Email master

Thank you, for choosing Parkview.
To help us meet all your healthcare needs, please fill out this form completely in ink.

PATIENT INFORMATION

Patient Name: (Last)____________ (First)____________ (MI)____

Address:____________ City:____________ State:______ ZIP:______

Home Phone: (______) ____________ ❑Cell Phone ❑Daytime/Work Phone: (______) ____________

Social Security #_____-_____-_____ Sex: ❑M ❑F Date of Birth:_____/_____/_____

E-mail: ____________

Marital Status:____________ Employed? ❑Yes ❑No Occupation/Position: ____________

Employer/School:____________ Spouse's Name:____________

Family Physician:____________ Referring Physician:____________

Are you a "Plain Church"* member? ❑Yes ❑No If yes: Bishop Name:____________ District: ____________

Denotes special billing

PERSON RESPONSIBLE FOR THE BILL (If other than the patient)

Patient Name: (Last)____________ (First)____________ (MI)____

Address:____________ City:____________ State:______ ZIP:______

Home Phone: (______) ____________ ❑Cell Phone ❑Daytime/Work Phone: (______) ____________

Social Security #_____-_____-_____ Sex: ❑M ❑F Date of Birth:_____/_____/_____

Marital Status:____________ Employed? ❑Yes ❑No Occupation/Position: ____________

Employer/School:____________ Spouse's Name:____________

INSURANCE INFORMATION

PRIMARY INSURANCE:____________	SECONDARY INSURANCE:____________
Policyholder Name: ____________	Policyholder Name: ____________
Relationship to Patient: ____________	Relationship to Patient: ____________
Policyholder's Address: ____________ ____________	Policyholder's Address: ____________ ____________
Policyholder's Phone #: (______) ____________	Policyholder's Phone #: (______) ____________
Policyholder's Birthdate: ____________	Policyholder's Birthdate:____________
Social Security #:_____–_____–_____	Social Security #:_____–_____–_____
Is plan through work? ❑Yes ❑No	Is plan through work? ❑ Yes ❑ No
Employer Name: ____________	Employer Name: ____________
Phone: (______) ____________	Phone: (______) ____________

PATIENT INFORMATION

242-PPG (6-15)

Patient ID Number:____________ Date:____________

WELCOME TO MIND-BODY MEDICINE!

Please complete these assessment tools, which assist our treatment team in providing ideal care to you

NAME: ______________________________

IN THE PAST 4 WEEKS:
(Please circle your responses)

HAVE YOU BEEN SEEING A COUNSELOR? NO YES
If so,
COUNSELOR'S OR CLINIC'S NAME: ____________________
HOW OFTEN ARE YOUR COUNSELING APPOINTMENTS?
TWICE WEEKLY / WEEKLY / EVERY 2 WEEKS / MONTHLY

HAVE YOU BEEN EMPLOYED OR ATTENDED SCHOOL? NO YES
If so,
HAVE YOU MISSED WORK OR SCHOOL? NO / YES

HAVE YOU CONSUMED ANY ALCOHOL? NO YES
If so,
HOW MANY DRINKS? 1 - 2 3 -4 5 OR MORE
HOW OFTEN? DAILY WEEKLY MONTHLY

HAVE YOU USED ANY MARIJUANA?
NOT AT ALL
1 TO 2 TIMES WEEKLY
MORE THAN 2 TIMES WEEKLY
NEARLY EVERY DAY

HOW OFTEN HAVE YOU EXERCISED?
NOT AT ALL
1 to 3 TIMES WEEKLY
MORE THAN 3 TIMES / WEEK
NEARLY EVERY DAY

TYPE OF EXERCISE: ______________________________

I authorize Parkview Health System, Inc., its affiliated healthcare providers, and their business units, including Parkview Physicians Group, (Parkview) to share information about me with the people listed below. This information may include:

- medical information (including test results),
- billing statement information, and
- appointment scheduling information (including referrals to other health care providers).

I intend for this authorization to include information relating to treatment for physical, mental and behavioral health illness, communicable disease, alcohol or drug abuse treatment, and HIV, AIDS or AIDS-related information.

Contact Name	Relationship	DOB	Phone Number
1.			
2.			
3.			
4.			
5.			
6.			

