CLARITY
INTEGRATIVE PSYCHIATRY

INTAKE FORM

Welcome to our practice. We look forward to serving as your behavioral health care professionals. In order for us to provide you with the best possible service, our practice policies are laid out on the following pages. Please take a few moments to read these policies carefully. Should you require any further clarification, the Clarity staff would be pleased to answer any questions. A copy of this policy for your keeping is available upon request.

Patient Information

Today's Date *
01/02/2024

Medical Provider *

Legal First Name *

Legal Last Name *

Preferred Name

Date of Birth *
__/__/____

Sex Assigned at Birth *
○ Male ○ Female ○ Intersex

Gender Identity

Phone Number *
(___) ___-____

Email Address *

Street Address *

City *

State *

Zip Code *
_____

Occupation

Employer

How did you first hear about Clarity Integrative Psychiatry? *
○ Facebook ○ Google Search ○ Patient Referral ○ Therapist Referral ○ Medical Provider ○ Other

In Case of Emergency / Emergency Contact

Name *

Relationship to Patient

Emergency Phone *

(___) ___-____

Email

May we reach out to this person if we cannot reach you for a scheduled appointment? *

○ Yes ○ No

Preferred Pharmacy

Name of Pharmacy

Phone Number

(___) ___-____

Street Address

City

State

Zip Code

_____

Insurance Information

We are a cash pay practice and are unable to directly assist with insurance billing. However, it is helpful for us to know some of your insurance information for prescribing and labs. Please complete the section below, if applicable.

Insurance Provider

Insurance Phone Number

(___) ___-____

As a reminder, our practice does not accept insurance. If you are interested in reimbursement from your insurance, please reach out to them directly to learn more.

By signing below, I certify all information is true and correct to the best of my knowledge.

Patient/Legal Guardian Signature *

Date *

01/02/2024

Patient/Legal Guardian Initials *

TREATMENT CONSENT FORM

Explanation of Consent

This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection of the procedures performed by the behavioral health professionals at the Clarity Integrative Psychiatry, LLC facilities. This form documents that the patient has consented to all services, including, but not limited to, psychiatric evaluation and medication management, allowing us to provide treatment. No guarantee of outcome can be made for any professional services rendered by the Clarity Integrative Psychiatry, LLC. If you have any questions concerning this or any other matter, it is your responsibility to check with your healthcare provider. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form and agree to follow the terms of this consent.

Consent to Treatment

I, (enter Initials/Guardian Initials in Box 1), for (enter Patient's Initials If Minor in Box 2), do hereby voluntarily consent to care and treatment by Naveen C. Thomas, MD and his assistants and/or designees. I am aware that the practice of medicine, psychiatry, clinical social work, and other therapy by a licensed professional is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment. I am aware that I am an active participant in the treatment process and that I share responsibility for such treatment. My responsibilities include informing the health care provider of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice and prescribed medication to the best of my ability, and ending treatment in a responsible way. If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent for them. This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

Box 1 *

Box 2

Patient/Legal Guardian Signature *

Date *

01/02/2024

POLICIES

Appointments & Scheduling

Office visits are by appointment only. An appointment means that that time is reserved specifically for you. The first appointment with Dr. Thomas will be an initial evaluation appointment of 60 or 90 minutes. The second appointment will be an extended follow-up appointment of 40 minutes. The third and following appointments will be standard 20 minute or extended 40 minute appointments. The appointment schedule will be determined by the provider within the patient's best interest.

Payment Policy

Payment in full is required to confirm a scheduled appointment; 100% deposit of the visit price is required before your scheduled appointment. Payment can be made by credit/debit card or HSA/FSA card.

Cancellation Policy

Forty-eight hours cancellation notice is expected for an initial appointment; twenty-four hours is expected for a follow-up appointment. If an appointment is canceled in less than that time, or you do not attend your scheduled appointment, we reserve the right to charge for up to the entire cost of the appointment.

Non-covered Services

Some services are not covered by the customary appointment fees, such as form completion, telephone consults with the doctor, medical records etc. Forms, letters, and other such paperwork are charged at $25.00 per page if they cannot be completed during the office visit. Telephone consults with Dr. Thomas for treatment management outside of scheduled appointments are charged at $100 per call. Requests to speak directly to the doctor are considered telephone consults. Messages left for the doctor regarding serious side effects or with the office regarding scheduling are not considered telephone consults. Messages requesting changes in patient plan or requiring a detailed email response from the doctor will be charged at $15.00 per response. Medical record copies start at $15.00 for the first 25 pages, plus a per sheet charge of $0.15 thereafter. At this time, it is not customary in our practice to provide services related to short or long term disability paperwork.

