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MENTAL HEALTH
INNOVATIONS

Arnold Mech, MD
Psychiatrist

PATIENT REGISTRATION FORM

Please complete all sections. The patient, if an adult is regarded as being responsible for all charges generated.

Date: _____

Last Name: _____ First: _____ S.S#: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: _____ Age: _____ Date of Birth: _____ Marital Status: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email: _____ Pharmacy: _____

Emergency contact: Last: _____ First: _____

Relationship to Patient: _____ Phone: _____ Alt: _____

Address: _____

INSURANCE INFORMATION

Person responsible for account: Last: _____ First: _____

Relationship to Patient: _____ Date of Birth: _____ S.S #: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Contact #: _____

Subscriber #: _____ Group #: _____

Name of Insured on Card: _____

Responsible party agrees to fill out new form when any of the above information changes. Wrong information may result in incorrect filing and subsequent charges.

SECONDARY INSURANCE

Insurance Company: _____ Contact #: _____

Subscriber #: _____ Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned, hereby authorize and direct my insurance carrier to pay directly to Mech Mental Health Innovations, PA all insurance benefits, if any, due to me under by insurance plan. I further agree to pay the balance of the charges not paid by my insurance. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as a legal guardian give consent for treatment for this and future services rendered. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Responsible Person/Patient

Signature: _____ Date: _____

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FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ Date of Birth: _____
Last First

1. I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventive exam or physical, prescription refills, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.
2. I understand and agree it is my responsibility and not the responsibility of the Physician or Office to know if my insurance will pay for my medical service or visit, preventive exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.
3. I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment whenever required.
4. I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider is not recognized by insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.
5. I understand that the physician may charge a $35.00 fee if I do not show up for my appointment or cancel without a 24-hour notice.
6. I understand that if I need a copy of my medical records, a printing fee will be charged.
7. I understand that any forms to be filled out by the physicians will have a fee assessed.
8. I understand that I will be required to provide a valid form of payment, either check or credit card which will be run electronically. Any returned check will be charged $30 penalty fee.
9. I understand that any account balance that is 90 days past due will be sent to collections and that it is my responsibility to ensure that my insurance and contact information is always current and updated.

Signature: _____ Date: _____
(Please sign here – Patient or responsible party)

Responsible Party Name: _____
(Please print name of Responsible Party if different from Patient)

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Authorization for Disclosure of Health Information

Patient Name: _____
Date of Birth: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:
Mech Mental Health Innovations
9191 Kyser Way, Suite 101
Frisco, TX 75033

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).
_____ Complete health records
_____ Physical exam
_____ Immunization record
_____ Lab results/X-ray reports
_____ Consultation reports
_____ Other (please specify: _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to the following individual(s):
_____Patient/Guardian _____Spouse _____Child
_____Co-worker _____Secretary _____Receptionist

6. Please indicate where you give the office permission to leave voicemails or texts concerning your appointments:
_____Home Phone _____Cell Phone _____Work Phone

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

_____ _____
Signature of patient or legal representative Signature of witness

Date: _____

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Informed Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

· Patient medical records
· Medical images
· Live two-way audio and video
· Output data from medical devices and sound and video files.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

· Improved access to medical care by enabling a patient to remain in a remote site while the physician obtains test results and consults from a distant/other site.
· More efficient medical evaluation and management.
· Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

· In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
· Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
· In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
· In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By reading this text, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
5. I understand that it is my duty to inform my doctor of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
7. I understand that my insurance deductibles and/or co-pays apply to telemedicine services.

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Patient Consent To The Use of Telemedicine Services

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Arnold Mech, MD to use telemedicine services in the course of my evaluation, diagnosis and treatment.

Signature of Patient: _____ Date:_____
(or authorized signer)

Authorized Signer: _____
(relationship to patient)

Witness: _____ Date:_____

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Patient Name:_____ **Date:**_____

HIPAA Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years.

What this is all about:
Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with Telehealth services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:
1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
3. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
4. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
5. We agree to provide patients with access to their records in accordance with state and federal laws.
6. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

I _____ , do hereby consent and acknowledge my Agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature:_____

Date:_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect December 01, 2021 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made these changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations.