This authorization will remain in effect until I revoke it in writing or replace it with an updated form. I know that I can revoke it at any time, except to the extent that action has already been taken in reliance upon it. I understand that no treatment, payment, enrollment or eligibility for benefits may be conditioned on whether I sign this authorization. I release Parkview from any legal responsibility or liability for sharing information with the people listed. I understand that these people might not keep my information confidential, and it might not be protected by federal and state privacy law any longer. I also understand that I am entitled to a copy of this form.

Patient Printed Name:______________________________ **Date of Birth:**____________

Patient Address: ____

City:______________________________ **State:**__________ **ZIP:** ____________

Patient/Parent/Guardian/Legal Representative Signature: ______________________

Relationship to Patient:______________________________ **Date:**____________

AUTHORIZATION FOR SHARING INFORMATION WITH PATIENT CONTACT LIST

Patient Name: ____________________

Patient ID Number: ____________________

DOB: ____________________

5050 (9-15)

MINI SCREEN 6.0.0

PLEASE COMPLETE THE WHITE PORTION OF THE QUESTIONNAIRE

NAME: ____________________ DATE OF BIRTH: ____________________

DATE OF SCREENING: ____________________

➤ Have you been depressed or down, most of the day, nearly every day, for the past two weeks?	NO	YES
➤ In the past two weeks, have you been much less interested in most things or much less able to enjoy the things you used to enjoy most of the time?	NO	YES
➤ In the past month did you think that you would be better off dead or wish you were dead?	NO	YES
➤ In the past month have you thought about killing yourself?	NO	YES
➤ Have you ever had a period of time when you were feeling 'up' or 'high' or 'hyper' or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)	NO	YES
➤ 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?	NO	YES
➤ Have you, on more than one occasion, had spells 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 surge to a peak, within 10 minutes of starting? CIRCLE YES ONLY IF THE SPELLS PEAK WITHIN 10 MINUTES.	NO	YES
➤ Did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?	NO	YES
➤ Do you feel anxious or uneasy in places or situations 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 bridge, traveling in a bus, train or car?	NO	YES
➤ In the past month did you have persistent fear and significant anxiety at being watched, being the focus of attention, or of being humiliated or embarrassed? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations.	NO	YES
➤ 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 had germs, or fear of contaminating others, or fear of harming someone even though you didn't want to, or fearing you would act on some impulse, or fear or superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images or impulses, or hoarding, collecting, or religious obsessions.)	NO	YES
➤ In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, or arranging things, or other superstitious rituals?	NO	YES

(PLEASE TURN OVER THE PAGE)

- 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. — NO YES
- Did you respond to the trauma with intense fear, helplessness, or horror? — NO YES
- During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions)? — NO YES
- In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions? — NO YES
- In the past 12 months, did you take any of these drugs more than once, to get high, to feel elated, to get a buzz, or to change your mood? — NO YES

amphetamines	speed, crystal meth	Dexedrine®, Ritalin®	diet pills, rush	THC, marijuana, cannabis, hashish
Cocaine, crack	steroids, GHB	Valium®, Xanax®	Ativan	barbiturates
heroin	morphine, methadone	opium, Demerol®	codeine	Percodan®, OxyContin®, Vicodin®
LSD, mescaline	PCP, angel dust, ecstacy	MDA, MDMA	ketamine	Inhalants glue, ether

- Have you ever believed that people were spying on you or that someone was plotting against you or trying to hurt you? — NO YES
- Have you ever heard things other people couldn't hear such as voices? — NO YES
- Have you ever had visions when you were awake or have you ever seen things other people couldn't see? — NO YES
- How tall are you?
  |__|__|__| inches
- What was your lowest weight in the past 3 months?
  |__|__|__| lbs

IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS/ HER HEIGHT? — NO YES

Height (ft in)	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7
Weight (lbs)	81	84	87	89	92	96	99	102	105	108	112
Height (ft in)	5'8	5'9	5'10	5'11	6'0	6'1	6'2	6'3			
Weight (lbs)	115	118	122	125	129	132	136	140			

- In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period? — NO YES
- In the last 3 months, did you have eating binges as often as twice a week? — NO YES
- Were you excessively anxious or worried about several routine things over the past 6 months? — NO YES

