Deena Gandhi, M.D.
56 Sugar Creek Center Blvd, #350
Sugar Land, Texas 77478
Phone 281-277-9137 Fax 281-277-9141

PLEASE PRINT:

Patient Name_____
Patient SS#_____
Patient Date of Birth_____**Sex**_____**Marital Status**_____
Address_____
City_____**State**_____**Zip Code**_____
Home Phone_____**Cell**_____**E-mail**_____
Patient Employer_____
Business Address_____
City_____**State**_____**Zip Code**_____**Work Phone**_____
Responsible Party_____
Relationship to Patient_____**Date of Birth**_____
Address (if different)_____
City_____**State**_____**Zip Code**_____
Phone_____**Work Phone**_____
Medical Insurance:
Insurance Name_____
ID#_____**Group #**_____
Effective Date_____**Deductible Met?**_____
Subscriber's Name_____**DOB**_____
Relationship to Patient_____
Do you have secondary/supplemental insurance?_____
If yes, please name_____
Pharmacy Name_____**Phone #**_____

In case of emergency, whom should we contact?

Name_____**Relationship**_____**Phone**_____
Name_____**Relationship**_____**Phone**_____
Who referred you to our office?_____

Assignment of Insurance Benefits:

I,_____**,(name of insured)hereby authorize**_____**(name of insurance) to pay & hereby assign directly DEENA GANDHI, M.D. benefits, if any, otherwise payable to me for her services as described on attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by & paid to DEENA GANDHI, M.D. be credited to my account in accordance with the above said assignment.**

Authorized Signature of Subscriber_____**Date**_____

Welcome! We are pleased that you have chosen our office for your healthcare.

The following information will give you a better understanding of how we work so we can establish a successful & comfortable relationship. Please make it your responsibility to have all questions answered in regard to your treatment at the time of your appointment. Do not hesitate to let me know if you need more time to discuss the treatment plan that best fits your needs. If you need to speak to me after your appointment please feel free to leave a message on my voicemail, which is checked regularly. Please remember to provide us with a daytime & evening phone number, as well as a pharmacy number in case that would be needed.
Due to the high demand for appointments, we ask that you *notify us of cancellations at least 24 hours in advance* or you will be charged for that visit. Keep in mind that insurance will not pay for broken appointments. This will be your responsibility. We will file claims with your insurance company if we are contracted with them. Please remember that your insurance is a contract between you & the company. If, after 60 days, we have not received payment for services rendered, we will turn to you for payment. It is imperative that you immediately notify us of any changes in your policy. We will need 2-3 days to get approval from your new insurance for your next visit to ensure payment.

While confidentiality is an important part of treatment, there are a few exceptions to this rule, for example: If there is evidence of abuse or neglect we are obligated to breech confidentiality under Texas law. Texas law requires all physicians to notify the police or medical authorities if a patient is a threat to himself/herself, or anyone else. Our policy is to also require patients to provide us with two emergency contacts, such as a close friend or relative. If applicable, please give us permission to communicate with your therapist or PCP, if needed, so that we can manage all aspects of your medical care.

Doctor_____Phone_____Fax_____

Therapist_____Phone_____Fax_____

If you have been diagnosed with a psychiatric disorder & started on medication to control symptoms, it is very important that you take all medications on a regular basis. The duration of treatment varies depending on your personal history. Therefore, even after you start feeling better, DO NOT STOP TAKING YOUR MEDICATIONS. If you do this you are putting yourself at risk of having these symptoms return. Certain medications that are misused or abused could cause serious side effects. We will go over the diagnosis & the various treatment options including some that may not be indicated for a particular diagnosis, but are generally accepted for use by general psychiatric practices. It is extremely important that you DO NOT DRINK ALCOHOL OR USE ILLEGAL DRUGS WITH THE MEDICATIONS. Women please inform us if you are pregnant or planning to become pregnant as there some medications that should not be taken. Please sign below to indicate that you have read & agree to the above listed conditions.

