PACT **Atlanta, LLC**

Welcome to PACT Atlanta, LLC!

Thank you for choosing PACT Atlanta, LLC for your mental and behavioral health needs!

Our office is a multidisciplinary practice that seeks to meet your individual needs. We currently have multiple Medical Doctors, Psychologists, Nurse Practitioners, Physician's Assistants, Therapists and Social Workers available that work together, in a team approach, to meet your therapeutic goals. PACT stands for Psychiatric Addictive Curative Therapies. As our name implies, we form a *PACT* with each of our clients to work together to achieve our mutual goals. We continuously strive to make each visit a satisfying experience. Please feel free to speak to a member of our staff regarding your experience at any time.

Todd M. Antin, MD, DFAPA is the founder and CEO of PACT Atlanta, LLC. He is Board Certified in Psychiatry, Addiction, Forensics, and Geriatrics by the American Board of Psychiatry and Neurology and has been honored as a Distinguished Fellow of the American Psychiatric Association. Dr. Antin has a diverse staff of specialists that will assist in your care. As our name suggests, both parties, the client and the treatment team, are active participants who work together to provide the best care possible.

Attached, you will find our "New Patient Packet," which will explain how our office works, our office policies and procedures, as well as forms and questionnaires for you to fill out so we can better meet each others expectations. *Pages 1-4 are for you to keep for your own records, and pages 5-14 are to be turned in to the receptionist at your visit.* If you have any questions or concerns, please do not hesitate to ask!

Things to Bring to Your First Appointment:

If you are coming for your first appointment, and have not received this packet in advance, please arrive 45 minutes early to read through and fill out this packet. You will also be required to present your drivers license, or another form of picture identification and your insurance card. If you are currently on any medication(s), please bring a listing of the name(s) and dose(s), so that we may have the most information available.

Office Hours:

PACT Atlanta, LLC is open Monday through Friday 9:00 a.m. to 5:00 p.m.

We are open on occasional Saturday's, depending on availability and by appointment only. Please check with a member of our team to inquire about Saturday appointments.

Emergency Situations:

If you have a life threatening emergency, please dial 911, or proceed to your nearest Emergency Room. If you have a non-life-threatening emergency during normal business hours, please contact our office at 404-292-3810 and a nurse or clinical staff member can assist you.

PACT Atlanta, LLC has a contact line for urgent after hours calls. This may be reached by dialing the main office number, 404-292-3810 and following the prompts. Your call will be assessed by a member of our team and will be routed to the appropriate provider that is on-call at the time, or you may be advised to visit your local emergency room. You may also be contacted by our staff and asked to schedule an appointment for the next business day.

This line is ONLY for URGENT calls. Appointment requests and prescription refills are NOT emergencies and are to be handled during the normal business hours listed above.

Phone Calls:

A receptionist is available to assist you during normal business hours by dialing our main number, 404-292-3810. Below is a list of the telephone extensions for each member of our team. You may use this when dialing our office to reach a specific person. While we strive to directly answer every incoming call, please remember that if someone you are calling is on the phone or attending to a client in our office, you may be directed to a voice mail. Please leave a message and someone will call you back as soon as possible.

Provider Phone Extensions:

Todd Antin, MD, DFAPA	ext. 205	Garnet King, APRN, BC	ext. 204
Alison Cole, LPC	ext. 223	Torre Prothro, PhD	ext. 210
Elizabeth Cutter, LMFT	ext. 222	Christina Davis, LPC	ext. 227
Cathy Espy, PA-C	ext. 219	Paul Olander, LCSW	ext. 218
Cliff Daniels, LCSW	ext. 208	Rajasree Praturi, MD	ext. 207
Linda Heaviside, MS, NCC	ext. 214	Alexandra Whiddon, ARNP, CNS	ext. 216
Laura Jalbert, LCSW	ext. 221	Brian Fujii, M.Div., LPC, MAC	ext. 209
Teresa Lane, APRN	ext. 215	Robin May, LPC	ext. 231
Melinda Paige, EdS,LPC,LMHC,NCC	ext. 230	Lynn Wagner, LPC	ext. 229

Administrative Staff and Phone Extensions:

Angelena Ledford, MBA/MHA, Practice Administrator…for billing, administrative or medical records inquires…ext. 212

