MARY BETH VALIULIS, M.D.

BOARD CERTIFIED PSYCHIATRIST
BOARD CERTIFIED SLEEP SPECIALIST

Mary Beth Valiulis, M.D. offers a comprehensive approach to mental health treatment and sleep medicine evaluations. This includes both psychotherapy and pharmacotherapy. She conducts cognitive behavioral therapy for anxiety, depression and sleep disorders, such as insomnia. She also offers Home Sleep Testing.

Enclosed is the New patient packet for you to complete and return to the office. Dr. Valiulis reviews the packet to determine if this is the appropriate treatment setting for your needs. They can be emailed, mailed, faxed or dropped off at the office. If the office is closed, you can place the packet in the locked mailbox to the right of the front door. It is important to read "Office Policies" carefully before becoming a patient, as Dr. Valiulis is not a provider for any insurance or Medicare. If this is an appropriate treatment setting, your care will begin at your first appointment. In order to reserve your appointment time, the initial visit is prepaid and will be scheduled at the earliest convenience. If you have any questions you can reach us at 318-797-3350.

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MARY BETH VALIULIS, MD
OFFICE POLICIES

CONFIDENTIALITY

All information between provider and patient is strictly confidential unless:

- The client authorizes release of information with his/her signature.
- The client presents a physical danger to self.
- The client presents a danger to others.
- Child/elder abuse/neglect is suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken. The release of information form must be signed in order to authorize any release of data regarding your medical care.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than 24 hours notice, you will be billed and held responsible for payment in full.

EMERGENCY PROCEDURES

If you need to contact Dr. Valiulis, leave a message and your call will be returned in a timely manner. If your call is urgent please leave a detailed message. If an emergency situation arises, you may need to go straight to the emergency room. If phone calls are over several minutes then, there may be a charge for lengthy telephone consultations.

FINANCIAL TERMS

You will be responsible for payment at the time services are rendered. Full payment may be Cash, Check or Credit Card (Visa or MasterCard).

Dr. Valiulis is NOT a provider for Medicare or Medicaid, therefore no services rendered by Dr. Valiulis can be submitted to Medicare or Medicaid. An OPT-OUT contract will be necessary to sign stating that the bill will not be sent for reimbursement to Medicare or Medicaid.

A statement will be provided after payment for services rendered that may be used for filing claims with your insurance company or to save for tax purposes. AGAIN, this statement may NOT be used for Medicare or Medicaid claims.

Your appointment is reserved for you. Therefore, you will be charged the session fee for any appointment either missed or not cancelled within twenty-four hours in advance. .

I further authorize and request that my treating provider carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. *Please sign below to acknowledge that you understand and agree to all of the above information.*

_____ _____

PRINT NAME OF PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

PATIENT INFORMATION RECORD TODAY'S DATE _____

LAST NAME_____FIRST_____

ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE_____ CELL PHONE_____

EMAIL_____ (Please circle the preferred method of contact)

AGE_____ DATE OF BIRTH_____ SSN _____

MARITAL STATUS (circle): single married divorced widowed separated

OCCUPATION: _____ EMPLOYER_____

WORK ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)

WORK PHONE_____

MEDICAL INSURANCE: _____

Do you have MEDICARE? Yes or No Do you have MEDICAID? Yes or No

_____
RESPONSIBLE PARTY How are you related to the patient _____

LAST NAME_____ FIRST_____

DATE OF BIRTH_____ AGE_____ SSN _____

ADDRESS_____

HOME_____CELL_____EMAIL_____
(Please circle the preferred method of contact)

OCCUPATION: _____EMPLOYER_____WORK PHONE_____

WORK ADDRESS_____

How did you hear about Dr. Valiulis? _____

(Please specify) Friend/Family, a current patient/previous patient, Yellow pages, Internet, www.valiulis.com, www.mcgannmedical.com or Other:

_____

If you were referred to our office by a physician or therapist, please list the name:

_____

WHAT DO YOU SEE AS YOUR PROBLEM(S)?

_____

_____

_____

_____

WHAT DO YOU SEE AS THE CAUSE(S)?

_____

_____

_____

WHAT ARE YOUR GOALS IN SEEKING MY ASSISTANCE?