Medication Refills

Refills are completed for patients under active treatment who keep regular, scheduled appointments. You will be provided with your prescription/s the day of your appointment. Do not wait until you are out of medications to take action, as we cannot guarantee a day of appointment or refill. Refill requests, early refill requests, and pharmacy transfers made outside of appointments will be charged at $40.00, payable at the time of request. Standards of care in the behavioral health field require that a stable patient must be seen at least once every six months. The frequency of appointments will be determined by the provider within the patient's best interest.

Weapons, Alcohol and Tobacco Use

At no time and with no exception are weapons, alcohol use, cannabis use, or tobacco use permitted in any of the Clarity Integrative Psychiatry, LLC premises.

Termination of Treatment

Patients have the right to discontinue treatment at any time. We encourage you to discuss and share your thoughts openly with the doctor. We also reserve the right to terminate treatment should the doctor conclude that he/she is unable to offer you the type of level or care that you require, should you be unwilling to adhere to the agreed upon treatment plan, or should you become noncompliant with the policies of this practice. Should termination of treatment become necessary, you will be notified so that you will have one month's notice to make arrangements to seek another behavioral health care professional.

Emergencies

We are not equipped to respond to life-threatening emergencies. For a life-threatening emergency please call 911 or proceed to your nearest emergency room for immediate assistance. Please keep us informed of any such developments, regarding both medical and mental health.

Statement of Policy

Our service is geared towards providing quality holistic and medical treatment to our patients. Fulfilling the paperwork requirements for sick leave, long or short term disability, work capacity, legal or custodial determinations, are generally outside the scope of this practice.

Client Policy Agreement

By signing below, I acknowledge that I have read and understood the above listed Client Policies and accept these policies. I agree that I am responsible for all charges not covered by insurance for services rendered.

Patient/Legal Guardian Signature *

Date *

01/02/2024

Patient/Legal Guardian Initials *

Contact Information

Phone Number: (678) 459-5493. **Email:** info@claritypsychiatry.com
Fax Number: (844) 921-0962. **Website:** www.Claritypsychiatry.com
Address: 1355 Terrel Mill Rd. Building 1460, Marietta, GA 30067

APPOINTMENT REMINDER CONSENT FORM

Patients in our practice may be contacted via text or voice messaging to remind you of an appointment and to provide general health reminders and information. By providing a mobile phone number, I consent to receiving appointment reminders and other healthcare communications/information from Clarity Integrative Psychiatry. By signing below, I consent to receive text or voice messages from the practice at my cell phone and any number forwarded or transferred to that number to receive communication as stated above.

I understand that this request to receive text and voice messages will apply to all future appointment reminders and health information unless I request a change in writing.

I understand that Clarity Integrative Psychiatry will not use the phone number I provide for marketing purposes and will not give the phone number I provide to any third parties.

I understand that Clarity Integrative Psychiatry will use the phone number I provide in accordance with HIPAA regulations and TCPA restrictions.

Text Message

I,(enter name in box below), authorize Clarity Integrative Psychiatry to send Appointment Reminders electronically via text message to my mobile phone. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for the patient/mobile phone number.

Patient Name

Mobile Phone Number

(___) ___-____

Voice Message

I,(enter name in box below), authorize Clarity Integrative Psychiatry to contact me for Appointment Reminders via voice messaging. If I am unavailable to answer the telephone, I give Clarity Integrative Psychiatry permission to leave a message on my answering machine.

Patient Name

Preferred Phone Number

(___) ___-____

I prefer to receive appointment reminders via (please select one) *

- ○ Text Message
- ○ Voice Message
- ○ Both

Patient/Legal Guardian Signature *

Date *

01/02/2024

Patient/Legal Guardian Initial *

CLINICAL HISTORY FORM

Patient Signature *

Patient Initials *

Date *

01/02/2024

Please describe the current complaint or problem as specifically as you can, in your own words: *

How long have you experienced this problem, or when did you first notice it? *

What stressors may have contributed to the current complaint or problem? *

Current Symptoms

CURRENT SYMPTOM CHECKLIST (Rate by circling the intensity of symptoms that are currently present)
0 = not present at this time
1 = present, bothers me a little, but not enough to be a problem
2 = present, bothers me and affects my quality of life, but still able to function
3 = moderate impact on quality of life and/or day-to-day functioning
4 = serious impact on quality of life and interferes with day-to-day functioning

Overeating/weight gain

Symptom	Severity		Symptom	Severity	
Depressed Mood	0 1 2 3 4	*	Knot in stomach	0 1 2 3 4	*
Feelings of guilt or worthlessness	0 1 2 3 4	*	Fear of Places	0 1 2 3 4	*
Difficulty concentrating	0 1 2 3 4	*	Twitches, tics, or spasms	0 1 2 3 4	*
Feeling irritable/restless	0 1 2 3 4	*	Can't sit still	0 1 2 3 4	*
Insomnia	0 1 2 3 4	*	Chest pain	0 1 2 3 4	*
Excessive sleeping	0 1 2 3 4	*	Upset stomach	0 1 2 3 4	*
Forgetfulness	0 1 2 3 4	*	Lump in throat	0 1 2 3 4	*
Loss of interest	0 1 2 3 4	*	Racing thoughts	0 1 2 3 4	*
Poor appetite/weight loss	0 1 2 3 4	*	Feelings of helplessness	0 1 2 3 4	*
Sadness/crying spells	0 1 2 3 4	*	Overspending	0 1 2 3 4	*
Tiredness/fatigue	0 1 2 3 4	*	Angry feelings	0 1 2 3 4	*

Current Symptoms - Ctd.

Thoughts of hurting myself	0	1	2	3	4	*	Angry behavior	0	1	2	3	4	*
Thoughts of killing myself	0	1	2	3	4	*	Thoughts of hurting others	0	1	2	3	4	*
Aches, pains, or headaches	0	1	2	3	4	*	Temper outbursts	0	1	2	3	4	*
Overeating/weight gain	0	1	2	3	4	*	Feel I'm being watched	0	1	2	3	4	*
Excessive worrying or indecisiveness	0	1	2	3	4	*	Feel others are against me	0	1	2	3	4	*
Feeling anxious/nervous	0	1	2	3	4	*	Hearing/seeing things	0	1	2	3	4	*
Panic attacks	0	1	2	3	4	*	Problem concentrating	0	1	2	3	4	*
Sweaty palms	0	1	2	3	4	*	Easily distracted	0	1	2	3	4	*
Mind going blank	0	1	2	3	4	*	Problem completing tasks	0	1	2	3	4	*
Heart Racing	0	1	2	3	4	*	Excessive energy	0	1	2	3	4	*

MEDICATION AND SUPPLEMENT LIST

Please list below all current medications (including over the counter medications) as well as any vitamins or supplements.

Name of Medication/Supplement	Dosage	Frequency

Medication Allergies/Other Notes

PSYCHIATRIC HISTORY

Have you ever been to a psychiatrist before? *

If so, what diagnosis were you given?

Please indicate medications you have previously been prescribed for mental health: (select all that apply)

- ☐ Abilify (Aripiprazole)
- ☐ Adderall (Mixed Amphetamine Salts)
- ☐ Ambien (Zolpidem)
- ☐ Buprenorphine (Suboxone)
- ☐ Buspar (Buspirone)
- ☐ Celexa (Citalopram)
- ☐ Catapres (Clonidine)
- ☐ Concerta
- ☐ Cymbalta (Duloxetine)
- ☐ Depakote (Sodium Valproate)
- ☐ Diazepam (Valium)
- ☐ Dexedrine (Dextroamphetamine)
- ☐ Elavil (Amitriptyline)
- ☐ Effexor (Venlafaxine)
- ☐ Other, please list:
- ☐ Invega (Paliperidone)
- ☐ Klonopin (Clonazepam)
- ☐ Lamictal (Lamotrigine)
- ☐ Latuda (Lurasidone)
- ☐ Lexapro (Escitalopram)
- ☐ Lithium Carbonate
- ☐ Lunesta (Eszopiclone)
- ☐ Metadate (Methylphenidate ER)
- ☐ Methadone
- ☐ Paxil (Paroxetine)
- ☐ Prozac (Fluoxetine)
- ☐ Pristiq (Desvenlafaxine)
- ☐ Restoril (Temazepam)
- ☐ Ritalin (Methylphenidate)
- ☐ Seroquel (Quetiapine)
- ☐ Strattera (Atomoxetine)
- ☐ Tegretol (Carbemazapine)
- ☐ Topamax (Topiramate)
- ☐ Trazodone
- ☐ Trileptal (Oxcarbazepine)
- ☐ Trintellix (Vortioxetine)
- ☐ Viibryd (Vilazadone)
- ☐ Vistaril (Hydroxyzine)
- ☐ Vyvanse
- ☐ Wellbutrin (Bupropion)
- ☐ Xanax (Alprazolam)
- ☐ Zyprexa (Olanzapine)
- ☐ Zoloft (Sertraline)

Which medication did you like most?