Treatment: We may use or disclose your health information to another healthcare provider for:

a) The provision, coordination, or management of health care and related service by healthcare providers;
b) Consultation between health care providers relating to a patient;
c) The referral of a patient for health care from one health care provider to another, or
d) Recall information

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include:

a. Billing and collection activities and related data processing;
b. Actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims;
c. Medical necessity and appropriateness of care reviews, utilization review activities; and
d. Disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Healthcare Operations: We may use and disclose your health information in connection with our health care operations such as quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Marketing Health Products or Services: We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without prior authorization.

To You, Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so or if it is necessary in our professional judgment.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you an opportunity to object to such uses of professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law, including judicial and administrative proceedings.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders and Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health related benefits and services that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to request a list of instances in which we or our business associates disclosed your information for purposes, other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities. If you request this accounting we may charge you a reasonable fee for responding to these requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternate locations. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

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Psychiatrist

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we have made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of the Notice. You may also submit a written complaint to the U.S Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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Patient Name:_____ **Date:**_____

Please list all medication, psychiatric, or otherwise that you are how taking.

Medication Name	MG	When and How Often

Please list any medication allergies below:

_____

Have you recently had lab work completed? □ Yes □ No

If so, what test and when?_____

Are you currently using a CPAP therapy or an oral appliance? □ Yes □ No

Are you taking any vitamin supplements (B12, Vit D, Iron)? □ Yes □ No

IF so, please list_____

Concerning Sleep:

How many hours do you sleep per night? _____

Do you have trouble failing asleep? □ Yes □ No

Do you feel rested in the morning? □ Yes □ No

Do you drink alcohol? □ Yes □ No

Do you use recreational drugs? □ Yes □ No

Do you use tobacco? □ Yes □ No

How much caffeine do you consume on a daily basis?_____

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Patient Name:_____ **Date:**_____

Please complete the following to allow the doctor or nurse practitioner to make necessary adjustments to your treatment plan.

In reference to your mood/symptoms, how do you feel since your treatment began?

☐ Much Improved ☐ Somewhat Improved ☐ No Change ☐ Worse ☐ Much Worse

In reference to your mood/symptoms, how do you feel since your last visit?

☐ Much Improved ☐ Somewhat Improved ☐ No Change ☐ Worse ☐ Much Worse

How would describe your mental/emotional status today?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

Please describe any new symptoms and summarize areas that continue to be of concern that you would like to discuss below:

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Patient Name:_____ **Date:**_____

Attention Deficit/Hyperactivity Disorder Rating Scale IV

Instructions: Circle the number that best describes you or your child's behavior over the past 6 months in each category.

	Never or Rarely	Sometimes	Often	Very Often
1. Fails to give close attention to details or makes careless mistakes at work/school	0	1	2	3
2. Has difficulty sustaining attention in tasks or activities that require focus	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish work	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids tasks that require extra mental effort	0	1	2	3
7. Loses things necessary for tasks or activities	0	1	2	3
8. Is easily distracted	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
				Subtotal Part A Score_____
10. Fidgets with hands or feet or frequently shifts positions while seated	0	1	2	3
11. Leaves seat at work/school or in church/synagogue or other situations in which remaining seated is expected	0	1	2	3
12. Moves excessively in situations in which it is inappropriate	0	1	2	3
13. Has difficulty engaging in leisure activities quietly	0	1	2	3
14. "On the go" or acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting turn, standing in lines	0	1	2	3
18. Interrupts or intrudes on others	0	1	2	3
				Subtotal Part B Score_____

Total Score (Part A + Part B):_____

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Patient Name:_____ **Date:**_____

FATIQUE ASSESSMENT SCALE (FAS)

Instructions: Below are a number of questions about possible complaints. Please circle the answer to each question that is applicable to you. Please give an answer to each question even if you do not have any complaints at the moment. The aim of this questionnaire is to find out how you experience your complaints. There are no correct or incorrect answers.

	Never	Sometimes	Regularly	Often	Always
1. I am bothered by fatigue	1	2	3	4	5
2. I get tried quickly	1	2	3	4	5
3. I don't do much during the day	1	2	3	4	5
4. I have enough energy for everyday life	1	2	3	4	5
5. Physically, I feel exhausted	1	2	3	4	5
6. I have problems thinking clearly	1	2	3	4	5
7. I have problems starting things	1	2	3	4	5
8. I feel no desire to do anything	1	2	3	4	5
9. Mentally, I feel exhausted	1	2	3	4	5
10. When I am doing something, I can concentrate quite well	1	2	3	4	5

Total Score_____

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Patient Name:_____ **Date:**_____

Holmes Stress Scale

Instructions: Total the values of all the life events that you experienced in the past year.

