TREATMENT PLANNING VISIT

NAME AND DATE: _____

This is longer visit with Dr. Grace to evaluate treatment directions, update information, and share practice updates. Treatment plans often involve a psychotherapy component (supportive, motivational enhancement, and others) as well as a medical component. **This may result in TWO copayments from your insurance.**

PRIVATE CONTACT (CIRCLE BELOW)

1. EMAIL AND TELEPHONE-You may contact and leave private information including patient link and portal information via email and telephone. This includes my consent for reminders and telemedicine.
2. NO PRIVATE INFORMATION- I do not wish to communicate any private information via email or telephone including telemedicine. Please just call me to schedule an appointment to do everything in the office.

FAMILY PLANNING It is important to avoid pregnancy while on medication if possible, notify provider immediately if you become pregnant, and be aware of risks of all psychotropics in pregnancy on package insert and general instructions. (CIRCLE BELOW)

1. THIS DOES NOT APPLY TO ME. I am unable to become pregnant at this time either because I am not a biologic female, I have passed menopause, or have had medical conditions or procedures that makes pregnancy impossible.
2. THERE IS VERY LITTLE CHANCE OF BECOMING PREGNANT. Either I am abstinent or practice highly reliable forms of birth control (pills, condoms, vasectomy of partner, etc). I understand the risk of pregnancy on medication and will let you know immediately if something changes in this regard.
3. I AM CURRENTLY PREGNANT OR TRYING TO BECOME PREGNANT

ARE THERE ANY NEW LIFE EVENTS IMPACTING YOUR MENTAL HEALTH? WHAT IS MOST IMPORTANT FOR YOU TO DISCUSS AT YOUR VISIT TODAY OTHER THAN ROUTINE FOLLOW-UP?

THOUGHTS OF NOT WANTING TO LIVE OR ESCAPE HAPPEN IN MENTAL HEALTH CONDITIONS. IT IS IMPORTANT TO RECOGNIZE THESE THOUGHTS PARTICULARLY WHEN THEY ARE WORSENING, EXTENDING TO OTHERS, AND REACHING THE POINT OF HOSPITALIZATION. IN THE LAST THIRTY DAYS, (CIRCLE ANY THAT APPLY)

- NONE OF THESE APPLY
- I have at times WISHED I was dead or could go to sleep and not wake up.
- I have had ACTUAL thoughts of killing myself or someone else.
- I have been thinking about HOW I might kill myself or someone else.
- I have had a CLEAR PLAN for killing myself or someone else.
- I have had INTENTION to act on these harmful thoughts.

Last 3 months: Have you done or prepared to do anything to end your life? Took or prepared to take pills, shot or prepared to shoot yourself, cut yourself, hang yourself, went to the roof but didn't jump, gave away valuables, wrote will or suicide note? IF SO DESCRIBE HERE

ARE YOU CURRENTLY ABUSING OR MISUSING ANY OF THE FOLLOWING (ALCOHOL, MARIJUANA, NICOTINE, CAFFEINE, PILLS, MEDICATIONS, KRATOM, AMPHETAMINE, OR OTHERS)? IS THIS AN INCREASE SINCE OUR LAST VISIT? (DESCRIBE BELOW)

ARE YOU HAVING ANY DISTURBANCES IN REALITY? HALLUCINATIONS? PARANOIA? UNUSUAL BELIEFS LIKE THE TELEVISION IS TALKING TO YOU OR PEOPLE CAN READ YOUR MIND? (DESCRIBE BELOW)

CURRENT HEIGHT/WEIGHT/BLOOD PRESSURE/PULSE

WHAT IS YOUR CURRENT APPROACH TO RISK IN YOUR CARE FOR THE LONG AND SHORT-TERM? (CIRCLE BELOW)

1. ”I am most interested in my short-term quality of life (next 6 months to 2 years). I understand this means I may end up taking medications or making choices that might result in decrease in the overall length of my life or produce significant side effects later."
2. ”Living longer and healthier overall means the most to me. I understand that some treatments might not be appropriate and am willing to have to some decrease quality of life in the short-term for more long-term health benefits down the road. I understand this may mean starting to come down or decrease some medications associated with long term risk, particularly sedating or sleeping agents.”

WHAT DO YOU CONSIDER YOUR NEEDS, CHALLENGES, AND BARRIERS TO IMPROVEMENT? (CIRCLE ALL THAT APPLY)

Physical Problems
Thinking Problems
Behavioral Problems
Addictive Behaviors
Legal Problems
Medical Problems
Learning Difficulties
Communication disorder
Developmental disability
Vision problems
Hearing problems
Physical disability
Social factors
Environmental factors
Socio-Economic Instability
Transportation

WHAT DO YOU CONSIDER YOUR STRENGTHS? (CIRCLE ALL THAT APPLY)

Family/Social/Community Support
Cognitive Ability
Insight/Judgment
Altruistic
Socio-Economic Stability
Coping Skills and Resiliency
Self-Efficacy
Self-Confidence
Motivated for Change
Spirituality
Externally Motivated
Recovery History
Desires Meaningful Activity
Relationship Stability
Physically Healthy
Perseverance
Emotional Stability
Sense of Humor
Parenting/Caregiving Skills
Makes Use of Education
Gainfully Employed
Speaks More Than One Language
Can Effectively Use Transportation
Vocational/Trade Skills
Effective Money Management
Healthcare System Navigational Skills
Ability to Appropriately Self-Advocate
Communication Skills
Maturity and Judgment Skills
Interpersonal Skills
Other:

NUTRITION. Pattern and quality of food is also important. We want to eat in a way that helps our bodies perform and recover. How is your nutrition? (CIRCLE BELOW)

1. NEED TO IMPROVE: Either I'm not sure what and how to eat or I struggle nearly every day trying to eat in a healthy pattern.
2. OKAY: I'm fairly clear what and how I should be eating and stick to a reasonable pattern at least half of the time.
3.EXCELLENT- I know what and how to eat and most days I stick to a reasonable diet and pattern.

