TAK
Center for Mental Health
1069 Central Street, Leominster MA 01453 T: 978.728.4957 F: 978.798.1366

We would like to take this opportunity to welcome you to our practice and to thank you for choosing

TAK Center for Mental Health.

Upon completion of this paperwork, please mail, email, or drop it off at the office. The office will call to schedule your appointment once we have received a completed packet from you. A week prior to being seen, we will call to confirm your appointment. **It is essential that we receive verbal confirmation from you. If we are unsuccessful at reaching you to obtain this verbal confirmation, your appointment will be cancelled.** Please make sure to call us back when we leave a message**. If you cancel your new patient appointment less than 24 hours prior to your scheduled appointment time, or you "no show" for your new patient appointment, there is a $250 rebooking charge that is due before we are able to reschedule your missed appointment.**

Our office is open for patient appointments Monday-Thursday, 8:00am-6:00pm.

You can reach us by phone Monday- Thursday 8:00am-6:00pm at 978-728-4957.

Before your first visit, please contact your insurance company to verify your Behavioral Health benefits; they will be able to tell you what your financial responsibility is for your visits (copay, deductible, co-insurance, etc) as well as if Dr. Rezai is within your insurance network.

Please fill out the enclosed forms and bring them with you to your appointment. During your initial visit, Dr. Rezai will be reviewing these forms as they contain information necessary to complete this process. It is very important to fill out each section of this paperwork as this will help Dr. Rezai provide you with the best possible care.

Please include a copy of your health insurance identification card with this packet. **(we will also need to scan it into our system when you come in for your visit) If you are meeting with the providers for a telehealth visit, the office will call you after your appointment to collect your copay and make a follow up appointment. There is a billing charge of $20.00 if you do not pay your copay at the time of your visit and this fee along with your copay will be due before your next scheduled appointment.**

If you have any questions while filling out the new patient questionnaire, about your first visit, or anything else that may come up, we are more than happy to help you and can be reached at 978-728-4957.

Once again, we would like to thank you for choosing TAK Center for Mental Health. We look forward to working with you.

Sincerely,

Dr. Ramteen Rezai, Meagan Dembitzky, CNP, Alice McLeod, CNP and Staff of TAK Center for Mental Health

Email address: takcmhinfo@takmedgroup.com

Mailing address: TAK Center for Mental Health 1069 Central Street, Leominster MA 01453

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Medication Agreement

A good provider-patient relationship is critical for good health care. Trust, understanding, and open communication is at its core. For this reason, the following treatment agreement has been developed in order to have a positive therapeutic relationship.

These mutually agreed upon conditions are the foundation for your treatment at TAK Center for Mental Health. If you do not comply with these conditions, your treatment will be terminated from the practice effective immediately.

I _____, agree to the following conditions:

1. I agree to obtain my Psychiatric medication prescriptions from this office only. I will have these prescriptions filled at one pharmacy. The pharmacy of my choosing is _____. If I have a change in pharmacy, I agree to notify the office as soon as the switch is made. I understand that my pharmacy records may be accessed to verify my compliance.

2. I agree to take my medications only as prescribed. I will not vary the dosage or interval of taking these medications without first discussing it with my Provider or the designated covering Provider.

3. I consent to this office having full and open communication with all of my health care Providers and my Pharmacist. I understand that this is important and allows you to provide full and appropriate care for me.

4. I understand that the Provider will only provide refills of my prescriptions during regular office hours; Monday-Thursday 8:00am-6:00pm, ideally at the time of my appointment. No other telephone request for refills will be provided. I understand that it is my responsibility to know when my medications are running low and I should call the office 4 days in advance of running out of medications for a refill.

5. I will keep all scheduled appointments. If I miss an appointment- a no show or cancellation/reschedule- I may be discharged from the practice, per the Terms and Treatment Agreement I have signed previously.

6. If I am a female of childbearing age, I agree to notify you if I become pregnant.

7. I agree to submit to planned and unannounced random oral, urine or blood testing in order to properly assess the effects of my medications and compliance. If I refuse the testing, the medication will be stopped. If the results of my testing show that I am positive for illegal drugs or medications not prescribed by this office (unless the Provider is aware that I am prescribed these medications from another Provider), I will be immediately discharged from this practice. I understand that I am responsible for any costs that may be incurred from this testing.