Death of a spouse	100
Divorce	73
Marital separation	65
Death of a close relative	63
Personal injury or illness	53
Marriage	50
Fired from job	47
Marital reconciliation	45
Retirement	45
Change in health of family member	44
Pregnancy	40
Sexual differences	39
Gain of a new family member	39
Change in financial status	38
Death of a close friend	37
Change to a career or line of work	36
Change in number of arguments with spouse	35
Mortgage or loan for major purchase	31
Foreclosure of mortgage	30
Change in responsibility at work	29
Son or daughter leaving home	29
Trouble with in-laws	29
Outstanding personal achievement	28
Husband/wife starting or stopping work	26
Begin or end school	26
Revision of personal habits	24
Trouble with supervisor/colleagues	23
Change in working hours	20
Change in working conditions	20
Change in residence	20
Change in school	20
Change in recreation	19
Change in church activities	19
Change in social activities	18
Mortgage or loan for lesser purchase (car, computer, etc.)	17
Change in sleeping habits	16
Change in number of family get togethers	15
Change in eating habits	15
Vacation	13
Christmas	12
Minor violations of the law	11
TOTAL	

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Patient Name:_____ **Date:**_____

Mech Depression Inventory

Concerning Matters of Body (Sensations & Experiences)	
1. Pain 0 = I do not have persistent physical pain 1 = I have occasional physical pain 2 = I have a moderate amount of persistent pain 3 = I live with great amounts of persistent pain	5. Eating Patterns & Changes in Appetite 0 = My appetite & eating patterns have not changed 1 = I eat somewhat more or less 2 = I eat significantly more or less than I used to 3 = I eat almost nothing, or I eat compulsively
2. Pleasure 0 = I experience much pleasure from my activities 1 = I experience less physical pleasure thank I used to 2 = I am experiencing a significant drop in pleasure 3 = I derive no pleasure from physical activities	6. Laughter & Tears 0 = I both laugh & cry as much as I always have 1 = I do not laugh and/or cry as readily as I once did 2 = I laugh and/or cry as readily as I once did 3 = I laugh almost never, I cry easily and much of the time
3. Physical Stamina & Energy Levels 0 = I have good physical stamina & high energy level 1 = I am not as strong as I used to be; my energy is less 2 = I sense that I am significantly weaker than I used to be 3 = I have almost no energy at all; I feel wasted, lethargic	7. Sexually (if applicable) 0 = My sexual experiences are pleasurable (or doesn't apply) 1 = The quality of my sexual experiences has decreased 2 = I am not nearly as interested in sex as I used to be 3 = I have little or almost no interest in sex at all
4. Quality & Quality of Sleep 0 = I get enough sleep & I feel rested 1 = I get less or require more sleep than I used to 2 = My sleep patterns have changed significantly as if of late 3 = I get very little quality sleep & I do not feel rested	8. Anger, Hostility, & Rage 0 = I get angry on occasion, but express anger appropriately 1 = I find myself getting angry more often than I used to 2 = I have difficulty with my anger, I am being hostile 3 = I often lose control of my anger, I go into rage
	Total:_____

Concerning Matters of the Heart – Emotional Responsiveness	
9. Sadness, Gloom, & Despair 0 = I am occasionally sad, but not for long periods of time 1 = I am increasingly sad; my outlook is coming gloomy 2 = I am sad most of the time; my outlook is gloomy 3 = I experience great sadness & despair most of the time	11. Emotional Stamina & Frustration Tolerance 0 = I have high frustration tolerance 1 = My emotional reserves are low; I am easily frustrated 2 = I feel drained; I am quite irritable and easily agitated 3 = I am spent; I am irritable and agitated most of the time
10. Joy, Gladness, & Fulfillment 0 = I experience much joy and fulfillment in my life 1 = I am experiencing much less joy and gladness in life 2 = I am quite unfulfilled; I experience almost no joy in life 3 = I experience no joy, gladness or fulfillment in life	12. Fear & Anxiety 0 = I do experience fear on occasion, but I do not live in fear 1 = I find myself more fearful than I used to be 2 = I am increasingly more fearful and anxious 3 = I am fearful, anxious and afraid most of the time
	Total_____

