Sherry Huey You-Surles, MD

Request for service

Patient Information

Date of Call_____

Name: _____ SS#_____

Address: _____ Tel Home ( ) _____

_____ Cell: ( ) _____

Date of Birth: _____ Tel. Wk ( ) _____

Single___ Married___ Div___ Widow_____ Sex: M ☐ F ☐

Referred by _____ Employer:_____

Email: _____

RESPONSIBLE PARTY

Name: _____ Relationship to Patient: _____

Address_____ Home Phone_____

City/State/Zip_____ Bus. Phone_____

Employed by_____ SS# _____

Date of Birth_____ Insurance Company_____

Policy#_____ ☐HMO☐ PPO Group#_____

Group#_____ Ins. Telephone #_____

Precert#_____ Customer Service_____

RISK ASSESSMENT: Do you consider the need for help as ☐Non Urgen☐ Urgent ☐Emergency

Clinical Chief Complaint: "What is the nature of the problem which promoted you to call?"

Chemical Dependency involvement (if any): Current Use_____daily/episodic

Type of Substance _____

Suicidal Ideation: Present ☐ Yes ☐No Homicidal Ideation: Present☐ Yes ☐ No

Hallucinations:☐ Yes☐ No

Hospital ☐ Yes☐ No When_____

Medication ☐ Yes ☐No Type_____

Are you currently seeing a therapist/psychiatrist? ☐ Yes_____ ☐No

In case of emergency Notify _____ Phone _____

Referred By: _____

Assignment Of Benefits: I hereby authorize payment directly to the attending physician of benefits due me for his/her services. I understand I am financially responsible for payment of all charges to this account, not the insurance company. I understand that the provider's charges may exceed any insurance carrier's reimbursement, and I am responsible for the total charge without respect to the amount of insurance reimbursement except in instances of PPO, HMO, or Managed Care benefits where contractual arrangements have been made between the company and provider regarding fees and reimbursement. I also understand that all office visits are payable at the time of service.

_____ Date: _____
Signature

Release of Information: I hereby authorize the attending physician to release any information acquired in the course of my examination or treatment to my insurance company and/or Utilization Review Organization contracted by my insurance company.

_____ Date: _____
Signature

Name:_____ _____ Date:_____ _____

Sherry Huey You Surles, M.D.
General consent for Treatment, Release of Information and Acknowledgment of Fee Disclosure

General Consent for Medical Treatment

I hereby give my consent for medical treatment by my physician Sherry Huey You-Surles. I understand that, should I require services in my doctor's absence, this consent is transferable to the covering physician as designated by my doctor.

_____
Signed

Release of Information

I consent to the ongoing release of verbal or written communication between my doctor, Sherry Huey You-Surles and

____My other physician(s) Initial

____My therapist Initial

I authorize that messages may be left for me regarding appointment reminders or instructions regarding my care

____On my home answering machine Initial

____With my spouse or other family member Initial

I acknowledge that telephone calls from my physician may be returned by cellular telephone. I may revoke consent for any or all of the above initialed items at any time in writing.

_____
Signed

Fee Disclosure Acknowledgment

Sherry Huey You-Surles, M.D. will make available its fee schedule for medical/psychiatric procedures, upon request. Most fees for any given patient are for sessions with your doctor or therapist. However, fees will also be incurred when you request services *in addition to* your regular sessions with your doctor.

The following is a brief, non-comprehensive, listing of services for which fees apply:

- Physician time required for telephone calls or completion of documents required by your insurance company for pre-certification of services or in order to process your insurance claims
- Time required for preparation of documents or letters for employment or legal purposes

  Time required for telephone calls required for coordination of your medical/psychiatric care between your doctor in this office and a physician or therapist in another office
- Telephone calls with your physician, during or after regular office hours
- Prescription medication refills .
  - > which must be called in to your pharmacy
  - > requiring an original prescription form to be mailed to you or your pharmacy
  - > requiring an original triplicate prescription form (e.g. for Ritalin or Dexedrine)
  - > if you request renewal of a prescription medication after-hours by your physician
- Photo-copying and/or mailing of medical records to other physicians, attorneys, or insurance companies
- Missed appointments or late cancellations (appointments canceled with less than 24 hours notice) are billed for the amount of time that was scheduled

The above fees may not be covered by your insurance plan.

