David Puder, M.D.
Psychiatry & Psychotherapy PLLC
NPI: 1770222432
222 W. Comstock Avenue Suite 202, Winter Park FL 32789
Phone: 909-702-2749
Fax: (909) 255-9752
Dr@DavidPuder.com

Dear patient,
I look forward to meeting with you at the upcoming appointment you set up. I hope to understand the unique hardships and strengths you possess, and if possible, help you in your journey.

As part of the process to establish care, I request my patients to answer questions before their first appointment. Please fill out the information and either fax, mail, bring in person, or email (see above contacts).

This information, along with all other information told to me will remain confidential. This information helps with several things including: tracking results, getting all important details, and understanding you more fully. I find that patients who take time filling it out get the most out of the first appointment. **If you have any previous psychological testing, please have them send in the results ahead of time if possible.**

Fee for the first visit is paid before the meeting, fee for follow up appointments is paid the day of the visit. Hour sessions are 50 minutes and thirty-minute sessions are 25 minutes in length. Any work done outside the time of planned visits will be billed at the hourly rate (writing letters, making superbills, or answering calls).

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call or email to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 48 hours (not counting weekend or vacation days) in advance you will be charged a "no-show" fee equal to the full normal visit price.**

For me the therapeutic relationship is a very important aspect that I seek to protect. I do so by not giving legal testimony for my clients. **I require that you employ independent forensic psychiatric services should this type of evaluation or testimony be required.**

By signing below, you are also consenting to treatment with myself over video or phone called "telemedicine" in cases we can't meet in person. These communications will not be recorded. You agree to find a way to access a good internet connection and have use of a PC, laptop, or mobile device if we are doing video visits. You have the right to withdrawal your consent at any time.

Your signature below shows that you have read the form above and understand the policies.
Sincerely,
David Puder, M.D.
Print Client Name:_____

Signature:_____ Date: _____

Patient Email Communication Consent Form

RISKS OF USING EMAIL

David Puder, M.D. offers patients the opportunity to communicate by email.
Sending patient information includes several risks of which the patient should be aware. The patient should not agree to communicate with David Puder via email without understanding and accepting these risks.

The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of David Puder or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
- Email is permanent. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- The use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Email can be used as evidence in court.

CONDITIONS OF USING EMAIL

David Puder will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, David Puder cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct of the physician. Thus, patients must consent to the use of email for patient information.

Consent to the use of email includes agreement with the following conditions:

- Emails to the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record.
- Email communication is not an appropriate substitute for clinical examinations. The patient is responsible for following up on David Puder’s email and for scheduling appointments where warranted.
- Given that patient emails are being used as a one-way mode of communication, the patient, under no circumstances should expect a response from any email sent to David Puder.
- The patient should not use email for communication regarding sensitive medical information, such as sexually transmitted disease, AIDS/HIV, mental health, developmental disability, or substance abuse. Similarly, the physician will not discuss such matters over email.
- David Puder is not responsible for information loss due to technical failures.
- The patient will notify David Puder should there be any change in email address.

INSTRUCTIONS FOR COMMUNICATION BY EMAIL

To communicate by email, the patient shall:

- Limit or avoid using an employer's computer.
- Inform David Puder of any changes in patient's email address.
- Review the email to make sure it is clear and that all relevant information is provided before sending to David Puder
- Inform David Puder that the patient received the email.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safe guarding computer passwords.
- Withdraw consent only by email or written communication to David Puder and staff.
- Should the patient require immediate assistance, or if the patient's condition appears serious or rapidly worsens, the patient should not rely on email. Rather, the patient should call our clinic for consultation or an appointment, visit our clinic office or take other measures as appropriate.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between physician/staff and me, and consent to the conditions outline herein, as well as any other instructions that the physician/staff may impose to communicate with patients by email. I acknowledge physician/staff's right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered.

I am at least 18 years of age and competent to contract on my own behalf.

_____ _____

Signature Date

_____

Print Name

Psychiatric Evaluation Intake Form

Name_____Date of Birth_____
Address_____
Best contact phone number _____Email Address _____
Primary Care Physician_____ Phone _____ Fax_____
Race/Ethnicity _____
Current marital status _____
If you are married or cohabitating with a partner, how long has it been? _____
Total number of marriages?_____ How many children do you have?_____
Spouse's/Partner's Name_____
Who else lives with you?_____
Highest degree obtained in school?_____
Current employer and employment status:_____
Occupation: _____
Spouse's/Partner's occupation_____
Pharmacy to send medications _____
Are you currently seeing a therapist? _____How long and how frequently?_____
If yes please provide the name and contact number: _____
Do I have permission to discuss information you tell me with them? _____
Have you ever been seen by a therapist or psychiatrist in the past? If yes, then please list:_____
_____

Have you ever been treated for by any of the following (check all that apply):

___ Depression ___ ADHD ___ Binge-eating ___ ECT Treatment
___ Anxiety ___ OCD ___ Schizophrenia
___ Panic Attacks ___ PTSD ___ Alcohol Problems (including AA)
___ Anorexia/Bulimia ___ Drug Problems ___ Bipolar (Manic/Depressive) Disorder

Please list in chronological order all prior psychiatric hospitalizations (if any) below:

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below:

Approximate date of attempt	How did you attempt (method)?

Please list all current medications (include birth control pills, over the counter medications, herbal remedies) (it may be helpful to bring them in)

Name of Medication	Dosage (Mg)	How many times a day?	On this for how long?	Side effects (if any)?	Prescribing physician

Please review the following list of medications. If you have taken any of these medications please fill out the specific boxes related to that medication.