Cheryl Davis, RN…for any medication related issues…ext. 206

Joshua Bailey, Director of Neuromodulation…ext 235

Emily Childers, MA, Front Office Coordinator…for follow-up appointments, billing, or front office issues…ext. 203

Ashlee Reynolds, Front Office Coordinator…for follow-up appointments or front office issues…ext. 201

Rebecca Soles, New Client Coordinator….for new client intake and questions…ext. 202

In order to provide the highest quality of care to our clients, and to ensure that an available time slot is available to you, please make your appointment in advance. "Reminder Cards" are available if appointments are made in the office and, as a courtesy, our office provides reminder calls two (2) days prior to your scheduled appointment. These calls are a courtesy, and it is important that you remember to write your appointment down in your schedule as well.

Walk-in appointments are not guaranteed and there will often be a significant wait. Due to the increased administrative costs, there is a $25 fee for all walk-ins that were not scheduled in advance.

Each client will be allocated one phone consultation between appointments at no charge. Additional phone calls or faxed messages that require a response from the physician or clinical staff will be billed to the client. Charges will be assessed based on complexity and length of phone calls. Most insurance carriers will not pay for phone consultations; therefore these charges will be your responsibility.

Missed Appointments:

To ensure quality of care, it is essential that you are an active participant in your treatment. Your time is very valuable to us: when an appointment is scheduled with our office, a member of our treatment team blocks out a specific amount of time for this appointment.

Our office requires 24-hours notice for a cancellation or rescheduling, otherwise a missed appointment fee may be applied to your account. This fee is up to the discretion of your provider, and if you wish to dispute any missed appointment fee on your account, you will need to take this up with the provider directly.

Please note, insurance does not cover missed appointments, these are the sole responsibility of the client.

Atlanta, LLC

Financial Policies:

PACT Atlanta, LLC and our providers participate on most insurance panels.
We also offer a reduced private pay rate. This rate varies based on the services provided.
At your first office visit, you are required to provide your insurance card and we will verify coverage and obtain prior authorization, if it is required. You will be notified by telephone, mail or e-mail, depending on the requested contact information you provide on the attached pages, if there is a problem with your account, coverage or a particular claim. Please note, verification of coverage is not a guarantee of benefits and claims processing is based on your coverage limitations and exclusions at the time of service, which is determined by your insurance company.
If you have insurance, please remember that we are bound by the type of plan that you have. PACT Atlanta, LLC does not determine your co-payment, co-insurance or deductible responsibility.
Some insurance companies require prior authorization for medications. This requires a significant amount of non-office visit time to complete the required forms and make the required phone calls to insurance companies. As such, there is a $10 charge for medication prior authorizations. If your insurance company requires such a prior authorization, you will be notified of this prior to completion and the charge that may be accrued to your account.
Any check that is returned by our bank for insufficient funds will result in a $29 fee. Any client who has a returned check may also be required to pay in cash for all future payments.

Forms:

If you have forms that need to be completed, these are to be done during office visits only. Please make an appointment with your provider of services and we will gladly assist. There may be additional fees to complete forms if the provider deems they need to be completed outside of an office visit.

Medical Records:

If you are coming to us from another practice or if you would like us to send a copy of your records to your Primary Care Physician (PCP), please sign the attached release of information, so that we may obtain your records prior to your next appointment. This will ensure continuity of care. It is our general office policy NOT to release medical records to the patient. However, we will release the records to another physician, provider, attorney or agency so they can be reviewed under supervision.

Prescriptions:

If you are prescribed medication from our office, we typically give enough refills to last until the next appointment. Our office policy requires that all prescription refill requests are made 24-hours in advance and must be requested by the pharmacy. This will allow our staff sufficient time to handle all medication refill requests as promptly as possible. The 24-hour advance notice also includes all written prescription requests as well.
If you need a refill or have a question about any prescribed medication, please contact the office to make an appointment or contact the nurse directly at extension 206.
Please note, prescription refill requests left after 3:00 p.m. may not be completed until the next business day.
There is a $25 administrative fee to replace lost prescriptions. There is an administrative fee for the administering of injectable medications.

Thank you again for choosing PACT Atlanta, LLC. If you have any questions or concerns, please do not hesitate to ask a member of our team.