8. I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of the reach of children. A copy of a police report will be required for any lost or stolen controlled substance medications. Refills will not be given early.

9. I agree to notify this office within 3 working days if any narcotics or other controlled medications are prescribed for me by any other sources. (Dentist, Emergency Depts., etc.)

10. I understand that my treatment in this office will be discontinued if I give to others, trade, sell, or misuse these drugs.

I have read this agreement, understand it and have had all questions answered to my satisfaction. I agree to the proper use of my medications and understand that my treatment will be carried out according to the conditions stated above. I understand that failing to keep this agreement will result in my care at this practice being terminated with a 30-day notice. A copy of this agreement will be given to me, and one will be kept in my medical record.

Patient/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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TERMS AND TREATMENT AGREEMENT

APPOINTMENT POLICY

It is very important that you keep your scheduled appointments. While we understand that there are situations that arise that may keep you from making your appointment, we ask that you kindly call the office at least 24 hours in advance to reschedule your appointment. Missing more than one in four visits, or being more than 10 minutes late for more than one in four visits, is grounds for termination from the practice.

Any patient that arrives 10 minutes late for their appointment will only be seen if the physician's schedule allows.

If you do not call to cancel or reschedule prior to 24 hours of your appointment, you may be charged for the missed visit. The first missed appointment will result in a $50 charge, the second a $100 charge, and the third a $150 charge and/or dismissal from the practice. This fee will be added to your account and is the patient's responsibility, as we cannot charge your insurance company for your missed appointments**.** ***Payment of this fee must be received prior to your next appointment.***

MEDICATION REFILLS

TAK Center for Mental Health requires that you use one pharmacy for your medication refills. This pharmacy should be listed on our HIPPA form.

Medication refills require a 48 hour notice. Refill requests will only be processed during normal business hours; Monday-Thursday 8:00am-6:00pm. ***Please do not wait until you are completely out of a medication to call for a refill.***

No medications will be refilled after hours or by the on call physician.

PAYMENTS AND FEES

We accept major credit cards and Health Savings Account cards for your convenience. If you are experiencing financial difficulties, you may qualify for certain special payment schedules. Co-payments are to be paid at the time of the appointment and are a patient's responsibility. Failure to pay your co-payment will result in a $20 billing charge. Deductibles will be billed to you after we hear from your insurance company and are the patient's responsibility.

INSURANCE

We accept most insurance health policies and generally our services are covered in full or in part by your health insurance or employee benefit plan. Our staff is available to assist you in determining your available coverage. Medical Reimbursement Accounts: You may use a pre-tax health reimbursement account or flexible spending plans. If your insurance policy is not accepted, you may call your carrier directly to see if our providers may be covered or it there is an out-of-network benefit available or you can self-pay for your visits. If you are self-paying, payment is due at the time the service is rendered.

_____ _____

Patient Signature (o*r Guardian if patient is under the age of 18*) Date

_____ _____

Witness Signature Date

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AUTHORIZATION/REQUEST FOR RELEASE of MEDICAL HEALTH RECORD

(Also known as Protected Health Information)

Date: / /

Patient Name _____ Date of Birth _____

Address _____

Provider Information

*Primary Care Physician or another Medical Professional

Name _____

Address _____

Phone Number_____

Fax Number _____

Please fax TAK Center for Mental Health the last office note/physical exam, any brain MRI/CT Scans, neurological testing, and most recent labs for the patient listed above to 978.798.1366

Behavioral Health Provider Information
Name Dr. Ramteen Rezai
Address 1069 Central Street, Leominster, MA 01453
Phone Number 978.728.4957
Fax Number 978.798.1366

I, (or on behalf of) _____ give permission to the providers listed above to exchange information about my medical and behavioral health.

In addition:

I authorize the exchange of information about any substance or alcohol abuse in my medical records.

[ ] Yes [ ] No

I authorize the exchange of information about any HIV blood tests results or HIV- or AIDS- related care in my medical records.