I have read and acknowledge the above paragraphs regarding fees.

_____
Signed

Sherry Huey You-Surles, M.D.

Patient Name: _____
Date: _____

Comprehensive Assessment Questionnaire - Adult

Presenting History

What is the main problem that caused you to seek help? _____

Why did you decide to seek help now? _____

Describe the main symptoms that are causing problems for you: _____

When did the problem first begin? _____

Describe any stresses in your life that may have contributed to the problem: _____

Please check the statement that best describes the course of the problem:

- ☐ The problems have stayed about the same since they started.
- ☐ The problems have steadily worsened since they started.
- ☐ The problems seem to come and go-At times I feel almost back to my usual self then the problems come back.
- ☐ The problems have ups and downs but haven't gone away completely since they started.

Describe the history of the problem from its onset until now: _____

Have you had a similar problem in the past? ☐ Yes ☐ No If so, please describe the episodes and the dates they occurred. _____

Where you treated for this problem? ☐ Yes ☐ No If so; please describe the treatment you received.

Patient Name: _____

Has this problem caused you to experience any decrease in your ability to function in the following areas? If so, please describe:

School performance: _____

Work performance: _____

Relationship with spouse/significant other: _____

Functioning as a parent: _____

Social Life: _____

Ability to manage chores at home: _____

Physician/Therapist Notes: _____

Past Medical History

Please list all medications you are currently taking:

Prescription Medication	Dose	Start Date (MMYY)

Over the counter medications:

Type	Dose	Frequency of Use

Allergies to Medications

Medication	Type of Allergic Reaction

Past Mental Health History:

Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

Name	Dates of Treatment

Patient Name: _____

Medical History (List any physical problems that have run in your family)

Problem	Relative	Maternal Side	Paternal Side	Treatment

Substance Use:

Do you use any of the following:

Substance	Yes	No	Amount	Frequency	Daily	Weekly	Date last used
Tobacco	☐	☐			☐	☐	
Caffeine	☐	☐			☐	☐	
Alcohol	☐	☐			☐	☐	
Marijuana	☐	☐			☐	☐	
Cocaine	☐	☐			☐	☐	
Amphetamines	☐	☐			☐	☐	
LSD	☐	☐			☐	☐	
Heroin	☐	☐			☐	☐	
Pain killers	☐	☐			☐	☐	
IV Drug Use	☐	☐					

Have you ever felt that you were abusing drugs or alcohol? ☐ Yes ☐ No

If so, describe when and the nature of the problem. _____

Have tried to stop drinking? ☐ Yes ☐ No If yes, what was the outcome. _____

Have you ever attended AA? ☐ Past ☐ Current If yes, do you have a sponsor and how often do you attend meetings. _____

Have you ever attended NA? ☐ Past ☐ Current If yes, do you have a sponsor and how often do you attend meetings. _____

Social History

Date of Birth: _____ Current Age _____ Place of Birth _____

Where did you grow up? _____

Please list your siblings and their current ages: _____

Are you close to your siblings? _____

Describe your father: _____

How would you describe your relationship with your father? _____

Patient Name: _____

Medications prescribed in the past?

Medication	Dates	Response

Have you ever been in a psychiatric hospital in the past? ☐ Yes ☐ No If so, please list the facility and the dates of treatment. _____

Have you ever attempted suicide? ☐ Yes ☐ No If yes, please describe the nature of the event and the date(s) of occurrence. _____

Medical History:

Who is your primary care physician? _____

Date of last visit: _____ Date of last physical: _____

Have you had any of the following:

☐ Heart Disease ☐ Hypertension ☐ Lung Disease ☐ Thyroid Problems
☐ Diabetes ☐ Asthma ☐ Seizures ☐ Arthritis
☐ Kidney Disease ☐ Liver Disease ☐ Cancer ☐ Chronic Pain
☐ Other _____