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Patient Name:_____ **Date:**_____

Mech Depression Inventory (continued)

Concerning Matters of the Mind – Thoughts & Beliefs	
13. Positive Mindset & Outlook on Life 0 = I think positive thoughts most of the time 1 = My outlook is dimming; my thoughts are less positive 2 = I am increasingly pessimistic; my thoughts are negative 3 = I dwell on the negative; I am very pessimistic about life	17. Sense of Accomplishment or Failure 0 = I am pleased with my accomplishments in life thus far 1 = I believe that I have failed more than I have succeeded 2 = I believe that I have accomplished little of worth 3 = I am a failure; I have accomplished nothing of value
14. Dwelling on past mistakes & events or experiences regrets 0 = I learn from my past, but my thoughts are future oriented 1 = I occasionally dwell on the past with thoughts of regret 2 = I have much regrets; my thoughts focus on my failures 3 = I am confused by thoughts of worthlessness and failure	18. Suicidal Thoughts 0 = I do not have thoughts of killing myself or ending my life 1 = I have had thoughts of killing myself, but will not do so 2 = I often think about killing myself; I might be better off 3 = I want to end my life, and would/may do so if I could
15. Self-Love or Loathing 0 = I am not perfect, but I think of myself in a positive light 1 = I think less highly of myself than I used to 2 = I am disappointed and think negative thoughts of myself 3 = I dislike or even loathe myself	19. Interest Inspiration & Creativity 0 = I have great interest in things; I appreciate creativity 1 = I have lessening interest in things; I do not get inspired easily 2 = I have little interest in things; creativity is unimportant 3 = I have lost nearly all interest; nothing inspires me
16. Self-Talk; Critical or Encouraging 0 = I am able to overcome obstacles as I encourage myself 1 = I am becoming increasingly self-critical 2 = My thoughts are full of negativity about myself 3 = I am confused and defeated about my self-critical thoughts	
	Total:_____

Concerning Matters of the Spirit – Volitional Drive	
20. Volitional Stamina; Discipline and Self Control 0 = I live a fairly disciplined life; I am able to control myself 1 = I occasionally lose control of my thoughts or actions 2 = I am increasingly undisciplined; I often lose control 3 = I am unable to control my thoughts or actions	22. Concentration & Focus 0 = I am able to focus and concentrate at length 1 = I am experiencing difficulty focusing and concentration 2 = It is very difficult to focus on anything for very long 3 = Completing this assessment was almost impossible
21. Motivation and Decisiveness 0 = My spirit is strong; I make decisions and motivate myself 1 = I'm increasingly indecisive; I often lack the will to act 2 = My spirit is weak; motivation low; decisions are difficult 3 = My spirit is broken; motivation almost non-existent; decision-marking has become very difficult	
	Total_____

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Mech
MENTAL HEALTH
INNOVATIONS

Arnold Mech, MD
Psychiatrist

Patient Name:_____ **Date:**_____

Mech Emotional Dysregulation Inventory

Instructions: Please circle the number which describes the extent to which each symptom has disturbed you during the past one to seven days, including today.

	Not at All	Mild I am not disturbed much	Moderate it is very disagreeable but I can bear it	Sever I could barely tolerate it
1. Anxious	0	1	2	3
2. Afraid	0	1	2	3
3. Petrified	0	1	2	3
4. Fear of impending doom	0	1	2	3
5. Fear your death is imminent	0	1	2	3
6. Dread that you may have no power over your emotions	0	1	2	3
7. Restlessness	0	1	2	3
				Subtotal Score____
8. Unsure of your stability on stand or walking	0	1	2	3
9. Dizziness	0	1	2	3
10. Unsteady gait (wobbly manner of walking)	0	1	2	3
11. Feel as if you may pass out	0	1	2	3
12. Unable to catch your breath	0	1	2	3
13. Unable to breath normally as if your throat were closing	0	1	2	3
14. Decreased sensation “pins and needles” around mouth or fingers	0	1	2	3
				Subtotal Score____
15. Arms or hands shake when attempting a task	0	1	2	3
16. Arms or hands shake when at rest	0	1	2	3
17. Facial flushing	0	1	2	3
18. Hot Flashes	0	1	2	3
19. Episodic increase in perspiration (unrelated to exertion)	0	1	2	3
20. Rapid heartbeat and/or pounding sensation in chest	0	1	2	3
21. Queasy or uneasy stomach sensation	0	1	2	3
				Subtotal Score____

Total Score_____

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Mech
MENTAL HEALTH
INNOVATIONS

Arnold Mech, MD
Psychiatrist

Patient Name:_____ **Date:**_____

Mech Emotional Dysregulation Inventory

Instructions: This inventory seeks to measure symptoms of ADHD-Triggered Dysregulation which have been present for at least 6 months. Please answer the following questions based on the last two weeks by indicating which response best describes your experience.

