ELM Medicine

Unit 4- 1521 Upper Ottawa Street
Hamilton, Ontario L8W 3J4

Phone: 905-318-3006
Fax: 833-268-3660
info.elmmedicine@gmail.com
www.elmmedicine.ca

Specialist Clinic. Internal Medicine. Infectious Diseases. Hepatitis B & C. Chronic Pain. Lifestyle Medicine Clinic. Stress Reduction Clinic

Dr. Atreyi Mukherji, MD, MPH, FRCPC

PATIENT INTAKE PACKAGE: STRESS REDUCTION CLINIC

Please complete the following documents in the package. All documents are required to be completed, before consultation.

1. Health Questionnaire
2. No Show Policy
3. Supplement disclaimer
4. Perceived Stress Scale
5. PROMIS29 Questionnaire
6. PHQ-9
7. GAD-7

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HEALTH QUESTIONNAIRE: STRESS REDUCTION CLINIC

PATIENT INFORMATION - PLEASE COMPLETE		
Patient's Last Name: First: ❒ Mr. ❒ Mrs. ❒ Ms.		
Home Address:	City:	Postal Code:
Email Address:	Home Phone:	Mobile Phone:
Date of Birth:	OHIP Number:	

1. What is your preferred method of contact by the office ?

_____

2. What is your goal for the visit ?

_____

_____

_____

3. List all medications that you are currently taking , either by prescription or over the counter. Please also bring a list or bottles of your medications, during the first office visit.

_____

_____

_____

_____

_____

4. List all vitamins and supplements that you are currently taking , either by prescription or over the counter.

_____

_____

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5. List any allergies to medications or other items.

_____

6. List all health problems that you have been diagnosed with, by a medical doctor.

_____

_____

_____

7. List all prior surgeries.

_____

_____

_____

8. PREVENTATIVE HEALTH	**(YES OR NO)**
Pap smear (women) in last 3 years:	
Mammogram in last 2 years:	
Colonoscopy or Stool check for Colon Cancer:	
Dental check up in last year :	
Influenza Vaccine:	
Pneumonia vaccine:	
Hepatitis A and or B Vaccine:	
Tetanus Vaccine:	
BCG Vaccine:	

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9. List any health problems in your immediate family (parents, grandparents, siblings, children)

_____

_____

_____

10. SOCIAL HISTORY

Marital status: _____

Children: _____

Drug benefits: _____

11. LIFESTYLE

(YES OR NO AND EXPLAIN)

Current or past tobacco use: _____

Current or past cannabis use: _____

Current or past alcohol use: _____

Patient Signature: _____

Date: _____

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NO SHOW POLICY

PATIENT NAME:_____ DATE OF BIRTH: _____

In order to serve you better, we want you to be aware of our clinic policy for scheduled appointments.

PLEASE INITIAL BESIDE EACH STATEMENT:

_____ We understand that sometimes you cannot make your appointment. It is your responsibility to notify our clinic if you cannot make the appointment, for any reason.

_____ Please cancel or reschedule your appointment during our regular clinic hours (Tuesday-Thursday) and a minimum of 2 business days prior to your appointment.

_____ NO SHOW: If you do not attend an appointment and do not contact the clinic to cancel within 2 business days, you will be charged a no show fee of $35 + HST.

_____ Changes made by us to your appointment: If we have changed your appointment and you fail to receive the message or you did not confirm the new appointment date, you will not be charged a fee.

_____ Arriving late for an appointment: We will do our best to accommodate you if you arrive late for your appointment. This may mean that you have to wait for the next available opening. If we cannot accommodate you, we will need to reschedule your appointment.

_____ You agree to provide up to date contact information to our receptionist.

_____ You agree to provide a valid email address, so we can email you health related education resources, or other communications.

Self reschedule of appointments on-line for follow up appointments, may be accessible in some cases. The same policy for rescheduling and no show apply.

Please sign below that you have read and understand these policies.

Patient Signature: _____

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Date: _____

SUPPLEMENT DISCLAIMER

Some patients in our clinic will be interested in taking supplements to manage their health . Dr. Mukherji in these instances may recommend evidence supported professional quality supplements, from professional supplement distributors.