Please list details of any of the above you have checked or any other health problems: _____

List any surgery you have had: _____

Women Only:

Who is your gynecologist? _____ Date of last examination _____

Date of last menstrual period. _____ Are your periods regular? ☐ Yes ☐ No

List any gynecological problems you have had: _____

Method of contraception: _____ How many pregnancies have you had? _____

How many children do you have _____ Are you currently pregnant? ☐ Yes ☐ No

Are you planning to become pregnant in the near future? ☐ Yes ☐ No

Family History:

Psychiatric History (List any blood relative who have had emotional problems-such as depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, anxiety problems)

Problem	Relative	Maternal Side	Paternal Side	Hospitalized

Patient Name: _____

Describe your mother: _____

How would you describe your relationship with your mother? _____

Describe your childhood: _____

Were your parents divorced? _____ If so, how old were you _____ Who did you live with after the divorce? _____ Did your mother remarry? ☐ Yes ☐ No Did your father remarry? ☐ Yes ☐ No What was your relationship with the stepparent(s)? _____

Were you ever subjected to any type of abuse? (emotional, physical, sexual) If so, please describe the events. _____

How old were you at the time of the abuse? _____
Have you lost a close family member or friend? ☐ Yes ☐ No Who? _____ When? _____
Do you have a history of any legal problems? ☐ Yes ☐ No Describe _____

Educational History

How did you do in school? _____ Did you complete high school? ☐ Yes ☐ No What kind of grades did you receive in school? _____ How did you get along with your peers? _____
How did you get along with your teachers? _____ Did you attend any special education classes? ☐ Yes ☐ No _____
Were you required to repeat any classes or grades? _____
Did you attend college? ☐ Yes ☐ No
Where? _____ Degree? _____ Year _____

Occupational History

Are you currently working? ☐ Yes ☐ No What is your occupation? _____
What is your current position? _____ Where do you work? _____
How long have you been there? _____ Are you satisfied with your job? ☐ Yes ☐ No
If no, please explain. _____

List your last two jobs and how long you were employed there: _____

Have you ever been fired? ☐ Yes ☐ No If so, please explain: _____

Describe any current job stresses you may be experiencing: _____

How well do get along with co-workers? _____ Supervisors? _____

Patient Name: _____

Relationship History

Are you currently ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
How long? _____ What is your sexual orientation? _____ Describe you relationship with your spouse or significant other: _____

List any stresses or problems in your relationship _____

If married, what is your spouse's occupation? _____ Where employed? _____
Have you been married before? (or long term committed relationship) ☐ Yes ☐ No How many times? _____
How long did these relationships last? _____ Please describe the reason for the break-up or divorce(s). _____

Do you have children? ☐ Yes ☐ No List their names and ages: _____
Describe any problems you may be experiencing with your children: _____

Please list everyone currently living in your home: _____

What is your religious preference? _____
Do you actively attend religious services? ☐ Yes ☐ No Where? _____ How often? _____
Hobbies: _____
Are you currently involved in any clubs or organizations? ☐ Yes ☐ No List _____

Are there any questions which you would like to discuss with the doctor/therapist? _____

Is there any other important information about you that has not been covered, which you feel the doctor/therapist should know: _____

PLEASE COMPLETE THE ATTACHED SYMPTOM CHECKLIST.

Sherry Huey You-Surles, M.D.
17430 Campbell Rd., Suite 100
Dallas, Texas 75252

PLEASE INDICATE THE SYMPTOMS YOU HAVE EXPERIENCED.
GIVE A RATING FROM 1 to 5 (1=THE MOST SEVERE)

_____**DEPRESSION**

_____**ANXIETY**
Obsessive thoughts
Compulsive behavior
Other

_____**WORRY**

_____**↓ ENERGY**

_____**↓ MOTIVATION**

_____**MOOD SWINGS**
PMS only
Other_____

_____**RACING THOUGHTS**

_____**IRRITABILITY**

_____**ANGER/RAGE**

_____**SLEEP**
Nightmares
Flashbacks
Increased/Decreased_____**hrs.**
Fragmentations
Other_____

_____**↓CONCENTRATION OR FOCUS**

_____**EATING DISORDERS**
Restrictive
Binging
Purging

_____**PANIC ATTACK (Agoraphobia)**

_____**PARANOIA**

_____**SOCIAL ANXIETIES**

_____**AUDITORY**
Hallucinations
Voices

_____**IMPULSE CONTROL**

_____**CHEMICAL DEPENDENCIES**

_____**OTHER ADDICTIONS**

_____**CONFUSION**

Mood Disorder Questionnaire (MDQ)

Instructions: Please answer each question as best you can.