PACT Atlanta, LLC

Statement of Privacy Policies

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of Protected Health Information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its providers and staff have the necessary medical and PHI to provide the highest quality medical care possible, while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its providers and staff for purposes of treatment, payment, and healthcare operations. To that end, our practice and its providers and staff will:

- Adhere to the standards set forth in the Notice of Privacy Policies (a copy is available at the front desk).
- Collect, use and disclose PHI only in the conformance with Georgia and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not sue or disclose PHI for uses outside of the practices' standard operations, such as marketing, employment, life insurance applications, disability applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us in writing not to do so.
- Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice, its providers and staff will implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff will respect patients privacy to the extent consistent with providing the highest quality medical are possible and with the efficient administration of the facility.
- Responsibly protect patient information and treat all PHI as sensitive and confidential. Consequently, our practice, its providers and staff, will:
    - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements.
    - Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release in writing, or state or federal law otherwise authorizes the release of PHI data.
- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than standard operations for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide the list to patients upon request, so long as the request is in writing.
- All providers and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that our practice has approved and that any patient has requested.
- All providers and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be available to the patient upon request.

Acknowledgement of Receipt of PACT Policies:

Please initial below that you have read and understand the following policies:

Policy:	Initials:
Welcome and Policy Information (Pages ****)	
Statement of Privacy Policies (Pages ****)	

My signature below shows that I have been informed of my rights and responsibilities, and that I have read and understand the information in the Policies listed above.

Signature: _____Date: _____

Name (Please Print): _____

PACT Atlanta, LLC

Client Information:

Personal Information:

Name: _____Date: _____
(First) (Middle) (Last)

Birthdate: _____/_____/_____ Age: _____Name you prefer to be called? _____

Address: _____

City: _____State: _____Zip: _____

Home Phone: _____Cell Phone: _____

E-mail address: _____Social Security Number: _____

By writing an e-mail address above, the client grants permission for PACT Atlanta, LLC to correspond via this e-mail address. Electronic communication is not a way of communicating new information regarding care or of communicating emergency treatment. You must call and talk to your individual provider regarding any information about your treatment at PACT Atlanta, LLC.

Employer Name: _____

City: _____State: _____ Marital Status: S M W D Sep

Work Phone: _____May we contact you at work? ☐ Yes ☐ No

Family Information:

Spouse/Partner Name: _____ Employer: _____

Child Name: _____ Age: _____Date of Birth: _____

Child Name: _____ Age: _____Date of Birth: _____

Child Name: _____ Age: _____Date of Birth: _____

Child Name: _____ Age: _____Date of Birth: _____

How did you hear about us? _____

What is the reason for your visit with us today? _____

_____

Emergency Contact Information:

Nearest relative not living with you, whom we may contact in case of emergency:

Name: _____Relationship: _____Phone: _____

Address: _____City: _____State: _____Zip: _____

Payment Authorization Information:

It is the policy of this office that payments are made at the time of your visit. Payment can be made by either cash, money order, check, debit or credit card.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account. I certify that the demographic information provided on Page 6 is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance coverage status or any of the above information immediately. I understand that many insurance panels have timely filing limits and if I do not provide my insurance to PACT Atlanta, LLC in a timely manner, this can result in claim denials and I will be financially responsible.

I hereby authorize my attending physician and consulting physicians to bill my insurance company directly for their services. I also authorize assignment of benefits to be sent directly to the physician. I understand that I am financially responsible to these physicians for charges not covered by my insurance company. A photo static copy of other reproduction of this authorization will be valid as the original.

PACT Atlanta, LLC will file claims with the insurance company that is provided to our office and we will follow-up on claim issues. Please note that we are not responsible for the decisions made by your insurance company and limitations of your insurance plan.

If you have any questions or concerns regarding the financial policies of PACT Atlanta, LLC, please contact Angelena Ledford at 404-292-3810, ext 212

I have read and understand the information provided above:

Signature: _____

Name: _____ Date: _____

PACT Atlanta, LLC

Coordination of Care/Release of Information

Communication between mental/behavioral health providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your mental/behavioral health provider to share protected health information (PHI) with your other provider, only as designated by you, the client. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization at any time, by contacting the office at404-292-3810, ext. 212.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You are not required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires one (1) year from the date of my signature below unless otherwise stated herein.**

_____is authorized to release protected health information related to the evaluation and
(Provider Name-Please Print)

treatment of _____ _____ /_____ /_____.
(Client Name) (Date of Birth – MM/DD/YYYY)