[ ] Yes [ ] No

1. I understand that, unless withdrawn, this authorization will expire 1 year from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the TAK Center for Mental Health at the address indicated above, in writing, and this authorization will cease to be effective on the date notified unless the information has already been released.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I hereby release all parties stated herewith from any liability resulting from the release of this information.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legally Authorized Representative Relationship and Date

_____ _____
Printed Name of Authorized Representative Date

Refusal to Release Information

[ ] I do not consent to release the information as described above. However, I understand that if I do not allow my providers to exchange information about me, their ability to fully coordinate my care may be limited. I understand that in an emergency situation my providers may exchange information about me to the extent necessary.

Signature of patient/guardian _____ Date _____

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AUTHORIZATION/REQUEST FOR RELEASE of BEHAVORIAL HEALTH RECORD

(Also known as Protected Health Information)

Date: / /

Patient Name _____ Date of Birth _____

Address _____

Provider Information

**Please include your therapist, previous Psychiatrist, or any other provider that you would like us to be able to speak with/contact*

Name _____

Address _____

Phone Number_____

Fax Number _____

Please fax TAK Center for Mental Health any Behavior Health office notes for the patient listed above to 978.798.1366

Behavioral Health Provider Information
Name Dr. Ramteen Rezai
Address 1069 Central Street, Leominster, MA 01453
Phone Number 978.728.4957
Fax Number 978.798.1366

I, (or on behalf of) _____ give permission to the providers listed above to exchange information about my medical and behavioral health.

In addition:

I authorize the exchange of information about any substance or alcohol abuse in my medical records.

[ ] Yes [ ] No

I authorize the exchange of information about any HIV blood tests results or HIV- or AIDS- related care in my medical records.

[ ] Yes [ ] No

1. I understand that, unless withdrawn, this authorization will expire 1 year from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the TAK Center for Mental Health at the address indicated above, in writing, and this authorization will cease to be effective on the date notified unless the information has already been released.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I hereby release all parties stated herewith from any liability resulting from the release of this information.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legally Authorized Representative Relationship and Date

_____ _____
Printed Name of Authorized Representative Date

Refusal to Release Information

I do not consent to release the information as described above. However, I understand that if I do not allow my providers to exchange information about me, their ability to fully coordinate my care may be limited. I understand that in an emergency situation my providers may exchange information about me to the extent necessary.

Signature of patient/guardian _____ Date _____

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NEW PATIENT QUESTIONNAIRE

Date _____

Name _____ Date of Birth _____

Who were you referred by? _____

Marital status: __married __single ___divorced __widowed __long term relationship

Do you have any children? __yes __no If yes, how many____ ages of children_____

Current living situation: ___ apartment/house ___ community residence

___ supported housing ___ shelter___ other: _____

How long have you lived at current residence? _____ Do you live alone? __ yes __ no

If no, who lives with you?

Name(s)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

FINANCES

What are your present sources of financial support? (Check all that apply)

__ Employment __ Savings __ Disability __ Worker's comp

__ Spouse __ Parents __ Retirement __ Investments __Other

_____

CURRENT PROBLEMS

Please check **all that currently apply**. (past month)

[ ] Depressed mood

[ ] Decreased motivation or pleasure

[ ] Crying [ ] Guilty feelings

[ ] Hopelessness

[ ] Suicidal thoughts

[ ] Recurrent thoughts of death

[ ] Change in sexual interest or drive

[ ] Impaired sexual performance

[ ] Eating disturbances

[ ] Sleep disturbance

[ ] Irritability

[ ] Anger

[ ] Aggression

[ ] Violent fantasies

[ ] Fear of losing control

[ ] Anxiety

[ ] Panic attacks

[ ] Embarrassed easily; very shy

[ ] Excessive worrying

[ ] Phobias

[ ] Intrusive daytime thoughts or flashbacks

[ ] Frequent nightmares

[ ] Feeling disconnected from self

[ ] Extreme happiness/energy

[ ] Extreme mood swings

[ ] Racing thoughts

[ ] Seeing or hearing things that are not real

[ ] Feel like people are trying to hurt you

[ ] Poor concentration

[ ] Problems with memory

[ ] Recent stressful life events

Comments: _____

PSYCHIATRIC HISTORY

Have you ever met with a mental health professional (psychiatrist/psychologist/therapist)?

[ ] yes[ ] no

If so, please provide the following information:

Name and degree	City	Problem	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been sexually, emotionally or physically abused by a family member or anyone else? **[ ] yes[ ] no**

Have you ever been hospitalized for a psychiatric problem? **[ ] yes[ ] no**

If so, please provide the following information for each hospitalization.