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 in to trouble?	☐	☐
... you were so irritable that you shouted at people or started fights or arguments?	☐	☐
... you felt much more self-confident than usual?	☐	☐
... you got much less sleep than usual and found you didn't really miss it?	☐	☐
... you were much more talkative or spoke much faster than usual?	☐	☐
... thoughts raced through your head or you couldn't slow your mind down?	☐	☐
... you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
... you had much more energy than usual?	☐	☐
... you were much more active or did many more things than usual?	☐	☐
... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
... you were much more interested in sex than usual?	☐	☐
... you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
... spending money got you or your family into trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting in to arguments or fights?

Please circle one response only.

No problem Minor problem Moderate problem Serious problem

4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? ☐ ☐

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? ☐ ☐

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

The Generalized Anxiety Disorder 7-Item (GAD-7) Screener

This screener can be used to assess patients at every visit

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, or 3 to the response categories below.

Total score for the seven items ranges from 0 to 21.

0-4	5-9	10-14	15-21
Minimal anxiety	Mild anxiety	Moderate anxiety	Severe anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3
Column totals				
			Total =	

If you circled a score for any problems >0, how difficult have the 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**
○	○	○	○

Developed by Drs. Robert L Spitzer, Janet BW Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display, or distribute.

Adult ADHD-RS-IV* with Adult Prompts†

The ADHD-RS-IV with Adult Prompts is an 18-item scale based on the *DSM-IV-TR®* criteria for ADHD that provides a rating of the severity of symptoms. The adult prompts serve as a guide to explore more fully the extent and severity of ADHD symptoms and create a framework to ascertain impairment. The first 9 items assess inattentive symptoms and the last 9 items assess hyperactive-impulsive symptoms. Scoring is based on a 4-point Likert-type severity scale: 0 = none, 1 = mild, 2 = moderate, 3 = severe. Clinicians should score the highest score that is generated for the prompts for each item.

Example: If one prompt generates a "2" and all others are a "1," by convention, the rating for that item is still a "2" Significant symptoms in clinical trials are generally considered at least a "2" – moderate.

	None	Mild	Moderate	Severe
1. Carelessness	0	1	2	3
Do you make a lot of mistakes (in school or work)? Is this because you're careless? Do you rush through work or activities? Do you have trouble with detailed work? Do you not check your work? Do people complain that you're careless? Are you messy or sloppy? Is your desk or workspace so messy that you have difficulty finding things?				
2. Difficulty sustaining attention in activities	0	1	2	3
Do you have trouble paying attention when watching movies, reading, or attending lectures? Or on fun activities such as sports or board games? Is it hard for you to keep your mind on school or work? Do you have unusual trouble staying focused on boring or repetitive tasks? Does it take a lot longer than it should to complete tasks because you can't keep your mind on the task? Is it even harder for you than some others you know? Do you have trouble remembering what you read and do you need to re-read the same passage several times?				
3. Doesn't listen	0	1	2	3
Do people (spouse, boss, colleagues, friends) complain that you don't seem to listen or respond (or daydream) when spoken to or when asked to do tasks? A lot? Do people have to repeat directions? Do you find that you miss the key parts of conversations because of drifting off in your own thoughts? Does it cause problems?				
4. No follow through	0	1	2	3
Do you have trouble finishing things (such as work or chores)? Do you often leave things half done and start another project? Do you need consequences (such as deadlines) to finish? Do you have trouble following instructions (especially complex, multistep instructions that have to be done in a certain order with different steps)? Do you need to write down instructions, otherwise you will forget them?				