SCHEDULE Maintenance of a consistent schedule is important. We want exercise, activity, stress, and stimulation in the first part of the day and recovery, relaxation and restoration in the second. How good is your schedule? (CIRCLE BELOW)

1. NEED TO IMPROVE: There is very little consistency to my day or there is consistency it is against the natural rhythm of the human body with fatigue and tiredness in the day and more activity, stimulation, and worry in the evening.
2. OKAY: There is some consistency (5 of 7 days) to my daily routine and it is generally in line with the natural rhythm of the human body with activity and stimulation in the day and relaxation and restoration in the evening.
3. EXCELLENT- There is good consistency to my daily routine and it is generally in line with the natural rhythm of the human body with activity and stimulation in the day and relaxation and restoration in the evening.

DESCRIBE THE CURRENT VERSION OF YOU? WHAT ARE YOUR CURRENT STRENGTHS? YOUR CURRENT LIMITATIONS? WHAT ARE YOUR GOALS FOR THE NEXT SIX MONTHS?

**ADDITIONAL PAPERWORK INCLUDES A WORKSHEET ON YOUR CURRENT IMPULSE CONTROL PLAN AS WELL AS PSYCHOLOGICAL SCALES THAT MEASURE ATTENTION, DEPRESSION, ANXIETY, PTSD, AND DISABILITY.

BY SIGNING BELOW YOU AFFIRM THE FOLLOWING:

1. **I have received a copy of my current medications, allergies, demographics insurance, smoking status, and emergency contact, and provided any appropriate updates.**
2. **I have a current copy of the policies and general instructions from John W. Grace, M.D., P.A.**
3. **I agree that in the event I am unable to reach the office or contact Dr. Grace I will contact 911 or go to the nearest emergency room.**

SIGNATURE AND DATE:_____

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**
☐	☐	☐	☐

GAD-7 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 score _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Name/ID: _____ Date: _____

DERS-18

Response categories:

1	2	3	4	5
Almost Never (0-10%)	Sometimes (11-35%)	About Half the Time (36-65%)	Most of the Time (66-90%)	Almost Always (91-100%)

1. _____ I pay attention to how I feel.
2. _____ I have no idea how I am feeling.
3. _____ I have difficulty making sense out of my feelings.
4. _____ I am attentive to my feelings.
5. _____ I am confused about how I feel.
6. _____ When I'm upset, I acknowledge my emotions.
7. _____ When I'm upset, I become embarrassed for feeling that way.
8. _____ When I'm upset, I have difficulty getting work done.
9. _____ When I'm upset, I become out of control.
10. _____ When I'm upset, I believe that I will remain that way for a long time.
11. _____ When I'm upset, I believe that I'll end up feeling very depressed.
12. _____ When I'm upset, I have difficulty focusing on other things.
13. _____ When I'm upset, I feel ashamed with myself for feeling that way.
14. _____ When I'm upset, I feel guilty for feeling that way.
15. _____ When I'm upset, I have difficulty concentrating.
16. _____ When I'm upset, I have difficulty controlling my behaviors.
17. _____ When I'm upset, I believe that wallowing in it is all I can do.
18. _____ When I'm upset, I lose control over my behaviors.

Original DERS (36 item) Citation: Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment*, *26*(1), 41-54.

DERS-18 (18 item) Reference: Victor, S. E., & Klonsky, E. D. (2016). Validation of a brief version of the Difficulties in Emotion Regulation Scale (DERS-18) in five samples. *Journal of Psychopathology and Behavioral Assessment, in press.*

DERS-18 Hand Scoring

1. Reverse-code the following items using this scale:

1 = 5 2 = 4 3 = 3 4 = 2 5 = 1

Item	Original Score	Reverse-Coded Score
1. I pay attention to how I feel		
4. I am attentive to my feelings		
6. When I'm upset, I acknowledge my emotions.		

2. Sum items for each subscale below. Note that for items with an asterisk (*), the **reverse coded score** should be used (see right-hand column above).

Awareness	**Clarity**	**Goals**
Item #1 * = _____	Item #2 = _____	Item #8 = _____
Item #4 * = _____	Item #3 = _____	Item #12 = _____
Item #6 * = _____	Item #5 = _____	Item #15 = _____
SUM = _____	SUM = _____	SUM = _____

Impulse	**Nonacceptance**	**Strategies**
Item #9 = _____	Item #7 = _____	Item #10 = _____
Item #16 = _____	Item #13 = _____	Item #11 = _____
Item #18 = _____	Item #14 = _____	Item #17 = _____
SUM = _____	SUM = _____	SUM = _____

3. To calculate the total score, sum the subscale scores below.

Awareness		Clarity		Goals		Impulse		Nonaccept.		Strategies		Total Score
_____	+	_____	+	_____	+	_____	+	_____	+	_____	=	_____

Original DERS (36 item) Citation: Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment*, *26*(1), 41-54.

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WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 2.0

12-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page...

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In the past 30 days, how much difficulty did you have in:						
S6	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days*** ____
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days*** ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days*** ____

This completes the questionnaire. Thank you.