1. Frustration Tolerance: Do you get easily frustrated and angry or feel like "giving up" when you attempt to focus on difficult tasks or attempt tasks that require an extended period of time? ☐ **yes** ☐ **no? (If "NO" skip to question 5)**

2. When frustrated and angry do you:
   0 = Keep on working and stay on task or take a short break then continue or try again **(If "0" skip to question 5)**
   1 = Feel like "quitting" or "giving up" and struggle to go on?
   3 = Get to a point of ceasing the work or a activity in anger, i.e. "shutting down"?
   4 = Show inappropriate verbal or nonverbal displays of frustration

3. Do these reactions occur:
   0 = Rarely
   1 = Sometimes
   2 = Regularly
   3 = Very often
   4 = Always

4. Which of the following trigger such reactions?
   A = Attempts at focusing on difficult tasks
   B = Attempts at focusing for extended periods of time
   C = Taking on an organized task
   D = Getting started with a task or project

5. Impulse Control: Do you experience disruption in functioning and/or aggressive behavior when you attempt to focus on difficult tasks or attempt tasks that require an extended period of time? ☐ **yes** ☐ **no? (If 0 circled skip to total)**

6. When you "lose control" of your emotions, do you find yourself:
   0 = Able to return quickly to the task at hand and be cooperative with others
   1 = Become loud
   2 = Become demanding
   3 = Become threatening
   4 = Become combative and/or destructive

7. Do these reactions in item 6 above occur:
   0 = Rarely
   1 = Sometimes
   2 = Regularly
   3 = Very often
   4 = Always

8. Which of the following trigger such reactions in item 6 above?
   A = Attempts at focusing on difficult tasks
   B = Attempts at focusing for extended periods of time
   C = Taking on an organizing task
   D = Getting started with a task or project

Total of items 2, 3, 6, and 7 =_____

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Mech
MENTAL HEALTH
INNOVATIONS

Arnold Mech, MD
Psychiatrist

Patient Name:_____ **Date:**_____

Mech Metabolic Inventory

Instructions: Please check yes or no.

Do you frequently	Yes	No
Crave sweets, candy, soft drinks or “diet” drinks?		
Eat sweets in mid-morning or mid-afternoon?		
Drink more than 3 mixed drinks, glasses of wine, or cans of beer per week?		
Use coffee, tea, or caffeinated soft drinks as a “pick-me-up”?		
Eat often to avoid feeling irritable of faint?		
Eat when upset or anxious?		
Are you hungry between meals?		
Feel tremulous or shaky when hungry?		
Feel weak at times?		
Feel light-headed at times?		
Irritability which is worse before meals, or is relieved by eating?		
Fatigue which is worse before meals, or is relieved by eating?		
Impulsiveness which is worse before meals, or is relieved by eating?		
Feel tired and/or nap after meals?		
Feel better in the morning if you skip breakfast?		
Disturbed sleep early in the sleep period?		
Have headaches when hungry (especially in late mornings or early afternoons)?		
Stomach aches or cramps?		
Frequent sighs or deep breaths?		
Difficulty making decisions when hungry?		
Trouble concentrating or paying attention to details when hungry?		
Hard time motivating yourself to get things done?		
Feel weak or as if legs might give out when hungry?		
Intermittent clumsiness, especially when hungry?		
Changes in moods when hungry?		
Difficulty working under pressure?		
Have allergies (food, medication, seasonal)?		
Have periods of exhaustion?		
Sleep during the day?		

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Mech
MENTAL HEALTH
INNOVATIONS

Arnold Mech, MD
Psychiatrist

Patient Name:_____ **Date:**_____

PHQ-10 Self Assessment

Instruction: Please answer the follow questions, circling the responses that more appropriately describe the patient's behavior. Over the last two weeks, How often has the patient been bothered by any of the following problems?

