

Primary Reason for Seeking Treatment or Evaluation:

____

Psychiatric History

Is this your first time seeing a mental health provider? Yes___ No____

If no, list your age at first contact with a mental health provider:____________________________

Reason for initial contact:____

Any prior mental health diagnoses?

____

Therapy History (Past and current):

Who	When	Where	Why

Current <u>medications and supplements</u> Please use an additional sheet if needed.

Name	Reason for taking it	Dose	Duration	Effect

Psychiatric History

Past Medications

The medications below are sometimes prescribed for psychiatric problems. Please circle any that you have taken in the past.

Abilify
Adderall
alprazolam
Ambien
amitriptyline
amoxapine
amphetamine
Anafranil
Antabuse
Asendin
atenolol
Ativan
atomoxetine
Aventyl
bupropion
Buspar
buspirone
carbamazepine
Carbatrol
Celexa
Centrax
chlordiazepoxide
chlorpromazine
citalopram
clomipramine
clonazepam
clorazepate
clozapine
Clozaril
Concerta
Cylert
Dalmane
Depakene
Depakote
desipramine
Desyrel
Dexedrine
dextroamphetamine
diazepam
divalproex sodium
doxepin
Effexor
Elavil
escitralopram
Eskalith
fluoxetine
fluphenazine
flurazepam
fluvoxamine
Focalin
gabapentin
Geodon
Halcion
Haldol
haloperidol
imipramine
Inderal
Klonopin
Lamictal
lamotrigine
Lexapro
Librium
lithium
Lithobid
Lithonate
Lithotabs
lorazepam
loxapine
Loxitane
ludiomil
Lunesta
Luvox
maprotiline
Mellaril
mesoridazine
Metadate
metamphetamine
Methylin
methylphenidate
mirtazapine
Moban
Modafanil
molindone
Nardil
Navane
nefazodone
Neurontin
Norpramin
nortriptyline
olanzapine
Orap
oxazepam
Pamelor
Parnate
paroxetine
Paxil
pemoline
perphenazine
phenelzine
Pimozide
prazepam
Prolixin
Primidone
propranolol
protriptyline
Provigil
Prozac
quetiapine
Remeron
Restoril
Risperdal
risperidone
Ritalin
Rozeram
Serax
Serentil
Seroquel
sertraline
Serzone
Sinequan
Stelazine
Strattera
Surmontil
Tegretol
temazepam
Tenormin
thioridazine
thiothixene
Thorazine
Tofranil
Topamax
topiramate
Tranxene
tranylcypromine
trazodone
triazolam
trifluoperazine
Trilafon
trimipramine
Valium
valproic acid
venlafaxine
Vivactil
Wellbutrin
Xanax
ziprasidone
Zoloft
zopiclone
Zydis
Zyprexa

Hospitalization History

If you have ever been hospitalized for a psychiatric problem, please indicate below. Use the back of the page if you need to.

When	Where	Reason

Continued on next page

Medical History

Medical problems

Please mark whether you or a blood-related family member (parent, sibling, grandparent, aunt or uncle) have had this medical problem now or in the past.

Now	Past	Family	Problem	Now	Past	Family	Problem
			Alcoholism				Other genetic diseases
			Anemia				Hay fever
			Anesthesia problem				Hearing problems
			Arthritis				High cholesterol
			Asthma				High blood pressure
			Bleeding problem				Immune disease
			Cancer, Breast				Kidney diseases
			Cancer, Colon				Mental retardation
			Cancer, Melanoma				Osteoporosis
			Cancer, Ovary				Epilepsy (seizure)
			Cancer, Prostate				Stroke
			Heart Attack				Substance abuse
			Birth Defects				Thyroid disorder
			Diabetes (childhood)				Smoking
			Diabetes (adult onset)				Tuberculosis
			Eczema				Migraines
			Food allergies				Gout
			AIDS/HIV				Glaucoma
			Hepatitis				Other
			Emphysema				Other

Substances

Please mark whether you are currently using any of the following substances now or in the past, whether prescribed or not.

Now	Past	Substance	Now	Past	Substance
		Alcohol			Mescaline
		Amphetamines			Methadone
		Cocaine			Opiates
		Ecstasy			PCP
		Hallucinogens			Peyote
		Heroin			Ritalin
		Illicit prescription drugs			Sedatives
		Ketamine			Other street drugs
		LSD			Tobacco products
		Marijuana			Tranquilizers

Continued on next page

Medical History, Continued

Symptoms and tests

Please circle whether you have had any of the following problems or tests in the **LAST YEAR**.