Choose One: **_____To** **_____From** **_____Bilateral**

PCP Name: _____ PCP Phone: _____

PCP Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

PCP Fax: _____

Other Name: _____ Other Phone: _____

Other Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Disclosure may include the following verbal or written information: (check all that apply):

___ Face sheet ___ History & physical ___ Laboratory/diagnostic testing results ___ School information
___ Discharge summary ___ Medication records ___ Behavioral health/psychological consult ___ Psychological eval/testing results
___ ER record report ___ Psychiatric evaluation ___ Psychosocial assessment ___ Other
___ Substance abuse treatment record ___ Summary of treatment records & contact dates ___HIV/AIDS

_____ **I hereby refuse to give authorization for any release of information**

_____
(Signature of Patient, Parent, Guardian or Authorized Representative) (Date)

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

Atlanta, LLC

Beck Depression Inventory:

Name: _____Date: _____

This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement that you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1.
0 I do not feel sad
1 I feel sad
2 I am sad all the time and I can't snap out of it
3 I am so sad and unhappy that I can't stand it

2.
0 I am not particularly discouraged about the future
1 I feel discouraged about the future
2 I feel I have nothing to look forward to
3 I feel the future is hopeless and that things cannot improve

3.
0 I do not feel like a failure
1 I feel I have failed more than the average person
2 As I look back on my life, all I can see is a lot of failures
3 I feel I am a complete failure as a person

4.
0 I get as much satisfaction out of things as I used to
1 I don't enjoy things the way I used to
2 I don't get real satisfaction out of anything anymore
3 I am dissatisfied or bored with everything

5.
0 I don't feel particularly guilty
1 I feel guilty a good part of the time
2 I feel quite guilty most of the time
3 I feel guilty all of the time

6.
0 I don't feel I am being punished
1 I feel I may be punished
2 I expect to be punished
3 I feel I am being punished

7.
0 I don't feel disappointed in myself
1 I am disappointed in myself
2 I am disgusted with myself
3 I hate myself

8.
0 I don't feel I am any worse than anybody else
1 I am critical of myself for my weaknesses or mistakes
2 I blame myself all the time for my faults
3 I blame myself for everything bad that happens

9.
0 I don't have any thoughts of killing myself
1 I have thoughts of killing myself, but I would not carry them out
2 I would like to kill myself
3 I would kill myself if I had the chance

10.
0 I don't cry any more than usual
1 I cry more now than I used to
2 I cry all the time now
3 I used to be able to cry, but now I can't cry even though I want to

11.
0 I am no more irritated by things than I ever was
1 I am slightly more irritated now than usual
2 I am quite annoyed or irritated a good deal of the time
3 I feel irritated all the time

12.
0 I have not lost interest in other people
1 I am less interested in other people than I used to be
2 I have lost most of my interest in other people
3 I have lost all of my interest in other people

13.
0 I make decisions about as well as I ever could
1 I put off making decisions more than I used to
2 I have greater difficulty in making decisions more than I used to
3 I can't make decisions at all anymore

14.
0 I don't feel that I look any worse than I used to
1 I am worried that I am looking old or unattractive
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe I look ugly

15.
0 I can work as well as before
1 It takes an extra effort to get started at doing something
2 I have to push myself very hard to do anything
3 I can't do any work at all

16.
0 I can sleep as well as usual
1 I don't sleep as well as I used to
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
3 I wake up several hours earlier than I used to and cannot get back to sleep

17.
0 I don't get more tired than usual
1 I get tired more easily than I used to
2 I get tired from doing almost anything
3 I am too tired to do anything

18.
0 My appetite is no worse than usual
1 My appetite is not as good as it used to be
2 My appetite is much worse now
3 I have no appetite at all anymore

19.
0 I haven't lost much weight, if any, lately
1 I have lost more than five pounds
2 I have lost more than ten pounds
3 I have lost more than fifteen pounds

20.
0 I am no more worried about my health than usual
1 I am worried about my physical problems, like aches, pains, upset stomach, or constipation
2 I am very worried about physical problems and it's hard to think about much else
3 I am so worried about my physical problems that I cannot think of anything else

Interpreting the Beck Depression Inventory

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circled zero on each question.