1. Little interest or pleasure in doing things 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day	6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
2. Feeling down depressed or hopeless 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day	7. Trouble concentrating on things, such as reading the newspaper or watching television 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
3. Trouble falling or staying asleep, or sleeping too much 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day	8. Moving or speaking so slowly that other people could notice. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
4. Feeling tired or having little energy 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day	9. Thoughts that you would be better off dead, or of hurting yourself 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
5. Poor appetite or over eating 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day	10. How many anti-depressant prescription medications do you currently take or have tried in the past? 0 1 2-4 5+ Not sure

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Mech
MENTAL HEALTH
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Arnold Mech, MD
Psychiatrist

Patient Name:_____ **Date:**_____

Yale-Brown Obsessive Compulsive Scale

Instruction: Please answer the follow questions, circling the responses that more appropriately describe the patient's behavior. Obsessions are unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. They usually involve themes of harm, risk and danger. Common obsessions are excessive fears of contamination; recurring doubts about danger; extreme concern with order, symmetry or exactness; fear of losing important things.

Concerning Obsessive Thoughts	
1. How much time is occupied by obsessive thoughts? 0 = None 1 = Less than 1 hr/day or occasional occurrence 2 = 1 to 3 hrs/day or frequent 3 = Greater than 3 and up to 8 hrs/day or very frequent occurrence 4 = Greater than 8 hrs/day or nearly constant occurrence	4. How much of an effort do you make to resist the obsessive thoughts? How often do you try to disregard or turn your attention away from these thoughts as they enter your mind? 0 = Try to resist all the time 1 = Try to resist most of the time 2 = Make some effort to resist 3 = Yield to all obsessions without attempting to control them, but with some reluctance 4 = Completely and willingly yield to all obsessions
2. How much do your obsessive thoughts interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of them? 0 = None 1 = Slight interference with social or other activities, but overall performance not impaired 2 = Definite interference with social or occupational performance, but still manageable 3 = Causes substantial impairment in social or occupational performance 4 = Incapacitating	5. How much control do you have over your obsessive thoughts? How successful are you in stopping or diverting your obsessive thinking? Can you dismiss them? 0 = Complete control 1 = Usually able to stop or divert obsessions with some effort and concentration 2 = Sometimes able to stop or divert obsessions 3 = Rarely successful in stopping or dismissing obsessions, can only divert attention with difficulty 4 = Obsessions are completely involuntary, rarely able to even momentarily alter obsessive thinking
3. How much distress do your obsessive thoughts cause you? 0 = None 1 = Not too disturbing 2 = Disturbing, but still manageable 3 = Very disturbing 4 = Near constant and disabling distress	
	Total:_____

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Arnold Mech, MD
Psychiatrist

Patient Name:_____ **Date:**_____

Yale-Brown Obsessive Compulsive Scale (continued)

Compulsions are urges that people have to do something to lessen feelings of anxiety or other discomfort. Often they do repetitive, purposeful, intentional behaviors called rituals. The behavior itself may seem appropriate but it becomes a ritual when done to excess. Washing, checking, repeating, straightening, hoarding and many other behaviors can be rituals. Some rituals are mental, for example, thinking or saying things over and over under your breath.

Concerning Compulsive Behaviors	
6. How much time do you spend performing compulsive behaviors? How much longer than most people does it take to complete routine activities because of your rituals? How frequently do you do rituals? 0 = None 1 = Less than 1 hr/day, or occasional performance of compulsive behaviors 2 = From 1 to 3 hrs/day, or frequent performance of compulsive behaviors 3 = More than 3 and up to 8 hrs/day, or very frequent performance of compulsive behaviors 4 = More than 8hrs/day, or near constant performance of compulsive behaviors (too numerous to count)	9. How much of an effort do you make to resist the compulsions? 0 = Always try to resist 1 = Try to resist most of the time 2 = Make some effort to resist 3 = Yield to almost all compulsions without attempting to control them, but with some reluctance 4 = Completely and willingly yield to all compulsions
7. How much do your compulsive behaviors interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of the compulsions? 0 = None 1 = Slight interference with social or other activities, but overall performance not impaired 2 = Definite interference with social or occupational performance, but still manageable 3 = Causes substantial impairment in social or occupational performance 4 = Incapacitating	10. How strong is the drive to perform the compulsive behavior? How much control do you have over the compulsions? 0 = Complete control 1 = Pressure to perform the behavior but usually able to exercise voluntary control over it 2 = Strong pressure to perform behavior, can control it only with difficulty 3 = Very strong drive to perform behavior, must be carried to completion, can only delay with difficulty 4 = Drive to perform behavior experienced as completely involuntary and overpowering, rarely able to even momentarily delay activity
8. How would you feel if prevented from performing your compulsion(s)? How anxious would you become? 0 = None 1 = Only slightly anxious if compulsions prevented 2 = Anxiety would mount but remain manageable if compulsions prevented 3 = Prominent and very disturbing increase in anxiety if compulsions interrupted 4 = Incapacitating anxiety from any intervention aimed at modifying activity	
	Total:_____