Either an electronic prescription through FULLSCRIPT or OPTIFAST CANADA (weight management patients only), will be provided.

If you decide to purchase supplements from these professional distributors , please be aware that Dr. Mukherji does not make any income or commissions from your purchases. As Dr. Mukherji does not make any commission, the vendor sells the supplements at wholesale price (25% below MRP-Minimum Retail Price), to current ELM Medicine patients. You are under no obligation to purchase supplements from these specific distributors .

Additionally, if you use these vendors, you must be seen in follow up every 3 months for monitoring and safety.

I have read and understood the above.

PATIENT INFORMATION - PLEASE COMPLETE		
Patient's Last Name: First: ❒ Mr. ❒ Mrs. ❒ Ms.		
Home Address: Email Address:	City: Home Phone:	Postal Code: Mobile Phone:
Date of Birth:	OHIP Number:	

Patient Signature: _____

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Date: _____

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PROMIS–29 Profile v1.0

Please respond to each question or statement by marking one box per row.

	Physical Function	**Without any difficulty**	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
1	Are you able to do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
2	Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
3	Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
4	Are you able to run errands and shop?	☐	☐	☐	☐	☐
	Anxiety **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
5	I felt fearful	☐	☐	☐	☐	☐
6	I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
7	My worries overwhelmed me	☐	☐	☐	☐	☐
8	I felt uneasy	☐	☐	☐	☐	☐
	Depression **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
9	I felt worthless	☐	☐	☐	☐	☐
10	I felt helpless	☐	☐	☐	☐	☐
11	I felt depressed	☐	☐	☐	☐	☐
12	I felt hopeless	☐	☐	☐	☐	☐
	Fatigue **During the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
13	I feel fatigued	☐	☐	☐	☐	☐
14	I have trouble starting things because I am tired	☐	☐	☐	☐	☐
	In the past 7 days…					
15	How run-down did you feel on average?	☐	☐	☐	☐	☐
	In the past 7 days…	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
16	How fatigued were you on average?	☐	☐	☐	☐	☐

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	Sleep Disturbance **In the past 7 days…**	**Very poor**	**Poor**	**Fair**	**Good**	**Very good**
17	My sleep quality was.....	☐	☐	☐	☐	☐
	In the past 7 days…	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
18	My sleep was refreshing.....	☐	☐	☐	☐	☐
19	I had a problem with my sleep	☐	☐	☐	☐	☐
20	I had difficulty falling asleep	☐	☐	☐	☐	☐
	Satisfaction with Social Role **In the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
21	I am satisfied with how much work I can do (include work at home)	☐	☐	☐	☐	☐
22	I am satisfied with my ability to work (include work at home).....	☐	☐	☐	☐	☐
23	I am satisfied with my ability to do regular personal and household responsibilities	☐	☐	☐	☐	☐
24	I am satisfied with my ability to perform my daily routines.....	☐	☐	☐	☐	☐
	Pain Interference **In the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
25	How much did pain interfere with your day to day activities?.....	☐	☐	☐	☐	☐
26	How much did pain interfere with work around the home?	☐	☐	☐	☐	☐
27	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
28	How much did pain interfere with your household chores?	☐	☐	☐	☐	☐

Pain Intensity
In the past 7 days…

29	How would you rate your pain on average?.....	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst imaginable pain**

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The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 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 asleep, 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're 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 in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those 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

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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 the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

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PERCEIVED STRESS SCALE

The questions in this scale ask you about your feelings and thoughts during the last month. **In each case, you will be asked to indicate by circling *how often* you felt or thought a certain way.**

Name _____ Date _____

Age _____ Gender (*Circle*): **M F** Other _____

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3. In the last month, how often have you felt nervous and "stressed"?	0	1	2	3	4
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
5. In the last month, how often have you felt that things were going your way?	0	1	2	3	4
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
7. In the last month, how often have you been able to control irritations in your life?	0	1	2	3	4
8. In the last month, how often have you felt that you were on top of things?	0	1	2	3	4
9. In the last month, how often have you been angered because of things that were outside of your control?	0	1	2	3	4
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4