Unexplained weight gain of 20 lbs	High blood pressure	Prolonged bleeding
Unexplained weight loss of 20 lbs	Heart murmur	Swollen lymph glands
Heat intolerance	Fainting episode	Anemia
Cold intolerance	Cardiovascular disease	Leukemia
Excessive appetite	Difficulty or pain swallowing	Blood disorder
Unusual thirst	Frequent vomiting	Persistent rash
Abnormal hair growth	Persistent gas, heartburn	Moles changed in size or color
Change in sexual drive	Frequent belly pain	Lumps or soreness of breast
Frequent eye pain	Persistent constipation	Bloody discharge from nipples
Failing vision	Change in bowel habits	Psoriasis
Hearing troubles	Blood in stool	Broken bone
Ear pain or discharge	Blood on toilet paper	Back pain
Severe nosebleeds	Black or tarry stools	Headaches
Painful teeth	Loss of appetite	Double vision
Persistent sores on lips or tongue	Ulcer	Dizzy spells
Persistent hoarseness	Jaundice or hepatitis	Blackouts
Loss of vision in one or both eyes	Diverticulitis	Lost ability to speak
Retinal detachment	Gall stones	Troubles with memory
Cataract	Polyp or tumor of bowel	Coordination problems
Eye, Ear, Nose, Throat surgery	Abdominal surgery	Stroke
Daily cough	Trouble passing urine	Seizure
Severe snoring	Bloody urine	Paralysis
Asthma	Kidney or bladder infection	Multiple sclerosis
Skipped or irregular heartbeat	Treatment for venereal disease	X-Rays
Chest pain or discomfort	Kidney or bladder surgery	MRI
Shortness of breath	Discharge from penis	CT
Swollen ankles or feet	Lump or swelling of testicle	EEG
Leg cramps brought on by walking	Decrease in erections	EKG

Brief Patient Health Questionnaire™ (PHQ-Brief)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Name____________________ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**________

1. Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?	**Not at all**	**Sever al days**	**More than half the days**	**Nearl y every day**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. 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	☐	☐	☐	☐
i. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

2. Questions about anxiety.

	NO	**YES**
a. In the <u>last 4 weeks</u>, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐
If you checked "NO", go to question #3.		
b. Has this ever happened before?	☐	☐
c. Do some of these attacks come <u>suddenly out of the blue</u> — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off <u>any</u> problems on this questionnaire so far, how <u>difficult</u> 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**
☐	☐	☐	☐

FOR OFFICE CODING: Maj Dep Syn if answers to #1a or b and five or more of #1a-i are at least "More than half the days" (count #1i if present at all). Other Dep Syn if #1a or b and two, three, or four of #1a-i are at least "More than half the days" (count #1i if present at all). Pan Syn if all of #2a-e are "YES."

4. In the last 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered	Bothered a little	Bothered a lot
a. Worrying about your health	☐	☐	☐
b. Your weight or how you look	☐	☐	☐
c. Little or no sexual desire or pleasure during sex	☐	☐	☐
d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
e. The stress of taking care of children, parents, or other family members	☐	☐	☐
f. Stress at work outside of the home or at school	☐	☐	☐
g. Financial problems or worries	☐	☐	☐
h. Having no one to turn to when you have a problem	☐	☐	☐
i. Something bad that happened recently	☐	☐	☐
j. Thinking or dreaming about something terrible that happened to you in the past - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

	NO	YES
5. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?	☐	☐

6. What is the most stressful thing in your life right now? ______________________________

____

	NO	YES
7. Are you taking any medicine for anxiety, depression or stress?	☐	☐

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.

a. Which best describes your menstrual periods?

☐ **Periods are unchanged** ☐ **No periods because pregnant or recently gave birth** ☐ **Periods have become irregular or changed in frequency, duration or amount** ☐ **No periods for at least a year** ☐ **Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive**

	NO (or does not apply)	YES
a. During the week before your period starts, do you have a serious problem with your mood - like depression, anxiety, irritability, anger or mood swings	☐	☐
b. If YES: Do these problems go away by the end of your period?	☐	☐
c. Have you given birth within the last 6 months?	☐	☐
d. Have you had a miscarriage within the last 6 months?	☐	☐
e. Are you having difficulty getting pregnant?	☐	☐

Developed by Drs Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke, and other colleagues, with an educational grant from Pfizer, Inc. For research information, contact Dr. Spitzer at rls8@columbia.edu. The names PRIME-MD® and PRIME-MD TODAY® are trademarks of Pfizer Inc.

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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

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?	☐ Yes	☐ No
...you were so irritable that you shouted at people or started fights or arguments?	☐ Yes	☐ No
...you felt much more self-confident than usual?	☐ Yes	☐ No
...you got much less sleep than usual and found you didn't really miss it?	☐ Yes	☐ No
...you were much more talkative or spoke much faster than usual?	☐ Yes	☐ No
...thoughts raced through your head or you couldn't slow your mind down?	☐ Yes	☐ No
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐ Yes	☐ No
...you had much more energy than usual?	☐ Yes	☐ No
...you were much more active or did many more things than usual?	☐ Yes	☐ No
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐ Yes	☐ No
...you were much more interested in sex than usual?	☐ Yes	☐ No
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐ Yes	☐ No
...spending money got you or your family into trouble?	☐ Yes	☐ No
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐ Yes	☐ No

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 select one response only.

☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem