Linda R. Ayers, M.N., A.R.N.P., B.C.
Certified Specialist In Adult Psychiatry
DEA Prescriptive Authority
18604 Corliss Ave. N.
Shoreline, WA 98133
(206) 361-1001
HeartsongLA@aol.com

New Client Registration

Name: ______________________________
First *Middle* *Last*

Address: ______________________________

City: __________ State: __________ Zip: __________

Home Phone: __________ Work Phone: __________

Cell Phone: __________ E-mail: __________

Date of Birth: __________ SSN: __________

Occupation: __________ Employer: __________

Insurance Information – *Regence and Premera policy holders only*

Primary Company: __________	Secondary Company: __________
ID#: ______ Group#: ______	ID#: ______ Group#: ______
Plan Name: __________	Plan Name: __________
Claims Address: __________	Claims Address: __________
Phone: __________	Phone: __________
Insured's Name: __________	Insured's Name: __________
Insured's DOB: __________	Insured's DOB: __________

Emergency Contact Information

Name: ______________________________
First *Middle* *Last*

Home Phone: __________ Work Phone: __________ Cell Phone: __________

I hereby authorize Linda R. Ayers, M.N., A.R.N.P., B.C., to bill my insurance carrier when applicable, and to release any information required for the claim. I also authorize any benefits to be paid directly to Linda R. Ayers, M.N., A.R.N.P., B.C., and understand that I am financially responsible for any balance due on my account.

Signed: ______________________________ Date: ______________________________

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I hereby authorize the release of information from the medical record of:

Name: ______________________________
Last *First* *Middle*

Address: ______________________________

____

Home Phone: ______________ Work Phone: ______________

Cell Phone: ______________ E-mail: ______________

Date of Birth: ______________ SSN: ______________

Information Released To:

Kevin F. Montgomery, M.D., F.A.C.S.
Robert Michaelson, M.D., Ph.D., F.A.C.S.
Alana Chock, M.D., F.A.C.S.
Northwest Weight Loss Surgery
125 – 130th St. S.E., 1ST floor
Everett, WA 98208

Information Released From:

Linda R. Ayers, M.N., A.R.N.P., B.C.
Heartsong Counseling
18604 Corliss Ave. N.
Shoreline, WA 98133

Please Release the Following Information:

Psychological evaluation in preparation for bariatric surgery.

Informed Consent For Release Of Confidential Information:

I understand that:

- I may revoke this consent in writing at any time except to the extent action has already been taken.
- This consent will expire 180 days after the date of my signature unless otherwise specified.
- This information may include HIV/AIDS, mental health and chemical dependency diagnosis, treatment, & test results.
- The information released is for the specific purpose stated above.
- My medical records may contain reports that only a qualified medical provider can interpret.
- I have been advised I should contact Linda R. Ayers, M.N., A.R.N.P., B.C., regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
- I will not hold Linda R. Ayers, M.N., A.R.N.P., B.C., liable for any misinterpretation of the information in my medical record as a result of not consulting her for the correct interpretation.

______________________________ ______________________________

Signature of Patient
(or legal representative)

Relationship to Patient
(if other than patient)

______________________________ ______________________________

Date

Valid Until
(180 days from date of signing)

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Beck Depression Inventory

Name: ______________________ Date: ______________________

1. 0. I do not feel sad.
   1. I feel sad.
   2. I am sad all the time.

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 that 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 worse than anyone 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.

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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 even cry even though I want to.

11. 0. I am no more irritated by things than I ever am.
    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 now.

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 than before.
    3. I can’t make decisions at all anymore.

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

15. 0. I can work about 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 tired more 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 greater than it used to be.
    2. My appetite is much worse now.
    3. My appetite is worse now than it has ever been.

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

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

21. 0. I have not noticed any recent change in my interest in sex.
    1. I am less interested in sex than I used to be.
    2. I am much less interested in sex now.
    3. I have lost interest in sex completely.

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Zung Self-Rating Depression Scale

Name: ______________________ Date: ______________________

1. I feel down-hearted and blue:
   - ❒ Little of the time
   - ❒ Some of the time
   - ❒ Good part of the time
   - ❒ Most of the time

2. Morning is when I feel best:
   - ❒ Little of the time
   - ❒ Some of the time
   - ❒ Good part of the time
   - ❒ Most of the time

3. I have crying spells or feel like it:
   - ❒ Little of the time
   - ❒ Some of the time
   - ❒ Good part of the time
   - ❒ Most of the time

4. I have trouble sleeping at night:
   - ❒ Little of the time
   - ❒ Some of the time
   - ❒ Good part of the time
   - ❒ Most of the time

5. I eat as much as I used to:
   - ❒ Little of the time
   - ❒ Some of the time
   - ❒ Good part of the time
   - ❒ Most of the time

6. I still enjoy sex:
   - ❒ Little of the time
   - ❒ Some of the time
   - ❒ Good part of the time
   - ❒ Most of the time

7. I notice that I am gaining weight:
   - ❒ Little of the time
   - ❒ Some of the time
   - ❒ Good part of the time
   - ❒ Most of the time

8. I have trouble with constipation:
   - ❒ Little of the time
   - ❒ Some of the time
   - ❒ Good part of the time
   - ❒ Most of the time

9. My heart beats faster than usual:
   - ❒ Little of the time
   - ❒ Some of the time
   - ❒ Good part of the time
   - ❒ Most of the time

10. I get tired for no reason:
    - ❒ Little of the time
    - ❒ Some of the time
    - ❒ Good part of the time
    - ❒ Most of the time

11. My mind is as clear as it used to be:
    - ❒ Little of the time
    - ❒ Some of the time
    - ❒ Good part of the time
    - ❒ Most of the time

12. I find it easy to do the things I used to:
    - ❒ Little of the time
    - ❒ Some of the time
    - ❒ Good part of the time
    - ❒ Most of the time

13. I am restless and can't keep still:
    - ❒ Little of the time
    - ❒ Some of the time
    - ❒ Good part of the time
    - ❒ Most of the time

14. I feel hopeful about the future:
    - ❒ Little of the time
    - ❒ Some of the time
    - ❒ Good part of the time
    - ❒ Most of the time

Continued next page…

15. I am more irritable than usual:
    - ❒ Little of the time
    - ❒ Some of the time
    - ❒ Good part of the time
    - ❒ Most of the time

16. I find it easy to make decisions:
    - ❒ Little of the time
    - ❒ Some of the time
    - ❒ Good part of the time
    - ❒ Most of the time

17. I feel that I am useful and needed:
    - ❒ Little of the time
    - ❒ Some of the time
    - ❒ Good part of the time
    - ❒ Most of the time

18. My life is pretty full:
    - ❒ Little of the time
    - ❒ Some of the time
    - ❒ Good part of the time
    - ❒ Most of the time

19. I feel that others would be better off if I were dead:
    - ❒ Little of the time
    - ❒ Some of the time
    - ❒ Good part of the time
    - ❒ Most of the time

20. I still enjoy the things I used to do:
    - ❒ Little of the time
    - ❒ Some of the time
    - ❒ Good part of the time
    - ❒ Most of the time

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Depression Symptoms Screening

Name: ______________________ Date: ______________________

1. Do you feel sad or irritable?
   - ❐ Yes
   - ❐ No

2. Have you lost interest in activities once enjoyed?
   - ❐ Yes
   - ❐ No

3. Have you experienced changes in weight or appetite?
   - ❐ Yes
   - ❐ No

4. Have you experienced changes in sleeping pattern?
   - ❐ Yes
   - ❐ No

5. Do you have feelings of guilt?
   - ❐ Yes
   - ❐ No

6. Are you unable to concentrate, remember things, or make decisions?
   - ❐ Yes
   - ❐ No

7. Have you experienced fatigue or loss of energy?
   - ❐ Yes
   - ❐ No

8. Have you experienced restlessness or decreased activity noticed by others?
   - ❐ Yes
   - ❐ No

9. Do you feel hopeless or worthless?
   - ❐ Yes
   - ❐ No

10. Have you had thoughts of suicide or death?
    - ❐ Yes
    - ❐ No

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Anxiety Symptoms Screening

Name: ______________________ Date: ______________________

1. Do you persistently relive an upsetting event from the past?
   ❐ Yes
   ❐ No

2. Do you feel compelled to perform certain activities repeatedly?
   ❐ Yes
   ❐ No

3. Do you experience shortness of breath, heart palpitation, or shaking while at rest?
   ❐ Yes
   ❐ No

4. Do you have a fear of losing control or going crazy?
   ❐ Yes
   ❐ No

5. Do you avoid social situations because of fear?
   ❐ Yes
   ❐ No

6. Do you have fears of specific objects?
   ❐ Yes
   ❐ No

7. Do you fear that you will be in a place or situation from which you cannot escape?
   ❐ Yes
   ❐ No

8. Do you feel afraid of leaving your home?
   ❐ Yes
   ❐ No

9. Do you have recurrent thoughts or images that refuse to go away?
   ❐ Yes
   ❐ No

10. Do you experience chronic anxiety?
    ❐ Yes
    ❐ No