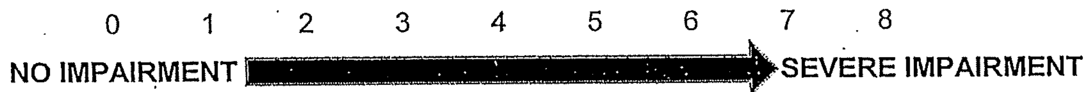
M.I.N.I. SCREEN 6.0.0 / English version / DSM-IV January 2010 © 2001-2010 Sheehan DV & Lecrubier Y. All rights reserv
Sheehan, J. Janavs, (University of South Florida-TAMPA, USA) ; Y. Lecrubier, T. Hergueta, E. Weiller, (INSERM-PARIS, FRANCE). T. Proeschel.

Work and Social Adjustment Scale (WSAS)

CIRCLE each of the following questions concerning your functioning
FOR THE PAST 2 WEEKS

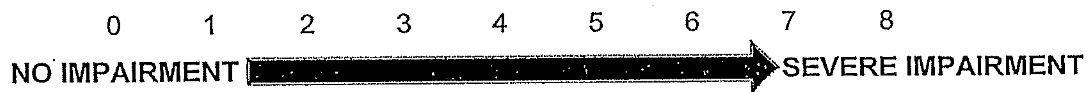
1. Because of my [disorder], **my ability to work is impaired.** 8 means very severely impaired to the point I can't work.

0 1 2 3 4 5 6 7 8



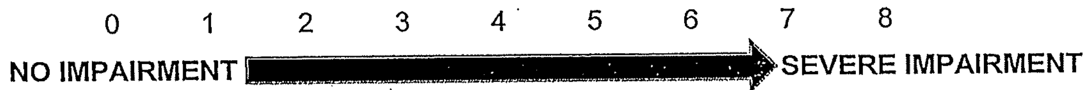
2. Because of my [disorder], **my home management** (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) **is impaired.**

0 1 2 3 4 5 6 7 8



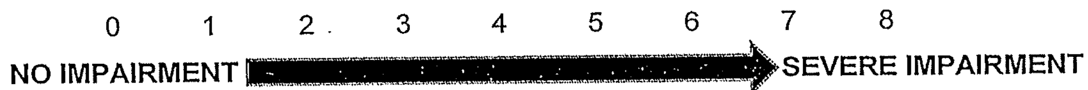
3. Because of my [disorder], my **social leisure activities** (with other people, such as parties, bars, clubs, outings, visits, dating, home entertainment) **are impaired.**

0 1 2 3 4 5 6 7 8



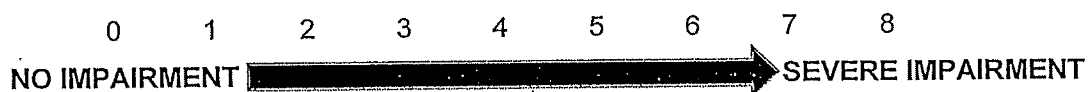
4. Because of my [disorder], my **private leisure activities** (done alone, such as reading, gardening, collecting, sewing, walking alone) **are impaired.**

0 1 2 3 4 5 6 7 8



5. Because of my [disorder], my ability to **form and maintain close relationships** with others, including those I live with, **is impaired.**

0 1 2 3 4 5 6 7 8



© 2002 Isaac Marks: Mundt et al (2002) Work and Social Adjustment Scale: a simple measure of impairment in functioning. British Journal of Psychiatry, 180, 461-464. Printed with permission for PPG Mind-Body Medicine

Patient Rated Inventory of Side Effects (PRISE)

Please indicate all symptoms you have experienced in the past week.
(These symptoms may or may not have been caused by your treatment)

1. GASTROINSTESTINAL
1.1 Check **ALL** symptoms that you have experienced during the past week regardless of cause: □ Diarrhea □ Constipation □ Dry Mouth □ Nausea/Vomiting □ No symptoms in this category 1.2 **If you had any symptoms** over the last week, how bad was your WORST symptom? □ Tolerable □ Distressing
2. HEART
2.1 Check **ALL** symptoms that you have experienced during the past week regardless of cause: □ Palpitation (skipping a beat) □ Dizziness on standing □ Chest pain □ No symptoms in the category 2.2 **If you had any symptoms** over the last week, how bad was your WORST symptom? □ Tolerable □ Distressing
3. SKIN
3.1 Check **ALL** symptoms that you have experienced during the past week regardless of cause: □ Rash □ Increased perspiration □ Itching □ Dry skin □ No symptoms in this category 3.2 **If you had any symptoms** over the last week, how bad was your WORST symptom? □ Tolerable □ Distressing