Name of Hospital	City	Year
_____	_____	_____
_____	_____	_____

In the past month:

Have you wished you were dead or wished you could go to sleep and not wake up? **[ ] yes[ ] no**

Have you actually had any thoughts of killing yourself? **[ ] yes[ ] no**

Have you been thinking about or planning how you might kill yourself? **[ ] yes[ ] no**

Have you had intention of acting on your thoughts or carrying out your plan? **[ ] yes [ ] no**

In the past (at any time):

Have you ever attempted to kill yourself? **[ ] yes[ ] no**

If yes, how many times and how long ago? _____

In the past month:

Have you ever purposely hurt yourself? (cutting, burning, etc.) **[ ] yes [ ] no**

In the past (at any time):

Have you ever had thoughts or fantasies about harming other people? **[ ] yes [ ] no**

Have you ever been violent toward other people? **[ ] yes[ ] no**

Do you currently have access to a gun? **[ ] yes[ ] no**

MEDICATIONS

List all prescribed **(psychiatric AND medical**) AND over the counter medications that you take regularly. Include vitamins, supplements, etc.

Medication Name	Dose	Tablets per Day	Date Started	Prescribed By
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list all psychiatric medications that either has **not been helpful** or that you **stopped taking**.

Medication	Max Dose	Length Taken	Last taken	Reason Stopped
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications? **[ ] yes [ ] no**

If so, please provide medication name and describe the reaction that you had.

_____

Have you ever had any other serious reactions to any specific medication? **[ ] yes [ ] no**

If so, please provide medication name and the reaction that you had.

_____

SUBSTANCE USE

Caffeine [ ] none [ ] cups of coffee per day _____ [ ] cans of soda a day _____ [ ] energy drinks _____

Cigarettes [ ] nonsmoker: I never smoked [ ] nonsmoker: I am a former smoker When did you quit? ___

[ ] smoker: packs per day _____ Would you like to quit smoking? [ ] yes [ ] no

Cannabis/marijuana [ ] none [ ] currently using

If you currently use cannabis/marijuana, how many times a week do you use and

in what form? _____

Is this use [ ] recreational [ ] prescribed for a medical condition

Alcohol Use – In the last year…

(One standard drink= a regular size can of beer (12oz); a small glass of wine (5oz); one "shot" (1.5oz) of liquor)

Please circle the correct answer:

1. In the last year, how often do you have a drink containing alcohol?
   (0) Never **(Skip Questions 2-10)**
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 4 times a week
   (4) 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more
3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during this last year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
8. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?
   (0) No
   (1) Yes, but not in the last year
   (2) Yes, during the last year
10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?
   (0) No
   (1) Yes, but not in the last year
   (2) Yes, during the last year

If you drink alcohol:

1. Have you ever felt you needed to cut down on your drinking? **[ ] yes [ ]no**
2. Have people annoyed you by criticizing your drinking? **[ ] yes [ ]no**
3. Have you ever felt guilty about drinking? **[ ] yes [ ]no**
4. Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover? **[ ] yes [ ]no**

Have you ever participated in a 12-step program (AA, NA, Gamblers, etc) [ ] yes[ ] no
Have you ever been treated in an outpatient drug-related program? [ ] yes[ ] no

Where? _____ When? _____

Have you ever been treated in an inpatient drug-alcohol rehab? [ ] yes[ ] no

Where? _____ When? _____

SUBSTANCE USE

Name of the drug (Please include prescription opiates and tranquilizers (Valium, Xanax, Halcion, Ativan, Librium etc)	Age first used	When last used	How often do you use?
Comments:			

If you are taking any medication from benzodiazepine family or tranquilizers (Valium, Ativan, Klonopin, Xanax, Librium, Halcion etc), are you willing to have them tapered off over time?