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INNOVATIONS

Arnold Mech, MD
Psychiatrist

Patient Name:_____ **Date:**_____

YMRS FOR SELF/FAMILY

Instruction: Please answer the follow questions, circling the responses that more appropriately describe the patient's behavior over the last two weeks. To get the most out of this inventory, it is a good idea to get the help of the family and/or friends.

1. Do you experience elevated moods? 0 = I do not experience elevated moods. 1 = My mood is mildly or possibly increased 2 = There is definite elevation; inappropriate so at times 3 = My mood is very elevated inappropriate so at times 4 = I am euphoric; I may laugh or sing inappropriately	6. Have there been changes in your thought pattern? 0 = There have been no changes 2 = I'm mildly distractible; my thoughts dart about 4 = I'm very distractible; I change topics often; my thoughts race 6 = I've been told that I'm difficult to follow, that I rhyme, or that I repeat what others say over and over again 8 = I've been told that communications with me is impossible
2. Do you experience increased energy or activity? 0 = No increased energy or activity 1 = I experience some increased energy or activity 2 = I gesture a lot. I'm told I'm animated 3 = I experience excessive energy; I'm told that I'm hyperactive or restless 4 = I experience (or am told that I experience) delusions and/or hallucinations	7. Has the content of your ideas/thoughts/plans changed? 0 = My ideas/thoughts/plans have not changed 1 = I've been told that I have questionable plans and/or interest 2 = I've been told that I have unusual projects or that I'm pre-occupied with religious concerns 3 = I've been told I have grandiose or paranoid ideas; I believe that others are "talking about me" 4 = I've experienced delusions and/or hallucinations
3. Are you experiencing decreases in your sleep duration? 0 = I am experiencing no decreases in sleep 1 = I am sleeping less than normal by up to one hour 2 = I am sleeping less than normal by more than one hour 3 = My need for sleep has decreased 4 = I feel that I do not need any sleep	8. Do you experience disruptive and/or aggressive behavior? 0 = No, I'm fairly cooperative 2 = I'm sarcastic; I'm told that I'm load at times 4 = I'm demanding, I occasionally make threats towards others 6 = I often threaten family or friends; I shout 8 = I'm combative and destructive
4. Are you experiencing irritability? 0 = I am not experiencing increased irritability 1 = I'm experiencing a mild increase in irritability 2 = I'm often irritable; recent episodes of anger or annoyance 3 = I'm experiencing irritability very frequently 4 = I'm told that I'm hostile and uncooperative	9. What kind of appearance do you maintain? 0 = I'm appropriately dressed and groomed 1 = I'm minimally unkempt 2 = I've been told that I'm poorly groomed, or overdressed 4 = My appearance is often disheveled or flashy 6 = My appearance is completely unkempt or very flashy
5. Has there been any change in your speech pattern? 0 = There has been no increase or change 2 = I'm more talkative 4 = I'm much more talkative 6 = I'm told that I'm pushy, and I'm difficult to interrupt 8 = My speech is hurried, uninterruptible, continuous	10. How do you feel about your behavior? 0 = I admit that I have a need for treatment 1 = I believe that I might have a need for treatment 2 = I admit my behavior has changed, but deny needing help 4 = My behavior may have changed but I deny needing help 3 = I deny any change in my behavior
Question 11 is for Adolescents or Adults as applicable or appropriate 11. Has your sexual interest increased? 0 = My sexual interest is normal; It is not increased 1 = My sexual interest is mildly increased 2 = My sexual interest is definitely increased 3 = My speech often contains suggestive sexual content 4 = I am sexually suggestive with and towards others	**Total Score:**_____

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