	None	Mild	Moderate	Severe
5. Can't organize	0	1	2	3
Do you have trouble organizing tasks into ordered steps? Is it hard prioritizing work and chores? Do you need others to plan for you? Do you have trouble with time management? Does it cause problems? Does difficulty in planning lead to procrastination and putting off tasks until the last moment possible?				
6. Avoids/dislikes tasks requiring sustained mental effort	0	1	2	3
Do you avoid tasks (work, chores, reading, board games) that are challenging or lengthy because it's hard to stay focused on these things for a long time? Do you have to force yourself to do these tasks? How hard is it? Do you procrastinate and put off tasks until the last moment possible?				
7. Loses important items	0	1	2	3
Do you lose things (eg, important work papers, keys, wallet, coats, etc)? A lot? More than others? Are you constantly looking for important items? Do you get into trouble for this (at work or at home)? Do you need to put items (eg, glasses, wallet, keys) in the same place each time, otherwise you will lose them?				
8. Easily distractible	0	1	2	3
Are you ever very easily distracted by events around you such as noise (conversation, TV, radio), movement, or clutter? Do you need relative isolation to get work done? Can almost anything get your mind off of what you are doing, such as work, chores, or if you're talking to someone? Is it hard to get back to a task once you stop?				
9. Forgetful in daily activities	0	1	2	3
Do you forget a lot of things in your daily routine? Like what? Chores? Work? Appointments or obligations? Do you forget to bring things to work, such as work materials or assignments due that day? Do you need to write regular reminders to yourself to do most activities or tasks, otherwise you will forget?				

Adult ADHD-RS-IV* with Adult Prompts†

	None	Mild	Moderate	Severe
10. Squirms and fidgets	0	1	2	3
Can you sit still or are you always moving your hands or feet, or fidgeting in your chair?				
Do you tap your pencil or your feet? A lot? Do people notice?				
Do you regularly play with your hair or clothing?				
Do you consciously resist fidgeting or squirming?				
11. Can't stay seated	0	1	2	3
Do you have trouble staying in your seat? At work?				
In class? At home (eg, watching TV, eating dinner)?				
In church or temple?				
Do you choose to walk around rather than sit?				
Do you have to force yourself to remain seated?				
Is it difficult for you to sit through a long meeting or lecture?				
Do you try to avoid going to functions that require you to sit still for long periods of time?				
12. Runs/climbs excessively	0	1	2	3
Are you physically restless?				
Do you feel restless inside? A lot?				
Do you feel more agitated when you cannot exercise on an almost daily basis?				
13. Can't play/work quietly	0	1	2	3
Do you have a hard time playing/working quietly?				
During leisure activity (nonstructured times or on your own such as reading a book, listening to music, playing a board game), are you agitated or dysphoric? Do you always need to be busy after work or while on vacation?				
14. On the go, "driven by a motor"	0	1	2	3
Is it hard for you to slow down?				
Do you feel like you (often) have a lot of energy and that you always have to be moving, are always "on the go"?				
Do you feel like you're driven by a motor?				
Do you feel unable to relax?				

	None	Mild	Moderate	Severe
15. Talks excessively	0	1	2	3
Do you talk a lot? All the time? More than other people? Do people complain about your talking? Is it a problem? Are you often louder than the people you are talking to?				
16. Blurts out answers	0	1	2	3
Do you give answers to questions before someone finishes asking?				
Do you say things before it is your turn?				
Do you say things that don't fit into the conversation?				
Do you do things without thinking? A lot?				
17. Can't wait for turn	0	1	2	3
Is it hard for you to wait your turn (in conversation, in lines, while driving)?				
Are you frequently frustrated with delays? Does it cause problems?				
Do you put a great deal of effort into planning to not be in situations where you might have to wait?				
18. Intrudes/interrupts others	0	1	2	3
Do you talk when others are talking, without waiting until you are acknowledged?				
Do you butt into others' conversations before being invited?				
Do you interrupt others' activities?				
Is it hard for you to wait to get your point across in conversations or at meetings?				

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