Patient or Responsible Party_____Date_____

NO YES

___ ___ **Have you been consistently depressed or down for the past 2 weeks?**
___ ___ **In the past 2 weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?**
___ ___ **Was your appetite increased or decreased nearly every day?**
___ ___ **Did your weight increase or decrease without intentionally trying?**
___ ___ **Did you have trouble sleeping nearly every night? (trouble falling asleep, waking in middle of the night, early morning waking, or sleeping excessively)**
___ ___ **Did you talk or move more slowly than normal or were you fidgety, restless, or have trouble sitting still most every day?**
___ ___ **Did you feel tired or without energy almost every day?**
___ ___ **Did you feel worthless or guilty almost every day?**
___ ___ **Did you have difficulty concentrating or making decisions almost every day?**
___ ___ **Did you repeatedly consider hurting yourself, feel suicidal, or wish you were dead?**

In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions? If your answer is "Yes", answer the questions below. If answer is "No", proceed to the following page.

NO YES

___ ___ **Did you need to drink more in order to get the same effect that you had when you first started drinking?**
___ ___ **When you cut down on drinking did your hands shake, or did you sweat or feel agitated? Did you avoid these symptoms? If "yes" to either, check "yes".**
___ ___ **During the times you drank alcohol, did you end up drinking more than you planned when you started?**
___ ___ **Have you tried to reduce or stop drinking alcohol, but failed?**
___ ___ **On the days you drank, did you spend substantial time obtaining alcohol, drinking, or recovering from the effects of alcohol?**
___ ___ **Did you spend less time working, enjoying hobbies, or being with others because of your drinking?**
___ ___ **Have you continued to drink even though you knew it caused you problems?**

PATIENT SELF-EVALUATION

Name_____ Date_____

Instructions: Using the numbers below, indicate how much you have been bothered by each symptom during the past week, including today, by writing in the blank the number that most closely corresponds to how you have been feeling.

1. **Not at all**
2. **Mildly (It did not bother me much.)**
3. **Moderately (It was very unpleasant, but I could stand it.)**
4. **Severely (I could barely stand it.)**

_____ **Numbness or tingling**
_____ **Feeling hot**
_____ **Wobbliness in legs**
_____ **Unable to relax**
_____ **Fear of the worst happening**
_____ **Dizziness or lightheaded**
_____ **Heart pounding or racing**
_____ **Unsteady**
_____ **Terrified**
_____ **Nervous**
_____ **Feelings of choking**
_____ **Hands trembling**
_____ **Shaky**
_____ **Fear of losing control**
_____ **Difficulty breathing**
_____ **Fear of dying**
_____ **Scared**
_____ **Indigestion or discomfort in abdomen**
_____ **Faint**
_____ **Face flushed**
_____ **Sweating (not due to heat)**

_____ **Total Score**

ATTENTION DEFICIT HYPERACTIVE DISORDER (ASBS CHECK LIST)

Name _____Date_____

Please answer the questions below, rating yourself on each of the criteria shown using the scale below. Beside each question write the number that best describes how you have felt & conducted yourself over the past 6 months.

#1 Never #2 Rarely #3 Sometimes #4 Often #5 Very Often

____ How often do you make careless mistakes when you have to work on a boring or difficult project?
____ How often do you have difficulty keeping your attention when you are doing boring or repetitive work?
____ How often do you have trouble wrapping up the final details of a project once the challenging parts have been done?
____ How often do you have difficulty getting things done in order when you have to do a task that requires organization?
____ When you have to do a task that requires a lot of thought, how often do you avoid or delay getting started?
____ How often do you misplace or have difficulty finding things at home or at work?
____ How often do are you distracted by activity or noise around you?
____ How often do you have problems remembering appointments or obligations?
____ How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?
____ How often do you leave your seat in meetings or other situations in which you are expected to remain seated?
____ How often do you feel restless or fidgety?
____ How often do you have difficulty unwinding & relaxing when you have time to yourself?
____ How often do you feel overly active & compelled to do things like you were driven by a motor?
____ How often do you find yourself talking too much when you are in social situations?
____ When you are in a conversation, how often do you find yourself finishing sentences of the people you are talking to before they can finish them themselves?
____ How often do you have difficulty waiting your turn in situations when turn taking is required?
____ How often do you interrupt others when they are busy?

The Mood Disorder Questionnaire (MDQ)

INSTRUCTIONS: Please answer each question as best you can.	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
... 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 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 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 able to work; having family, money or legal troubles; getting into arguments or fights? ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (i.e. 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?	◯	◯