_____

_____

WHAT HAS BEEN HAPPENING OVER THE PAST WEEK OR TWO THAT HAS BROUGHT YOU INTO THE CLINIC?

_____

HAVE THERE BEEN ANY EVENTS THAT YOU THINK HAVE CAUSED YOUR PROBLEM OR MADE IT WORSE?

_____

_____

HAVE YOU PREVIOUSLY SOUGHT ANY TREATMENT FOR THIS PROBLEM? (Please explain)

_____

_____

_____

HOW OLD WERE YOU WHEN YOU FIRST HAD THESE SYMPTOMS?

_____

HOW MANY EPISODES HAVE YOU HAD?

_____

_____

WHEN WAS THE LAST EPISODE?

_____

_____

_____

_____

Please list prior treatment and diagnoses:

Depression or Bipolar	Anxiety	Schizophrenia or psychosis	Alcohol or Drug problems	Suicidal thoughts or attempts	Psychiatric hospitalization	Other psychiatric problems
Insomnia	Sleep apnea	Heavy Snoring	Narcolepsy	Sleep Walking	Restless legs syndrome	Other sleep disturbances

<u>If you are currently experiencing suicidal or homicidal thoughts please go to the closest Emergency Room ASAP...</u>

Have you ever tried to hurt yourself and/or tried to commit suicide? YES or NO
Explain:

_____
_____
_____

Allergies (please list all allergies including drug, environmental and food with reactions):

_____
_____

Have you ever had an anaphylactic reaction? YES or NO Explain: _____

_____

MEDICATION List current medications and dosages, including over-the-counter medications.

_____
_____
_____
_____

PREVIOUS MEDICATIONS: name, date started, side effects, date stopped & effectiveness.

_____
_____
_____
_____
_____

SOCIAL HISTORY

Do you smoke, dip or chew? YES or NO Did you previously smoke? YES or NO

How many years of smoking? _____ How much per day? _____

Do you drink alcohol? YES or NO How much? _____ drinks per day/week/month?

How many caffeinated drinks do you drink daily? (coffee, tea, or cola) _____

Do you use illegal drugs or abuse prescription medicine? YES or NO (please list past and current use)

_____

Please check if you have had any of the following:

__ High blood pressure __ Diabetes __ Anemia

__ Skin condition __Asthma/Emphysema __Acid Reflux __Thyroid condition

__ Fibromyalgia __Anxiety __Seizures __ Vision problems

__ Stroke __ Depression __ Head injury or brain surgery

__ Parkinson's disease __ Other psychiatric disorder_____

__ Heart disease: CHF, heart failure, MI, heart attack_____

__ Other medical problems (please list)

_____

_____

Prior Surgeries (please List): _____

_____

_____

FAMILY HISTORY (Please check all that apply)

	Depression or Bipolar	Anxiety	Alcohol or Drug problems	Schizophrenia or psychosis	Suicidal thoughts or attempts	Psychiatric hospitalization
Mother						
Father						
Sister(s)						
Brother(s)						
Grandparents						
	Sleep apnea	Heavy Snoring	Narcolepsy	Insomnia	Restless legs syndrome	Other sleep disturbances
Mother						
Father						
Sister(s)						
Brother(s)						
Grandparents						

MOOD DISORDER QUESTIONNAIRE (MDQ)

INSTRUCTIONS:
Please answer each question as best you can. Circle Yes or No

Has there ever been a period of time when you were not your usual self &...

Yes No – 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?
Yes No – you were so irritable that you shouted at people or started fights or arguments?

Yes No – you felt much more self-confident than usual?
Yes No – you got much less sleep than usual and found that you didn't really miss it?
Yes No – you were more talkative or spoke much faster than usual?
Yes No – thoughts raced through your head or you couldn't slow your mind down?
Yes No – you were so easily distracted by things around you that you had trouble concentrating or staying on track?
Yes No – you had much more energy than usual?
Yes No – you were much more active or did many more things than usual?
Yes No – you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?
Yes No – you were much more interested in sex than usual?
Yes No – you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
Yes No – spending money got you or your family in trouble?

2 If you checked YES to more than one of the above, have several of these ever happened during the same period of time? Yes or No

3 How much of a problem did any of these cause you–like being unable to work; having family, money or legal trouble; getting into arguments or fights?

No problem / Minor problem / Moderate problem / Serious problem

Name_____ Date_____

AUTOBIOGRAPHY

Please compose an autobiography for my use. Include all information concerning past events that you consider pertinent to your present circumstance. Be especially complete in descriptions
of your relationship with your parents and other important individuals from your past and your present life (e.g., spouse). This effort, though laborious, will save time for us in arriving at an understanding of your difficulties.

SLEEP HISTORY

What is your main sleep problem? _____

How long have you had this problem? _____

Please list any previously diagnosed sleep disorders._____

Do you take anything to help you sleep? YES or NO

If yes, what? _____ How often? _____

Check any of the following that apply:

___ Loud snoring

___ Breathing or snoring stops for brief periods in my sleep

___ I have had an automobile accident as the driver

___ Awaken gasping for breath

___ Do not feel restored when I awaken

___ Difficulty falling asleep

___ Difficulty remaining asleep

___ Awaken too early

___ Become sleepy during the day

(Please circle any/all that apply)

__ sitting __ talking

__ riding __eating

__ driving __ standing

Sleep Environment (circle the answer)

My bedroom is

LOUD or QUIET and LIGHT or DARK?

My mattress is

SOFT or HARD or JUST RIGHT?

Do you go to sleep with the television on?

YES or NO

Is your sleep disturbed because of your bed partner or others in your household (children or pets)?

YES or NO

Occupation:

What do you usually do at work? _____

How does your sleep problem affect your work?

_____

_____

Have you been diagnosed with sleep apnea? ____

Do you use a CPAP? _____, what pressure? ____

Do you use an oral appliance? _____

Epworth sleepiness scale:

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0= would never doze
1= slight chance of dozing
2= moderate chance of dozing
3= high chance of dozing

Situation:

Sitting and reading……. 0 1 2 3

Watching TV……..…… 0 1 2 3

Sitting, inactive, in a public place (e.g., a theater or meeting) ……. 0 1 2 3

As a passenger in a car for an hour without a break …….. 0 1 2 3

Lying down to rest in the afternoon when circumstances permit…… 0 1 2 3

Sitting and talking with someone …….. 0 1 2 3

Sitting quietly after lunch without alcohol …… 0 1 2 3

In a car, while stopped for a few minutes in traffic …… 0 1 2 3

EES Total _____

Neck size _____ inches

Current Height: _____

Current Weight: _____

Weight 5 yrs ago: _____

Indicate ON AVERAGE how often you experience the following symptoms:

Times weekly	Symptom
	My mind races with many thoughts when I try to fall asleep.
	I often worry whether or not I will be able to fall asleep.
	Fatigue
	Awaken with a dry mouth
	Morning headaches
	Pain which delays or prevents my sleep
	Pain which awakens me from sleep
	Vivid or lifelike visions (people in room, etc.) as you fall asleep or wake up
	Inability to move as you are trying to go to sleep or wake up
	Sudden weakness or feel your body go limp when you are angry or excited
	Irresistible urge to move legs or arms
	Creeping or crawling sensation in legs before falling asleep
	Legs or arms jerking during sleep
	Sleep talking
	Sleep walking
	Nightmares
	Fall out of bed
	Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
	Bed-wetting
	Frequent urination disrupting sleep
	Teeth grinding
	Wheezing or cough disrupting sleep
	Sinus trouble, nasal congestion, or post-nasal drip interfering with sleep
	Shortness of breath disrupting sleep

Please be as accurate as possible. Indicate AM and PM. If your work and/or sleep schedule changes during the week, then indicate your schedule using the "shift work" column.

Activity	Usual schedule	Weekends	Shift work
Lay down in bed			
Lights out			
I usually fall asleep in (minutes, hours)			
How many times do you awaken each night?			
Number of times you have difficulty returning to sleep			
The total time I spend awake in bed			
Final wake up from sleep			
What time do you usually get out of bed from sleep?			
How many hours of sleep do you get on average?			
If you take naps, how long?			
Begin work time			
End work time			