Integrated Clinical Neurosciences
Saad A Shakir, MD & Associates
Silicon Valley TMS and Silicon Valley TMS of San Francisco
Saad A. Shakir, MD, DFAPA, FACIP, Chief Medical Officer
Erin M. Griffiths, MA, DO, Associate Medical Director
Tammy Saah, MD, General Psychiatry

TO BE COMPLETED BY PATIENT

PATIENT REGISTRATION

(Please fill in completely. Where not applicable, write N/A)

PATIENT INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____ E-MAIL: _____

CITY: _____ ZIP CODE: _____ SSN: _____

PHONE NUMBER: _____ DATE OF BIRTH: _____

SEX: ☐MALE ☐FEMALE MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widow

EMPLOYER: _____ POSITION: _____

WORK ADDRESS: _____ WORK PHONE: _____

SPOUSE NAME: _____ HOME PHONE: _____

EMPLOYER: _____ POSITION: _____

WORK ADDRESS: _____ WORK PHONE: _____

IF PATIENT IS A MINOR

PARENT/GUARDIAN'S NAME: _____ RELATIONSHIP: _____

DATE OF BIRTH: _____ : SEX: ☐MALE ☐FEMALE SSN: _____

ADDRESS (if different from above): _____

CITY & STATE: _____ ZIP: _____

HOME PHONE (if different from above): _____ WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____ GROUP/POLICY NUMBER: _____

PHONE NUMBER: _____ FAX NUMBER: _____

NAME OF INUSRED: _____ DATE OF BIRTH: _____

REFERRAL INFORMATION

REFERRED BY: _____

CONTACT INFO:_____

PRIMARY PHYSICIAN (if different from above): _____

EMERGENCY INFORMATION

Emergency Contact: _____

Phone number: _____ Relationship: _____

I AUTHORIZE SAAD A. SHAKIR, M.D., INC. TO EXCHANGE MEDICAL (PSYCHIATRIC) INFORMATION CONCERNING MY EVALUATION AND/OR TREATMENT WITH THE PROFESSIONAL REFERAL SOURCE NOTED ABOVE AND :

_____

_____

IF MORE RECORDS ARE NEEDED, A SEPARATE RELEASE WILL BE COMPLETED FOR THAT PURPOSE.

SIGNED: _____ **DATE**: _____

_____

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

Privacy Officers: Grace Guerrero, Office Manager

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy will be posted in the reception area, and a copy of any amended Notice of Privacy Practices will be available at each appointment. I understand that I have the right to restrict how Saad A. Shakir, M.D. & Associates uses or disclose my protected health information to carry out treatment, payment and health care operations; that Saad A. Shakir, M.D. & Associates is not required to agree to the restrictions and; that Saad A. Shakir, M.D. & Associates bound by restrictions to which it agrees.

I request the following restrictions to how my health information is used or disclosed:

_____

_____

_____

_____

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_____

_____

_____

I have the right to revoke this consent by notifying Saad A. Shakir, M.D. & Associates in writing, except to the extent that Saad. A. Shakir, M.D. & Associates has taken action in reliance on my consent.

_____ _____
Signature Date

_____ _____
Print Name Telephone

If not singed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

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CONSENT FOR TREATMENT

I hereby give my consent for any diagnostic or therapeutic services Saad A. Shakir, M.D. & Associates, including diagnostic evaluation, examination, consulting, psychotherapy and other therapies as appropriate.

I understand that communication between me and my mental health professional* is confidential and privileged to the full extent of the applicable laws. Under these laws, the mental health professional* may disclose information about me to the staff of Saad A. Shakir, M.D., Inc., in the provision of therapy or appropriate referrals, and not otherwise without my written permission.

I further understand that certain circumstances are exceptions to the laws of confidentiality, under which a mental health professional* is legally required to report.
These include:

1. Intent to harm myself (suicide)
2. Intent to harm another person
3. Child abuse, physical and /or sexual
4. Abuse of an elder or dependent adult
5. Domestic violence

If a mental health professional* reasonably believes that one of the exceptions apply, he or she will make every effort to resolve the issue by discussing it with me before reporting to the proper agency.

I understand that in group therapy, there is a risk of disclosure of my confidential information by other group members and I will not hold the mental health professional* liable for any breach of confidentiality by other group members.

_____ _____

Date Signature

_____

If not the patient, please print your name and relationship to the patient

*The term "mental health professional" includes any physician, therapist, counselor, or nurse that I may come in contact with in treatment at Saad A. Shakir, M.D., Inc.

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Credit Card Authorization Form

I, _____, hereby authorize Saad A. Shakir M.D. and Associates Inc, to charge my credit card for the amounts invoiced.

Patient's Name: _____

Name on card: _____
(If different from patient's Name)

Type of Card: AMERICAN EXPRESS / DISCOVER / VISA / MasterCard / OTHER
If other, please specify: _____

Credit Card Number: _____
Expiration Date: _____
CVC Code: _____

Credit Card Billing Address
Street: _____
City: _____
State: _____
Zip Code: _____
Telephone: _____
Email (optimal): _____

As the credit card holder, I also authorize Saad A. Shakir M.D. and Associates Inc. to charge my credit card for future services and also for late cancellations or failed appointments.

Your completion of this authorization form helps us to protect you, our valued patients, from credit card fraud. Saad A. Shakir M.D. and Associates Inc. will keep all information entered on this form strictly confidential.

_____ _____
Cardholder's Signature Date

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Patient Report

The information requested on this form will be used to assist the staff in evaluating your health status and treatment needs. It will not be used for any other purpose.

(A) General Information

NAME: _____ DATE: _____

(B) Please describe the problems/needs that you would like help for:

_____

_____

_____

(C) Previous medical and/or emotional treatment you have received (include dates, hospitalizations, and surgeries)

_____

_____

_____

(D) List names and addresses of physicians or therapists you have seen in the past two years:

(a) Primary: _____

(b) Other(s): _____

(c) Last date of last physical exam: _____

(E) Medications Currently Used:

Drug Name	Strength (mg)	Frequency

Do you have any medication allergies? ☐ Yes ☐ No (If yes, please specify on the space provided below)

_____

_____

(F) Personal habits (indicate frequency and quantity per daily use):

☐ Alcohol _____ ☐ Tobacco _____

☐ Recreational Drugs _____ ☐ Caffeine _____

(G) Social History:

(a) Highest level of education: _____

(b) School presently attending at *(if appropriate)*: _____

(c) Occupation: _____

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(d) Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

(H) Family History:

	Age	Occupation	Health/Status Problem
Spouse			
Father			
Mother			
Siblings			
Children			

(I) Family Psychiatric History (if applicable, indicate family member):

(a) Mental or emotional problems:

_____

_____

(b) Alcohol/Drug Use:

_____

_____

(J) Are you experiencing problems in any of the following areas? *(If so, please specify)*

(a) Work: _____

_____

(b) Finances: _____

_____

(c) Health (include allergies): _____

_____

(d) Family: _____

_____

(e) School: _____

_____

(f) Living Arrangements: _____

_____

(g) Legal: _____

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Symptom Checklist

Please check any symptoms you have recently experienced:

- ☐ Headaches
- ☐ Dizziness
- ☐ Unexplained pain
- ☐ Menstrual problems/changes
- ☐ Urinary problems
- ☐ Changes in bowel habits (specify)

_____

- ☐ Diarrhea
- ☐ Chronic constipation
- ☐ Other physical symptoms (specify)

_____

- ☐ Heart pounding/racing
- ☐ Feelings of panic
- ☐ Difficulty relaxing
- ☐ Change in appetite
- ☐ Vomiting
- ☐ Nausea
- ☐ Weight gain
- ☐ Weight loss
- ☐ Fatigue/low energy
- ☐ Early morning awakening
- ☐ Loss of/decreased enjoyment, in pleasure events
- ☐ Changes in energy level
- ☐ Decreased effectiveness at home, work, school
- ☐ Needing to be with others excessively
- ☐ Needing to be alone excessively
- ☐ Excessive, constant guilt
- ☐ Crying spells
- ☐ Thoughts/attempts to hurt self
- ☐ Thoughts of death
- ☐ Thoughts of suicide
- ☐ Thoughts of hurting others
- ☐ Difficulty concentrating
- ☐ Difficulty making decisions
- ☐ Feelings of inadequacy
- ☐ Low self-esteem
- ☐ Feeling slowed down
- ☐ Feeling restless at times
- ☐ Feeling hopeless
- ☐ Feeling helpless
- ☐ Mood changes (specify)

_____

- ☐ Changes in memory (specify)

_____

- ☐ Tremors
- ☐ Changes in walk
- ☐ Changes in speech
- ☐ Changes in writing
- ☐ Changes in driving
- ☐ Increased suspicions/concerns
- ☐ Nightmares
- ☐ Hallucinations
- ☐ Excessive/unusual fears
- ☐ Hearing voices
- ☐ Repetitive/bothersome thoughts (specify)

_____

- ☐ Recurrent/bothersome behaviors
- ☐ Feelings of unreality
- ☐ Unusual behaviors (specify)

_____

- ☐ Impulsive Behavior (Problems related to gambling, drinking, eating, spending money, others)
- ☐ Irritability/excessive anger
- ☐ Sexual problems (Describe)

_____

- ☐ Difficulty in relationship
- ☐ Difficulty with mate
- ☐ Difficulty with children
- ☐ Difficulty with co-workers
- ☐ Recommendation of family, friends, associates, to seek help

COMMENTS: _____

_____

_____

_____

_____

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Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General
- ☐ Being overweight
- ☐ Recent weight gain or weight loss
- ☐ Poor appetite
- ☐ Increased appetite
- ☐ Abnormal sensitivity to cold
- ☐ Cold sweats during the day
- ☐ Tired or worn out
- ☐ Hot or cold spells
- ☐ Abnormal sensitivity to heat
- ☐ Excessive sleeping
- ☐ Difficulty sleeping
- ☐ Lowered resistance to infection
- ☐ Flu-like or vague sick feeling
- ☐ Sweating excessively at night
- ☐ Urinating excessively
- ☐ Excessive daytime sweating
- ☐ Excessive thirst
- ☐ Other _____

Neurological
- ☐ Pacing due to muscle restlessness
- ☐ Forgotten periods of time
- ☐ Dizziness
- ☐ Drowsiness
- ☐ Muscle spasms or tremors
- ☐ Impaired ability to remember
- ☐ "Tics"
- ☐ Numbness
- ☐ Convulsions / fits
- ☐ Slurred speech
- ☐ Speech problem (other)
- ☐ Weakness in muscles
- ☐ Other _____

Respiratory
- ☐ Asthma, wheezing
- ☐ Cough
- ☐ Coughing up blood or sputum
- ☐ Shortness of breath
- ☐ Rapid breathing
- ☐ Repeated nose or chest colds
- ☐ Other _____

Chest and Cardiovascular
- ☐ Ankle swelling
- ☐ Rapid / irregular pulse
- ☐ Breast tenderness
- ☐ Chest pain
- ☐ High blood pressure

Head, Eye, Ear, Nose, & Throat
- ☐ Facial pain
- ☐ Headache
- ☐ Head injury
- ☐ Neck pain or stiffness
- ☐ Frequent sore throat
- ☐ Blurred vision
- ☐ Double vision
- ☐ Overly sensitive to light
- ☐ See spots or shadows
- ☐ Hearing loss in both ears
- ☐ Ear ringing
- ☐ Disturbances in smell
- ☐ Runny nose
- ☐ Dry mouth
- ☐ Sore tongue
- ☐ Other _____

Gastrointestinal and Hepatic
- ☐ Trouble swallowing
- ☐ Nausea or vomiting (throwing up)
- ☐ Abdominal (stomach / belly) pain
- ☐ Anal itching
- ☐ Painful bowel movements
- ☐ Infrequent bowel movements
- ☐ Liquid bowel movements
- ☐ Loss of bowel control
- ☐ Frequent belching or gas
- ☐ Vomiting blood
- ☐ Rectal bleeding (red or black blood)
- ☐ Jaundice (yellowing of skin)
- ☐ Other _____

Musculoskeletal
- ☐ Back pain or stiffness
- ☐ Bone pain
- ☐ Joint pain or stiffness
- ☐ Leg pain
- ☐ Muscle cramps or pain
- ☐ Other _____

Skin, Hair
- ☐ Dry hair or skin
- ☐ Itchy skin or scalp
- ☐ Easy bruising
- ☐ Hair loss
- ☐ Increased perspiration
- ☐ Sun sensitivity
- ☐ Other _____

Genitourinary
- ☐ Itchy privates or genitals
- ☐ Painful urination
- ☐ Excessive urination
- ☐ Difficulty in starting urine
- ☐ Accidental wetting of self
- ☐ Pus or blood in urine
- ☐ Decreased sexual desire
- ☐ Other _____

Females
- ☐ No menses
- ☐ Menstrual irregularity
- ☐ Painful or heavy periods
- ☐ Premenstrual moodiness, irritability, anger, tension. bloating, breast tenderness, cramps, headache
- ☐ Painful menstrual periods
- ☐ Painful intercourse or sex
- ☐ Sterility infertility
- ☐ Abnormal vaginal discharge
- ☐ Other _____

Males
- ☐ Impotence (weak male erection)
- ☐ Inability to ejaculate or orgasm
- ☐ Scrotal pain
- ☐ Abnormal penis discharge
- ☐ Other _____

Explanation

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☐Low blood pressure _____
☐Other

BURN'S ANXIETY INVENTORY

Instructions: Circle the answer that best describes how much that symptom or problem has bothered you during the past seven (7) days.

Category I: Anxious Feelings	Not at all	Somewhat	Moderately	A lot
1.Anxiety, nervousness, worry or fear	0	1	2	3
2.Feeling that things around you are strange, unreal or foggy	0	1	2	3
3.Feeling detached from all or part of your body	0	1	2	3
4. Sudden, unexpected panic spells	0	1	2	3
5. Apprehension or a sense of impending doom	0	1	2	3
6. Feeling tense, stressed, "uptight" or on edge	0	1	2	3
Category II: Anxious Thoughts				
7. Difficulty Concentrating	0	1	2	3
8. Racing thoughts or having your mind jump from one thing to next	0	1	2	3
9. Frightening fantasies or daydreams	0	1	2	3
10. Feeling that you're on the verge of losing control	0	1	2	3
11. Fears of cracking up or going crazy	0	1	2	3
12. Fears of fainting or passing out	0	1	2	3
13. Fears of physical illness or heart attacks or dying	0	1	2	3
14. Concerns about looking foolish or inadequate in front of others	0	1	2	3
15. Fears of being alone, isolated or abandoned	0	1	2	3
16. Fears of criticism or disapproval	0	1	2	3
17. Fears that something terrible is about to happen	0	1	2	3
Category III: Physical Symptoms				
18. Skipping or racing or pounding of the heart	0	1	2	3
19. Pain, pressure or tightness in the chest	0	1	2	3
20. Tingling or numbness in the toes or fingers	0	1	2	3
21. Butterflies or discomfort in the stomach	0	1	2	3
22. Constipation or diarrhea	0	1	2	3
23. Restlessness or jumpiness	0	1	2	3
24. Tight, tense muscles	0	1	2	3
25. Sweating not brought on by heat	0	1	2	3
26. A lump in the throat	0	1	2	3
27. Trembling or shaking	0	1	2	3
28. Rubbery or "jelly" legs	0	1	2	3
29. Feeling dizzy, light-headed or off balance	0	1	2	3
30. Choking or smothering sensations or difficulty breathing	0	1	2	3
31. Headaches or pains in the neck or back	0	1	2	3
32. Hot flashes or cold chills	0	1	2	3
33. Feeling tired, weak or easily exhausted	0	1	2	3
Add Column:				

Name_____Date_____Total_____
0-4 Minimal or No Anxiety; 5-10 Borderline; 11-20 Mild; 21-30 Moderate; 31-50 Severe; 51-99 Extreme Anxiety or Panic

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THE BURNS DEPRESSION INVENTORY

NAME: _____ DATE: _____

INSTRUCTIONS: The following is a list of symptoms that people sometimes have. Put a check ( ) in the space to the right that bests describes how much that symptom or problem has bothered you during this past week.	0 – NOT AT ALL	1- SOMEWHAT	2- MODERATELY	3- A LOT
SYMPTOM LIST				
Sadness: Do you feel sad or down in the dumps?	0	1	2	3
Discouragement: Does your future look hopeless?	0	1	2	3
Low Self-Esteem: Do you feel worthless?	0	1	2	3
Inferiority: Do you feel inadequate or inferior to others?	0	1	2	3
Guilt: Do you get self-critical and blame yourself?	0	1	2	3
Indecisiveness: Is it hard to make decisions?	0	1	2	3
Irritability: Do you frequently feel angry or resentful?	0	1	2	3
Loss of interest in life: Have you lost interest in your career, hobbies, family and friends?	0	1	2	3
Loss of motivation: Do you have to push yourself to do things?	0	1	2	3
Poor Self-Image: Do you feel old and unattractive	0	1	2	3
Appetite Changes: Have you lost your appetite? Do you overeat or binge compulsively?	0	1	2	3
Sleep Changes: Is it hard to get at good night's sleep? Are you excessively tired and sleeping too much?	0	1	2	3
Loss of Libido: Have you lost your interest in sex?	0	1	2	3
Concerns about Health: Do you worry excessively about your health?	0	1	2	3
Suicidal Impulses? Do you have thoughts that life is not worth living or think you'd be better off dead?	0	1	2	3
Add up your total and record it here:	0			
Total:				

0-4 Minimal or no Depression 5-10 Borderline Depression 11-20 Mild Depression
21-30 Moderate Depression 31-45 Severe Depression

The Feeling Good Handbook, *David Burns, M.D., Penguin Group, 1999.*

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	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.	0	1	2	3
Add columns:		+	+	
			Total:	

10. If you checked off any problems, how difficult at all 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

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GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by the following problems?
(Use "✔" to indicate your answer)

	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
Add score for each column				
Total				

If you checked off any problems, how difficult at all 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 GAD-7 originates from Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. GAD-7 © Pfizer Inc. all rights reserved

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Prior Treatment History

We are happy to provide the consultation for you and to discuss available treatment options for your condition.

In order for us to have the most productive consultation and recommendations we would very much welcome any and all information you can provide about your condition at the time of the consultation if at all possible. You might not remember all the details however sometimes consulting others who are familiar with your condition (family members or friends), your prior records as well as pharmacy refill records can help complete the list.

Please take a few minutes to complete the following prior treatment questionnaire. Check the medications you have tried, and in the comments include dosage and approximate length of treatment and outcome.

A. MEDICATION TREATMENT:

Medication Class & Examples	Dates Taken (mo/year-mo/year)	Highest Dosage	Side Effects, Reason for Discontinuation, etc…
1. *SSRIs (Selective Serotonin Reuptake Inhibitors):* __Prozac (Fluoxetine) __Zoloft (Sertraline) __Paxil (Paroxetine) __Celexa (Citalopram) __Lexapro (Escitalopram) __Luvox (Fluvoxamine)			
2. *SNRIs (Selective Serotonin & Norepinephrine Reuptake Inhibitors):* __Effexor (Venlafaxine) __ Pristiq (Desvenlafaxine) __Cymbalta (Duloxetine)			
3. Atypical Antidepressants: __Wellbutrin (Buproprion) __Remeron (Mirtazepine) __Serzone (Nefazadone) __Trazadone (Desyrel) __Viibryd			

__Brintellix __Fetzima	_____ _____
4. *Tricyclic Antidepressants:* __Elavil (Amitriptyline) __Tofranil (Imipramine) __Pamelor (Nortriptyline) __Norpramin (Desipramine) __Aventyl (Protriptyline) __Asendin (Amoxapine) __Ludiomil (Maprotyline) Other_____	_____ _____ _____ _____ _____ _____ _____ _____
5. *Monoamine Oxidase Inhibitors (MAOIs):* __Nardil (Phenelzine) __Parnate __Emsam patches	_____ _____ _____ _____ _____ _____
6. *Neuroleptics(SCA):* __Abilify (Aripiprazole) __Seroquel (Quetiapine) __Risperdal (Risperidone) __Zyprexa (Olanzepine) __Geodon (Ziprazidone) __Saphris __Latuda __Invega Other_____	_____ _____ _____ _____ _____ _____ _____ _____ _____
7. *Mood Stabilizers:* __Lithium __Depakote __Tegretol __Trileptal __Lamictal (Lamotrigine) Other_____	_____ _____ _____ _____ _____ _____ _____
8. *Augmentation* __Thyroid supplements (Synthroid, Levoxyl, Cytomel,	_____ _____ _____

Armour thyroid,etc.) __Psychostimulants (Ritalin, Adderral, Dexedrine, Vyvanse,Provigil, Nuvigil) __Buspar (Buspirone) __Deplin (L-Methylfolate), Other_____	_____ _____ _____ _____ _____ _____

B. PSYCHOTHERAPY:

__Supportive __Cognitive Behavioral (CBT) __DBT __EMDR Other (please specify): _____	_____ _____ _____ _____ _____ _____ _____ _____

C. Electro Cortical Therapy (ECT, Shock therapy):
Comments_____
_____

D. Prior Transcranial Magnetic Stimulation (TMS):
Comments_____
_____

E. Psychiatric admissions or Partial Hospital Treatment:
Comments_____
_____