Total Score _____

Levels of Depression:

1-10 - These ups and downs are considered normal
11-16 – Mild mood disturbance
17-20 – Borderline clinical depression
21-30 Moderate Depression
31-40 – Severe Depression
Over 40- Extreme depression

PACT **Atlanta, LLC**

Obsessive Compulsive Screener:

Name: _____Date: _____

	Yes	No
1. Do you have thoughts that bother you or make you anxious and that you can't get rid of, regardless of how you try?		
2. Do you have a tendency to keep things extremely clean or to wash your hands very frequently, more than other people you know?		
3. Do you check things over and over to excess?		
4. Do you have to straighten, order, or tidy so much that it interferes with other things you want to do?		
5. Do you worry excessively about acting or speaking more aggressively than you should?		
6. Do you have great difficulty discarding things even when they have no practical value?		

People with Obsessive Compulsive Disorder (OCD) usually have difficulty with some of the following activities. Answer each question by circling the appropriate number next to it:

0-No problem with activity- takes me the same time as everyone else. I do not need to repeat or avoid it.
1- Acitivity takes me twice as long as most people, or I have to repeat it twice, or I tend to avoid it.
2- Activity takes me three times as long as most people, or I have to repeat it three or more times, or I usually avoid it.

Score:			Activity:
0	1	2	Taking a bath/shower
0	1	2	Washing hands or face
0	1	2	Care of hair (washing, combing, brushing)
0	1	2	Brushing teeth
0	1	2	Dressing and undressing
0	1	2	Using toilet to urinate
0	1	2	Using toilet to defecate
0	1	2	Touching people or being touched
0	1	2	Handling waste or waste bins
0	1	2	Washing clothes
0	1	2	Washing dishes
0	1	2	Handling or cooking food
0	1	2	Cleaning the house
0	1	2	Keeping things tidy
0	1	2	Bed making
0	1	2	Cleaning shoes
0	1	2	Touching door handles
0	1	2	Touching genitals, petting, or sexual intercourse
0	1	2	Throwing things away
0	1	2	Visiting a hospital
0	1	2	Turning lights and taps on and off
0	1	2	Locking or closing doors or windows
0	1	2	Using electrical appliances (ex. Heaters)
0	1	2	Getting to work
0	1	2	Doing own work
0	1	2	Writing
0	1	2	Form filing
0	1	2	Mailing letters
0	1	2	Reading
Total Score: _____			

Total scores greater than 10 increase the possibility of OCD, and further evaluation is recommended.

Total scores greater than 20 are highly suggestive of OCD.

PACT **Atlanta, LLC**

Mood Disorder Questionnaire (MDQ)

Name: _____Date: _____

Two questions for screening:

1. Have any of your blood relatives been diagnosed as "Manic-Depressive" or as having Bi-polar Depression? _____
2. Have you ever had far more energy than usual, slept very little, and engaged in activities that have been risky or dangerous? _____

Answer **Yes** or **NO** to each of the following questions:

Question	Yes	No
Has there ever been a period in time when you were not your usual self and...		
1. You felt so good or hyper that other people thought that you were not your normal self, or that you were so hyper that you got into trouble?		
2. You were so irritable that you shouted at people or started fights or arguments?		
3. You feel much more self-confident than usual?		
4. You got much less sleep than usual and found that you didn't really miss it?		
5. You were much more talkative or spoke much faster than usual?		
6. Thoughts raced through your head or you couldn't slow your mind down?		
7. You were so easily distracted by things around you that you have trouble concentrating or staying on track?		
8. You had much more energy than usual?		
9. You were much more social or outgoing than usual- for example, you telephone friends in the middle of the night?		
10. You were much more active or did many more things than usual?		
11. You were much more interested in sex than usual?		
12. You did things that were unusual for you, or that other people might have thought were excessive, foolish, or risky?		
13. You spent so much money that it got you or your family into trouble?		

14. Did any of the situations you said **YES** to ever happen during the same period of time?		

15. Choose only 1 response:
    How much of a problem did any of these situations cause you (example, being unable to work, having family, money, or legal problems or getting into serious arguments or fights)?
    a. It was not problem
    b. It was a minor problem
    c. It was a moderate problem
    d. It was a serious problem

PACT **Atlanta, LLC**

Restless Legs Syndrome (RLS) Questionnaire

Name: _____Date: _____

Restless Legs Syndrome (RLS) may be described as uncontrollable urges to move the limbs in order to stop uncomfortable, painful, or odd sensations in the body, mostly common in the legs. Moving the affected body part modulates the sensations, providing temporary relief.

On this questionnaire, please read each of the statements. Then, circle the appropriate response.

1. Overall, how would you rate the RLS discomfort in your legs or arms?	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
2. Overall, how would you rate the need to move around because of your RLS symptoms?	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
3. Overall, how much relief of your RLS arm or leg discomfort did you get from moving around?	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
4. How severe was your sleep disturbance due to your RLS symptoms?	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
5. How severe was your tiredness or sleepiness during the day due to your RLS symptoms?	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
6. How severe was your RLS as a whole?	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
7. How often did you get RLS symptoms?	**None**	**1 day a week or less**	**2-3 days a week**	**4-5 days a week**	**6-7 days a week**
8. When you had RLS symptoms, how severe were they on an average day?	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
9. Overall, how severe was the impact of your RLS symptoms on your ability to carry out your daily affairs – for example, home, family, social, school or work life?	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
10. How severe was your mood disturbance due to your RLS symptoms – for example, angry, depressed, sad, anxious, or irritable?	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**

How would you describe your leg sensations (please circle)?

Creeping Crawling Tingling Aching

Burning Pulling Painful Itching

Other: _____

If you have been experiencing RLS symptoms, please discuss the following with your healthcare provider:

- Do you sometimes have the urge to move your legs, associated with uncomfortable leg sensations?
- Do you get relief, at least temporarily, from the urge or leg sensations when you move?
- Do your leg symptoms begin or get worse when you are resting or inactive?
- Do your leg symptoms get worse in the evening or at night?

PACT Atlanta, LLC

Attention Deficit Disorder with Hyperactivity Screening

Patient Name: _____ Date: _____

Inattention:

Question:	Yes	No
1. Often does not give close attention to details or makes careless mistakes in school, work or other activities.		
2. Often has difficulty sustaining attention in tasks or play activities?		
3. Often does not seem to listen when spoken to directly.		
4. Often does not follow through on instructions and fails to finish school work, chores or duties (not due to oppositional behavior or failure to understand directions).		
5. Often has difficulty organizing tasks and activities.		
6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as school work or homework).		
7. Often loses things necessary for tasks or activities, such as toys, assignments, books or tools.		
8. Is often easily distracted by extraneous stimuli.		
9. Is often forgetful in daily activities.		

Hyperactivity:

Question	Yes	No
1. Often fidgets with hands or feet or squirms in seat.		
2. Often leaves seat in classroom or in other situations in which remaining in seat is expected.		
3. Often runs about or climbs excessively in situations in which it is inappropriate (adolescents or adults may have feelings of restlessness.		
4. Often has difficulty playing or engaging in leisure activities quietly.		
5. Is often "on the go" or often acts as if "driven by a motor."		
6. Often talks excessively.		

Impulsivity:

Question	Yes	No
1. Often blurts out answers before questions are completed.		
2. Often has difficulty waiting turn.		
3. Often interrupts or intrudes on others, such as butting into conversations or games.		

Total Hyperactivity-Impulsivity Score: _____

Adapted from DSM-IV Diagnostic Criteria for Attention Deficit/Hyperactivity Disorder: Diagnostic and Statistical Manual of Mental Disorders. 4th edition. Washington, D.C.: American Psychiatric Association, 1994.

PACT **Atlanta, LLC**

Screening for Anxiety

Name: _____Date: _____

Question	Yes	No
1. Do you feel that you worry excessively about many things?		
2. Do you experience sensations of shortness of breath, palpitations or shaking while you rest?		
3. Do you have a fear of losing control of yourself or of "going crazy?"		
4. DO you avoid social situations because of feelings of fear?		
5. Do you have specific fears of certain objects – example, animals or knives?		
6. Do you feel afraid that you will be in a place or a situation from which you feel that you will not be able to escape?		
7. Does the idea of leaving home frighten you?		
8. Do you have any recurrent thoughts or images in your head that refuse to go away?		
9. Do you feel compelled to perform certain behaviors repeatedly – example, checking that you locked the doors or turned off the gas?		
10. Do you persistently relive an upsetting event from the past?		

Thank you for choosing PACT Atlanta, LLC!

We look forward to working with you!

Please keep pages 1-4 for your records, and give pages 5-14 to the receptionist.

Your provider will be with you shortly!