Patient Rated Inventory of Side Effects (PRISE)

4. NERVOUS SYSTEM
4.1 Check **ALL** symptoms that you have experienced during the past week regardless of cause: □ Headache □ Tremors □ Poor coordination □ Dizziness □ No symptoms in this category 4.2 **If you had any symptoms** over the last week, how bad was your WORST symptom? □ Tolerable □ Distressing
5. EYES/EARS
5.1 Check **ALL** symptoms that you have experienced during the past week regardless of cause: □ Blurred vision □ Ringing in ears □ No symptoms in this category 5.2 **If you had any symptoms** over the last week, how bad was your WORST symptom? □ Tolerable □ Distressing
6. GENITAL/URINARY
6.1 Check **ALL** symptoms that you have experienced during the past week regardless of cause: □ Difficulty urinating □ Painful urination □ Frequent urination □ Menstrual irregularity □ No symptoms in this category 6.2 **If you had any symptoms** over the last week, how bad was your WORST symptom? □ Tolerable □ Distressing

Patient Rated Inventory of Side Effects (PRISE)

7. SLEEP

7.1 Check **ALL** symptoms that you have experienced during the past week regardless of cause:

- ☐ Difficulty sleeping
- ☐ Sleeping too much
- ☐ No symptoms in this category

7.2 **If you had any symptoms** over the last week, how bad was your WORST symptom?

- ☐ Tolerable
- ☐ Distressing

8. SEXUAL FUNCTIONING

8.1 Check **ALL** symptoms that you have experienced during the past week regardless of cause:

- ☐ Loss of sexual desire
- ☐ Trouble achieving orgasm
- ☐ Trouble with erections or sexual arousal
- ☐ No symptoms in this category

8.2 **If you had any symptoms** over the last week, how bad was your WORST symptom?

- ☐ Tolerable
- ☐ Distressing

9. OTHER

9.1 Check **ALL** symptoms that you have experienced during the past week regardless of cause:

- ☐ Anxiety
- ☐ Poor concentration
- ☐ General feeling of unhealthiness (malaise)
- ☐ Restlessness
- ☐ Fatigue
- ☐ Decreased energy
- ☐ Other: ______________________________
- ☐ No symptoms in this category

9.2 **If you had any symptoms** over the last week, how bad was your WORST symptom?

- ☐ Tolerable
- ☐ Distressing

Rush AJ, Fava M, Wisniewski SR, Lavori PW, Trivedi MH, Sackeim HA, Thase ME, Nierenberg AA, Quitkin FM, Kashner TM, Kupfer DJ, Rosenbaum JF, Alpert J, Stewart JW, McGrath PJ, Biggs MM, Shores-Wilson K, Lebowitz BD, Ritz L, Niederehe G. Sequenced treatment alternatives to relieve depression (STAR*D): rationale and design. Controlled Clinical Trials. 2004; 25:119–142

PDQ-20 VERSION

FOR THE PAST 4 WEEKS, HOW OFTEN DID YOU:

	NEVER		SOMETIMES		ALMOST ALWAYS
1. Lose your train of thought when speaking?	0	1	2	3	4
2. Have difficulty remembering names, even people you have met several times?	0	1	2	3	4
3. Forget why you came into the room?	0	1	2	3	4
4. Have trouble getting things organized?	0	1	2	3	4
5. Have trouble concentrating on what people are saying during a conversation?	0	1	2	3	4
6. Forget if you have already done something?	0	1	2	3	4
7. Miss scheduled appointments or meetings?	0	1	2	3	4
8. Have difficulties with daily planning?	0	1	2	3	4
9. Have trouble concentrating (e.g. watching a television program or reading a book)?	0	1	2	3	4
10. Forget what you did the night before?	0	1	2	3	4
11. Forget the date unless you looked it up?	0	1	2	3	4
12. Have trouble getting started, even if you had a lot of things to do?	0	1	2	3	4
13. Find your mind drifting?	0	1	2	3	4
14. Forget what you talked about after a telephone conversation?	0	1	2	3	4
15. Forget to do things like turn off the stove or turn on your alarm clock?	0	1	2	3	4
16. Feel like your mind went totally blank?	0	1	2	3	4
17. Have trouble holding phone numbers in your head, even for a few seconds?	0	1	2	3	4
18. Forget what you did last weekend?	0	1	2	3	4
19. Forget to take your medication?	0	1	2	3	4
20. Have trouble making decisions?	0	1	2	3	4