[ ] yes [ ] no

FAMILY HISTORY

Is there any **family history** of any of the following psychiatric problems? **Please write the relationship of the family member next to the problem (ie mother, father, sister, brother, etc).**

[ ] Depression _____

[ ] Mania _____

[ ] Suicide or suicide attempts _____

[ ] Anxiety or panic disorder _____

[ ] Schizophrenia _____

[ ] Paranoia _____

[ ] Autism _____

[ ] Eating disorder _____

[ ] Substance abuse _____

[ ] Obsessive compulsive disorder _____

[ ] Hospitalization for mental illness _____

[ ] Other _____

[ ] Outpatient treatment for mental illness _____

Is your Father __alive __deceased __unknown? If deceased, what did he pass from? _____ At what age?____

Is your Mother __alive __deceased __unknown? If deceased, what did she pass from? _____ At what age?____

MEDICAL HISTORY

Physician/Program Name Address Telephone Number

_____ _____ _____

_____ _____ _____

_____ _____ _____

Date of last Physical Exam _____ Weight _____ Height _____

Have you ever been hospitalized for a medical (physical) reason? **[ ] yes [ ] no**

Date of Hospitalization _____

What was the reason for your hospitalization? _____

Have you ever had surgery? **[ ] yes [ ] no**

Nature of Surgery Hospital Date

_____ _____ _____

_____ _____ _____

Please indicate if you have ever received any of the following testing; if not, please mark with "N/A".

	Date	Result (if known) and facility preformed at
CT Scan (brain)	_____	_____
MRI (brain)	_____	_____
EEG	_____	_____
Neuropsychological Testing	_____	_____

Do you have any of the following medical illnesses?	No.	Yes. Please provide further information
AIDS/HIV		
Blood pressure problem		
Cancer		
Diabetes		
Epilepsy/seizures		
Gastrointestinal		
Head Injury (Head trauma		
Heart disease		
Kidney disease		

Liver disease		
Neurological disease (stroke, neuropathy, headaches etc.)		
Thyroid disease		
Musculoskeletal problems		
Sleep Apnea		
Other		

Do you currently have any of these physical symptoms?	**No**	**Yes. Please provide further information.**
Bleeding or bruising		
Cardiac (heart) problem (heart-racing, chest pain, etc.)		
Diarrhea or constipation		
Dizziness, lightheadedness or fainting		
Feel cold or hot		
Headaches		
Muscle spasms or weakness		
Weight change		
Other		

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone number(s): _____

Patient Signature: _____ Date: _____

TAK Center for Mental Health

HIPAA & Consent

Today's date: / / **Primary Care Physician:**

Patient's last name:	**First:**	**Middle Initial:**	**Marital status (circle one):** Single / Mar / Div / Sep / Wid
Former name (if applicable):	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F
Street address:		**Home phone no.:** ( )	**Cell phone no.:** ( )
P.O. box:	**City:**	**State:**	**ZIP Code:**

Race (check all that apply): ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race	**Ethnicity (check one):** ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Social Security No.: _____ - _____ - _____	**E-mail Address:**	**Preferred Pharmacy/Location:**

By signing below, I acknowledge the following:

- I give TCMH (TAK Center for Mental Health) consent to access my prescription history, including all past prescribed medication, in order to verify future prescription refills.
- I give TCMH consent to bill my insurance company for any fees related to services provided by their staff, perform reasonable and necessary medical examinations, testing and treatment at the discretion of its healthcare professionals based on their clinical judgment of my condition.
- I give TCMH consent to bill me directly for any charges denied by my insurance company, and for any charges incurred in the event of lack of insurance coverage at the time of care.
- I understand that TCMH is not responsible for any bills incurred by me for testing, imaging, or services provided by outside facilities, including those services ordered by their staff.
- I give TCMH consent to call, text, and/or email an appointment reminder to the phone number listed above. I understand that there may be a voicemail left for me at this phone number.
- I acknowledge that I have been given access to TCMH's Notice of Privacy Practices.
- I authorize TCMH to discuss my health information with the following person(s):

_____ _____ _____
Name Telephone # Relation

_____ _____ _____
Name Telephone # Relation

❑ Self Only: *If checked, TCMH will not release your information to anyone except as outlined in our Notice of Privacy Practices. Please initial* _____

I release TAK Center for Mental Health (TCMH) from all responsibility and liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to TCMH, provided that I do so in writing and to the extent that we have already disclosed the information in reliance on this authorization.

_____ _____
Patient Signature (*or Guardian if patient is under the age of 18*) Date

_____ _____
Witness Signature Date

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	**YES**	**NO**
...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 that you didn't really miss it?	☐	☐
...you were 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 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 in 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?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem