Stephen M Popkin, M.D.
4100 E Mississippi Avenue #600
Denver, CO 80246
Telephone- 303.759.3215
Fax- 303.759.3515

Date_____

PATIENT INFORMATION
Name_____Date of Birth_____
Home Address (Street)_____
City_____ State_____ Zip_____
Home Phone #_____Cell Phone #_____
Email Address _____
Social Security #_____ Driver's License #_____
Status: Single_____ Married_____ Other_____
Employer_____Work Phone #_____
Occupation_____
Employer Address_____

SPOUSE INFORMATION
Name_____Date of Birth_____
Occupation_____ Social Security #_____
Employer_____ Work Phone #_____
Employer Address_____

IN CASE OF AND EMERGENCY PLEASE NOTIFY
Name_____ Phone#_____
Address_____ Relationship_____

WHO REFEREED YOU TO THIS OFFICE_____
I AGREE TO PAY FOR ALL APPOINTMENTS NOT CANCELED WITHIN TWO FULL BUSINESS DAYS WITH A MINIMUM OF 48 HOURS NOTICE.

Date_____ Signed_____

I UNDERSTAND THAT A $10.00 REBILLING FEE WILL BE CHARGED TO MY ACCOUNT MONTHLY IF IT IS MORE THAN THREE MONTHS PAST DUE.

Date_____ Signed_____

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AUTHORIZATIONS AND AGREEMENTS WITH DR. STEPHEN M. POPKIN. PLEASE READ CAREFULLY AND SIGN. THE PARAGRAPHS CONTAIN SEVERAL ASSIGNMENTS.

Print Patient's Name_____

MEDICAL INSURANCE
I authorize the medical insurance company to pay directly for the above physicians services. I, however, understand that both I and the person who signs below are responsible for all my fees, including any fees not paid by the insurance company.

Patient or Parent
Signature_____Date_____

RELEASE OF INFORMATION
I authorize Dr. Stephen M. Popkin to release information about me to the medical insurance company and the referring physician. This authorization will end if I give written instructions to Dr. Stephen M. Popkin, to that effect which I may do at any time.

Patient or Parent
Signature_____Date_____

FINANCIAL RESPONSIBILITY
We, the undersigned, understand and agree that each of us is responsible for the patients fees to Dr. Stephen M. Popkin, including any fees not paid by medical insurance; that if the account is not paid when due, all collection fees and court costs, including the account balance, will be paid by the undersigned; that a rebilling fee of $10.00 per month will be charged on any balance outstanding after 90 days; that we are responsible for full therapy fees resulting from appointments not kept or canceled within two full business days with a minimum of 48 hours' notice; that fees for all services must be paid at the time services are rendered.

Patient or Parent
Signature_____Date_____

Responsible Party Signature_____Date_____

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Date_____

INSURANCE INFORMATION (PRIMARY)
Insurance Company Name_____
Phone#_____
Address_____
PolicyHolder Name_____ Relationship to Patient_____
Policy # _____ Group#_____

INSURANCE INFORMATION (SECONDARY)
Insurance Company Name_____
Phone#_____
Address_____
PolicyHolder Name_____Relationship to the Patient_____
Policy# _____Group#_____

ASSIGNMENT OF BENEFITS
I, undersigned, have insurance with _____ and assign directly to Dr. Stephen M. Popkin, all medical benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signed_____ Date_____

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AUTHORIZATION TO BILL CREDIT CARD

I authorize Stephen M. Popkin, M.D., or his designated staff, to bill my credit card for services rendered. I understand these services may include, but are not limited to, scheduled appointments, telephone consultations, review of records and any missed appointment or scheduled appointment not canceled within the 48 hours required notice.

Once my credit card has been charged, I understand that I will receive a receipt of charges.

This authorization shall remain in existence as long as I am a patient of Stephen M. Popkin, M.D., or until I provide a written retraction to this agreement.

I understand that I am responsible for notifying Dr. Stephen M. Popkin of any changes in my credit card status.

Patient Name_____
Credit Card #_____
CVC2 Code (3 digit code located on the back of card)_____
Expiration Date on Card_____
Type of Card: Visa_____ MasterCard_____
Cardholder Name_____
Cardholder Address (where credit card bill is mailed)_____
_____

Cardholder Signature_____

Witness Name_____

Witness Signature_____

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Patients Name: **Date:**

Chief Complaint (Reason for visit)

History of Present Illness

List all presenting complaints (new and chronic) and describe in detail using the elements located in the margin. (Examples of complaints- depression, anxiety, insomnia, memory, medication side effects, substance abuse)

Elements
Please complete all elements the *first time* you fill out this form. For later visits check boxes if no change

Check if no changes since previous visit

- ☐ Location of Symptoms
- ☐ Duration: How long have you been experiencing the symptoms?
- ☐ Associated signs and symptoms
- ☐ Modifying Factors: What have you done to obtain relief from the symptoms?
- ☐ Severity: Mild, moderate, severe,or worst ever. 1-10 1: least 10: worst
- ☐ Timing: When do you experience the symptoms?
- ☐ Context: What situations or activities tend to bring on the symptoms?

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Past History

Check if no changes since previous visit

☐ Prior major illnesses and injuries:
(Include dates)

☐ Prior hospitalizations:
Medical and Psychiatric
(Include dates and condition treated)

Check if no changes since previous visit

☐ Prior surgeries:

☐ Allergies:
Medication, food, environmental

☐ Current Medications:
Include dosage, prescribing physician, condition for which medicine is prescribed, and duration of treatment. Include over the counter and herbal remedies. Also include response to medication and side effects.

Family History

Check if no changes since previous visit

☐ Health Status:
Of parents, siblings, children and ages.

☐ Major Illnesses:
List all major illnesses including psychiatric, neurologic, alcoholism, drug abuse, suicide, and suicide attempts, of family members. (include grandparents, uncles, and aunts)

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Social History

Check if no changes since previous visit

- ☐ Marital status and/or living arrangements
  If married how many times?
- ☐ Current Employment:
  How long employed?

Check if no changes since previous visit

- ☐ Level of Education:
- ☐ Use of Drugs, Alcohol, and Tobacco:
  How many drinks do you consume in the average day?
- ☐ What is the most you have had to drink in a 24 hr period during the last year?
- ☐ Check if you were or someone told you that you were drinking
  too much. If so, describe.
- ☐ Have you ever used drugs? If applicable include marijuana. Also include the last time you took drugs.

Sexual History

Check if no changes since previous visit

- ☐ Sexual preference
- ☐ Do you have any concern about your sexual experience?
- ☐ Do you have any history of sexual abuse or trauma?

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REVIEW OF SYSTEMS & ACTIVE MEDICAL PROBLEMS

	Current problems
1. Overall Health Status	yes___ none ___
2. Eyes	yes___ none ___
3. Ears/Nose/Mouth/Throat	yes___ none ___
4. Cardiovascular	yes___ none ___
5. Respiratory	yes___ none ___
6. Gastrointestinal	yes___ none ___
7. Genitourinary	yes___ none ___
8. Muscular	yes___ none ___
9. Skin	yes___ none ___
10. Neurological	yes___ none ___
11. Endocrine (glands)	yes___ none ___
12. Hematologic/Lymphatic (Blood diseases)	yes___ none ___
13. Allergies/Immune	yes___ none ___

NOTES IF CURRENT PROBLEMS

Mini Screen

Patients Name: Patients Number:
Patients Date of Birth: Date of Interview:
Interview Completed By: If yes go to the corresponding M.I.N.I module

Have you been consistently depressed or down, most of the day, nearly everyday, for the past two weeks? Yes No

In the past two weeks, have you been less interested in most things or less able to enjoy the things you use to enjoy most of the time? Yes No

In the past month did you think you would be better off dead or wish you were dead? Yes No

Have you ever had a period of time when you were feeling 'up' or 'high' or so full of energy or full of yourself that you got into trouble, or that other people thought you weren't your usual self? (Do not consider time you were intoxicated off drugs or alcohol) Yes No

Have you ever been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified? Yes No

Have you, on more than one occasion, had spell or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? Code YES if only the spells peak in 10 minutes. Yes No

Do you feel anxious or uneasy in places or situations where you might have a panic attack or panic-like symptoms, or where help might not be available or escape might be difficult: like being in a crowd, standing in a line (queue), when you are away from home or alone at home, or when crossing a bride, traveling in a bus, train or car? Yes No

In the past month were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations? Yes No

In the past month have you been bothered by recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive or distressing? (e.g. the idea that you were dirty, contaminated, or that you had germs, or fear of contaminating others, or fear of harming someone even though you didn't want to, or fearing that you would act on some impulse, or fear or superstition that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting, or religious obsessions.) Yes No

In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting and checking things over and over, or repeating, collecting, or arranging things, or other superstitious rituals? Yes No

Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples of traumatic events include serious accidents, sexual or physical assault. A terrorist attack, being held hostage, kidnapping, fire, discovering a body, sudden death of someone close to you, war or natural disaster. Yes No

During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks, or physical reactions)? Yes No

In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions? Yes No

Now I'm going to show you/ read the list below of street drugs or medications. In the past 12 months, did you take any of these drugs more than once, to get high, to feel better, or to change your mood? Yes No

Amphetamines	Demerol	Ether
Speed	Methodone	Glue
Crystal meth	Codeine	GHB
Rialin	Percodan	Grass
Cocaine	LSD	THC, Marijuana
Freebase	PCP	Cannabis, Hashish
Crack	Mescaline	Barbiturates, Valium
Heroin	Ecstasy	Dexedrine
Morphine	MDMA	Steroids
Opium	Inhalants	

How tall are you? Inches

What was your lowest weight in the past 3 months? Lbs

Is the patients weight lower than the threshold corresponding to his/her height? Yes No
See table below

Females	4'10	4'11	5'0	5'1	5'3	5'4	5'5	5'6	5'7	5'8	5'9
Weight	85	86	87	89	94	97	99	102	104	107	109
Males	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10	5'11	6'0	6'1
Weight	108	110	111	113	115	115	118	120	122	125	127

In the past three months, did you have eating binges or times when you ate a very large amount of food with-in a 2- hour period? Yes No

Have you worried excessively or been anxious about several things over the past 6 months? Yes No

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	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 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 into arguments or fights? *Please circle one response only.* 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?	○	○

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Rapid Mood Screener (RMS)

Are you among the millions of people who have depressive symptoms? Answer the following questionnaire about your medical history and provide it to your doctor or nurse to assist in an important conversation about your mood.

Please select one response for each question. You can complete the **RMS** in less than 2 minutes.

Patient Name _____ Date _____

	YES	NO
1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	☐	☐
2. Did you have problems with depression before the age of 18?	☐	☐
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	☐	☐
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	☐	☐
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	☐	☐
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	☐	☐

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Rapid Mood Screener (RMS)

GUIDE FOR HEALTH CARE PROFESSIONALS

Approximately 70% of patients with bipolar I disorder (BP-I) are initially misdiagnosed, with a mean delay of 5 to 10 years between illness onset and diagnosis. Most commonly patients are misdiagnosed with major depressive disorder (MDD).[1,2]

The Rapid Mood Screener (RMS) was developed by a team of multidisciplinary experts (primary care clinician, psychiatry nurse practitioner, psychiatrists, pharmacist, behavioral therapists, psychometricians and health economists) to provide a pragmatic approach to address the need for timely and accurate evaluation of bipolar disorder. The screener was validated in a study of patients with BP-I and MDD.[3]

Clinical Utility

The RMS is a brief self-report screening instrument for BP-I that should take less than 2 minutes to complete. A positive screen should be followed by a comprehensive evaluation.

Scoring & validity*

"YES" responses to 4 or more of the 6 items is considered a positive screen providing high confidence for BP-I, with an estimated 88% sensitivity, 80% specificity, and 84% accuracy

Sensitivity = percentage of patients who have BP-I disorder that are correctly identified as positive

Specificity = percentage of patients who do not have BP-I and who are correctly identified as negative

Accuracy = percentage of patients correctly predicted as BP-I or not

*"YES" to 3 or more of the 6 items also suggests a higher likelihood of BP-I than MDD with an estimated 97% sensitivity, 59% specificity, and 77% accuracy

1. Hirschfeld, RM et al. J Clin Psychiatry. 2003; 64(2):161-174.
2. Berk M, et al. J Affect Disord. 2007;103(1-3):181-186.
3. McIntyre RS, et al. Curr Med Res Opin. 2020 (in press).

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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?
(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				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
add columns:		+	+	
TOTAL:				

10. 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 _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at *http://www.pfizer.com*. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

GAD-7

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

(For office coding: Total Score T____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. 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 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?	0	1	2	3
2. Difficulty sustaining attention in activities 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?	0	1	2	3
3. Doesn't listen 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?	0	1	2	3
4. No follow through 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?	0	1	2	3
5. Can't organize 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?	0	1	2	3
6. Avoids/dislikes tasks requiring sustained mental effort 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?	0	1	2	3
7. Loses important items 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?	0	1	2	3
8. Easily distractible 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?	0	1	2	3
9. Forgetful in daily activities 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?	0	1	2	3

Adult ADHD-RS-IV with Adult Prompts†*

	None	Mild	Moderate	Severe
10. Squirms and fidgets 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?	0	1	2	3
11. Can't stay seated 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?	0	1	2	3
12. Runs/climbs excessively 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?	0	1	2	3
13. Can't play/work quietly 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?	0	1	2	3
14. On the go, "driven by a motor" 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?	0	1	2	3
15. Talks excessively 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?	0	1	2	3
16. Blurts out answers 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?	0	1	2	3
17. Can't wait for turn 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?	0	1	2	3
18. Intrudes/interrupts others 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?	0	1	2	3

*From *ADHD Rating Scale-IV: Checklists, Norms and Clinical Interpretation*. Reprinted with permission of The Guilford Press: New York. ©1998 George J. DuPaul, Thomas J. Power, Arthur A. Anastopoulos and Robert Reid. This scale may not be reproduced in any form without written permission of The Guilford Press. www.guilford.com

†Prompts developed by Lenard Adler, MD, Thomas Spencer, MD, and Joseph Biederman, MD.

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