NAME: ____________________

GAD-7

Over the <u>LAST 2 WEEKS</u>, how often have you been bothered by any of the following problems?	Not at all	Some - 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

GAD7 total score ☐

IN THE PAST 2 WEEKS, HOW OFTEN HAVE YOU EXERCISED?

Not at all   Some -several days   More than half the days   Nearly every day

IN THE PAST 2 WEEKS, HOW OFTEN HAVE YOU USED ALCOHOL OR MARIJUANA (CIRCLE EITHER IF APPROPRIATE)?

Not at all   Some -several days   More than half the days   Nearly every day

PHQ- 9

Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?	Not at all	Some - 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 or staying asleep **OR** Sleeping too much--**(please circle which problem if applicable)**	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite **OR** Overeating— **(please circle which problem if applicable)**	0	1	2	3
6 Feeling bad about yourself — or that you are 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 **AND/OR** thoughts of hurting yourself in some way—(please circle which problem is applicable)	0	1	2	3

ARE YOU CURRENTLY INVOLVED IN COUNSELING? YES NO

PHQ9 total score [ ]

Mood Disorder Questionnaire

Patient Name ______________________ Date of Visit ______________

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	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?	☐	☐
...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 that you didn't really miss it?	☐	☐
...you were 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 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 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?	☐	☐

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?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

PLEASE LIST ALL MEDICATIONS

PLEASE CIRCLE ALL MEDICATIONS THAT YOU RECALL TAKING AT ANY TIME IN THE PAST

Antiepileptics
Depakote/ER (valproate)
Dilantin (phenytoin)
Keppra (levetiracetam)
Lamictal (lamotrigine)
Lyrica (pregabalin)
Neurontin/Horizant/Gralise (gabapentin)
Tegretol (carbamazepine)
Topamax/ Trokendi (topiramate)
Trileptal (oxcarbazepine)

Antihistamines
Vistaril/Atarax (hydroxyzine)
Benadryl (diphenhydramine)
Periactin (cyproheptadine)

Anxiolytics
Ativan (lorazepam)
Klonopin (clonazepam)
Librium (chlordiazepoxide)
Valium (diazepam)
Xanax/XR (alprazolam)
Tranxene (clorazepate)

Sedative-hypnotics and sleep aids
Ambien/CR (zolpidem)
Intermezzo / Edular / ZolpiMist spray (zolpidem)
Lunesta (eszopiclone)
Halcion (triazolam)
Sonata (Zaleplon)
Rozerem (ramelteon)
Restoril (temazepam)
Dalmane (flurazepam)
Belsomra (suvorexant)
Silenor (doxepin 3 and 6 mg)

Psychotropics
Abilify (aripiprazole)
Clozaril (clozapine)
Geodon (ziprasidone)
Haldol (haloperidol)
Invega (paliperidone)
Latuda (lurasidone)
Prolixin (fluphenazine)
Risperdal (risperidone)
Saphris (asenapine)
Seroquel/XR (quetiapine)
Loxitane (loxapine)
Rexulti (brexpiprazole)
Thorazine (chlorpromazine)
Triavil (Elavil/Trilafon)
Trilafon (perphenazine)
Zyprexa/Zydis (olanzapine)
Vraylar (cariprazine)
Fanapt (iloperidone)

Lithium (Eskalith/Lithobid)

MAOI antidepressants
Emsam Patch (selegiline)
Nardil (phenelzine)
Parnate (tranylcypromine)