Brand Name	Generic Name	Check if yes	How long did you take it?	What dosage did you take?	Did it help?	How often in a day?	Any side effects?
Luvox	Fluvoxamine						
Paxil	Paroxetine						
Celexa	Citalopram						
Lexapro	Escitalopram						
Zoloft	Sertraline						
Prozac	Fluoxetine						
Effexor	Venlafaxine						
Pristiq	Desvenlafaxine						
Cymbalta	Duloxetine						
Fetzima	Levomilnacipran						
Savella	Milnacipran						
Desyrel	Trazodone						
Serzone	Nefazodine						
Wellbutrin	Bupropion						
Viibryd	Vilazodone						
Trintellix	Vortioxetine						
Buspar	Buspirone						
Asendin	Amoxapine						
Elavil	Amitriptyline						
Ludiomil	Maprotiline						
Norpramin	Desipramine						
Pamelor	Nortriptyline						
	Doxepin						
Tofranil	Imipramine						
Anafranil	Clomipramine						

Nardil	Phenelzine						
Parnate	Tranylcypromine						
	Selegiline patch						

Continued list of medications taken. Please review the following list of medications. If you have taken any of these medications please fill out the specific boxes related to that medication.

Brand Name	Generic Name	Check if yes	How long did you take it?	What dosage did you take?	Did it help?	How often in a day?	Any side effects?
Abilify	Aripiprazole						
Risperdal	Risperidone						
Invega	Paliperidone						
Geodon	Ziprasidone						
Zyprexa	Olanzapine						
Seroquel	Quetiapine						
Clozaril	Clozapine						
Saphris	Asenapine						
Latuda	Lurasidone						
Vraylar	Cariprazine						
Rexulti	Brexpiprazole						
Caplyta	Lumateperone						
Nuplazid	Pimavanserin						
Fanapt	Illioperidone						
Prolixin	Fluphenazine						
Haldol	Haloperidol						
Navane	Thiothixene						
	Trifluperazine						
	Pimozide						
	Perphenazine						
	Loxapine						
	Thioridazine						
	Loxapine						
Mellaril	Thioridazine						
Thorazine	Chlorpormazine						
Other:							

Brand Name	Generic Name	Check if yes	How long did you take it?	What dosage did you take?	Did it help?	How often in a day?	Any side effects?
Valium	Diazepam						
Xanax	Alprazolam						
Librium	Chlordiazepoxide						

Klonopin	Clonazepam						
Ativan	Lorazepam						
Restoril	Temazepam						
Lunesta	Eszopiclone						
Ambien	Zolpidem						
Sonata	Zaleplon						
Ramelteon	Rozerem						
	Chloral Hydrate						

Continued list of medications taken. Please review the following list of medications. If you have taken any of these medications please fill out the specific boxes related to that medication.

Brand Name	Generic Name	Check if yes	How long did you take it?	What dosage did you take?	Did it help?	How often in a day?	Any side effects?
	Lithium						
Depakene Depakote	Valproate Valproic acid						
Tegretol	Carbamazepine						
Topamax	Topiramate						
Lamictal	Lamotrigine						
Trileptal	Oxcarbazepine						
	Gabapentin						

Brand Name	Generic Name	Check if yes	How long did you take it?	What dosage did you take?	Did it help?	How often in a day?	Any side effects?
Dexedrine	Dextroamphetamine						
Ritalin, Metadate, Concerta	Methylphenidate						
Cylert	Pemoline						
Vyvanse	Lisdexamfetamine						
Adderall	Amphetamine						
Focalin	Dexmethylphenidate						
Strattera	Atomoxetine						
Provigil	Modafinil						
Nuvigil	Armodafinil						

	Clonidine						
Intuniv	Guanfacine						

Family History: Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate put paternal or maternal)

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression								
Anxiety								
Panic Attacks								
Post Traumatic Stress								
Bipolar Manic/Depression								
Schizophrenia								
Alcohol problems								
Drug problems								
ADHD								
Suicide attempts								
Psychiatric hospital stay								

Medical History: Do you have, or have you ever had any of the following? Please circle ones you have and write in details below.

High Blood Pressure	Gastrointestinal Problems (ulcers, pancreatitis, irritable bowel, colitis)	Viral Illness (Herpes, Epstein-Barr, Chronic Hepatitis)
Lung Disease	Arthritis or Rheumatoid Problems	Cancer
Diabetes	Liver Damage or Hepatitis	Genital Problems
Heart Disease	Other Endocrine/Hormone Problems	Eating Disorder
Thyroid Disease	Neurological Problems (stroke, brain tumor, nerve damage)	Eye Problems

Anemia	Gynecological/hysterectomy	Chronic Pain
Asthma	Urinary Tract or Kidney Problems	Fibromyalgia
Skin Disease	Migraine or Cluster Headaches	Other:
Seizures	Ear/Nose/Throat Problems	Head Injury
	High Cholesterol	Sleep Apnea

List all prior surgeries and hospitalizations for medical illnesses:

_____
_____
_____
_____

Are you allergic to any medication or food? If so, please list below:

_____
_____

Last Menstrual Period (if applicable):_____
Contraceptive method _____

What is your normal diet like?
Breakfast:_____
Lunch: _____
Dinner _____

What type of exercise do you do?_____
How much and how often do you exercise?_____
_____

When was your last drink of alcohol?_____
In the past 30 days, about how many days have you had at least one alcoholic drink?_____
What is the maximum number of drinks you have had in one day in the past month?_____
Circle any of the following you have had: DUI, DWI, Public Intoxication, Seizures, DT's