Tricyclic antidepressants
Vivactil (protriptyline)
Elavil (amitriptyline)
Anafranil (clomipramine)
Adapin/Sinequan (doxepin)
Silenor (doxepin 3 and 6 mg)
Tofranil (imipramine)
Norpramin (desipramine)
Pamelor (nortriptyline)

SNRI antidepressants
Effexor/XR (venlafaxine)
Pristiq (desvenlafaxine)
Cymbalta (duloxetine)
Savella (milnacipran)
Fetzima (levomilnacipran)

SSRI antidepressants
Prozac (fluoxetine)
Luvox/CR (fluvoxamine)
Celexa (citalopram)
Lexapro (escitalopram)
Paxil/CR (paroxetine)
Zoloft (sertraline)
Symbyax (fluoxetine/olanzapine)

Serotonin Receptor Modulators
Viibryd (vilazodone)
BuSpar (buspirone)
Serzone (nefazodone)
Desyrel / Oleptro (trazodone)
Remeron (mirtazapine)
Brintellix/ Trintellix (vortioxetine)

Wellbutrin variants
Wellbutrin/SR/XL (bupropion)
Aplenzin (174, 348, 522 mg)
Forfivo (450 mg)
Zyban

Dopamine agonists:
Mirapex (pramipexole)
Requip (ropinirole)

Alpha 1A Antagonist
Minipress (prazosin)

Alpha 2A Agonist
Intuniv (guanfacine extended release)
Tenex (guanfacine)
Catapres (clonidine)
Catapres TTS (clonidine patch)
Kapvay (clonidine extended release)

Stimulants
Evekeo (amphetamine salts)
Adderall/XR (mixed amphetamine salts)
Mydayis (mixed amphetamine salts)
Dextroamphetamine tablets (immediate)
Dexedrine Spansule/XR (dextroamphetamine
Vyvanse (lisdexamfetamine)
Zenzedi (dextroamphetamine sulfate)
Metadate CD (methylphenidate HCl)
Focalin/XR (dexmethylphenidate)
Concerta (methylphenidate ER)
Daytrana Patch (methylphenidate)
Quillivant (liquid methylphenidate)/Chew
Ritalin/SR/LA (methylphenidate)
Aptensio XR (methylphenidate HCl)

Norepinephrine reuptake inhibitors
Strattera (atomoxetine)

Cholinesterase Inhibitors
Aricept (donepezil HCL)
Exelon (rivastigmine)
Reminyl (galantamine)
Razadyne/ER (galantamine)

NMDA Antagonist
Namenda (memantine HCL)
Nuedexta(dextromethorphan/quinidine)
Namzaric (memantine/ donezpezil)

Beta Blockers
Tenormin (atenolol)
Inderal (propranolol)
Corgard (nadolol)
Toprol/Lopressor (metoprolol)
Betoptic (betaxolol)
Visken (pindolol)

Wake Promoting Agents
Provigil (modafinil)
Nuvigil (armodafinil)

Alcohol Dependence medications
Antabuse (disulfiram)
Campral (acamprosate)
Revia/Vivitrol (naltrexone)

Supplements
Cerefolin NAC / N-acetylcysteine
Melatonin
Axona (caprylidene)
Folic acid
Deplin / Enlyte / Enbrace / MethylPro / l-methylfolate
Sam-e
St. John's wort
Vitamin D
Magnesium

Map and Directions

YELLOW RIVER RD.
FLAUGH RD.
69
N
BASS RD.
3
1
N. SCOTT RD.
N. HADLEY RD.
N. THOMAS RD.
EXIT 305
ILLINOIS RD.
14
ILLINOIS RD.
POINTE INVERNESS WAY
PPG
Mind-Body
Medicine
GETZ RD.
W. JEFFERSON BLVD.
69
COVINGTON RD.
3
1
SMITH RD.
W. JEFFERSON BLVD.
ABOITE CENTER RD.
ENGLE RD.

Directions

- Take I-69 to Exit 305b (Illinois Road).
- Turn left onto Hadley Road.
- Turn left into the Pointe Inverness office park.
- We are the 4th office building on the left (building 6920).

6920 Pointe Inverness Way, Suite 120
Fort Wayne, Indiana 46804
(260) 436-4060

PARKVIEW
PHYSICIANS GROUP
MIND-BODY MEDICINE