Which did you like least?

Were you ever in the hospital for a psychiatric or substance abuse disorder? *

○ Yes ○ No

Have you ever attempted to hurt yourself or commit suicide? *

○ Yes ○ No

Do you have access to any weapons? *

○ Yes ○ No

Do you currently see a therapist or counselor? *

○ Yes ○ No

PROBLEMATIC SUBSTANCE ABUSE & USAGE

Substance	**Amount Used**	**Frequency**	**Start Date** (year)	**End Date** (year)
Tobacco				
Alcohol				
Sedatives/Benzodiazepines				
Hallucinogens/LSD				
Stimulants/Amphetamines				
Cocaine/Crack				
Painkillers (morphine, heroin, oxycontin, etc)				
Marijuana				
Other	please list			

Alcohol or drug treatment history:

☐ Outpatient ☐ Inpatient ☐ 12-step program ☐ Stopped on own

PERSONAL MEDICAL HISTORY

(Please check all that apply and list details in the space beside the category, or in the space below.)

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Brain Tumor
- ☐ Cancer
- ☐ Cholesterol
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ ENT
- ☐ Eye Problems
- ☐ GERD/Heartburn
- ☐ GYN
- ☐ Head Injury
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hysterectomy
- ☐ Irritable Bowel
- ☐ Kidney
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Nerve Damage
- ☐ Neurological
- ☐ Pancreatitis
- ☐ Seizures
- ☐ Skin Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid
- ☐ Ulcers
- ☐ UTI
- ☐ Other

How many Bowel Movements do you have in 1 week? *

Do you get frequent or uncomfortable abdominal gassiness or bloating? * ○ Yes ○ No

Are you sensitive to any foods? * ○ Yes ○ No

Have you ever had a history of repeated infections requiring antibiotics (including childhood) * ○ Yes ○ No

SOCIAL HISTORY

Living Situation

○ Alone ○ With spouse and/or childern ○ With Roommates ○ With Parents *

Occupational History: What is your current employment status?

○ Employed full-time ○ Employed part-time ○ Unemployed ○ Self-employed ○ Student ○ Other *

Current occupation?

Are you satisfied with your employment? * ○ Yes ○ No

Marital History: Please check the box which best describes your current situation.

☐ Never Married ☐ Married (once) ☐ Married (multiple times) ☐ Divorced (once) ☐ Divorced (multiple times) *
☐ Separated ☐ Widowed ☐ Significant relationship

Sexual Orientation:

○ Heterosexual ○ Homosexual ○ Bisexaual ○ Other *

Educational History: Please check the box which best describes your current situation.

○ Current Student ○ Some high school ○ High school graduate ○ Some college ○ Associate degree ○ Bachelor degree *
○ Graduate degree ○ Vocational training

Legal History:

Do you currently have any pending criminal charges? * ○ Yes ○ No

Are you on probation? * ○ Yes ○ No

Have you ever been arrested/convicted of a crime? * ○ Yes ○ No

Trauma History

Trauma History:

Have you ever experienced emotional abuse? * ○ Yes ○ No

Have you ever experienced physical abuse? * ○ Yes ○ No

Have you ever experienced sexual abuse? * ○ Yes ○ No

Have you ever experienced any other type of severe trauma? * ○ Yes ○ No

FAMILY PSYCHIATRIC HISTORY

Please select all that apply

Alchohol/Drug Addiction

Anxiety

Attention Deficit

Bipolar Spectrum

Depression

Eating Disorder

Post Traumatic Stress

Schizophrenia

Suicide or Suicide Attempt/s

Autism Spectrum

Other:

Please comment on any "other" family psychiatric history

Financial Policy Form

Page 1

CLARITY
INTEGRATIVE PSYCHIATRY

FINANCIAL POLICY

Thank you for choosing Clarity Psychiatry. As your mental healthcare provider, we are committed to providing you with the highest quality care. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due 24-48 hours in advance of your scheduled appointment and is required prior to your appointment in order for an appointment to be confirmed. Our office accepts debit and credit cards, HSA and FSA cards.

If no payment or arrangement has been made within 24 hours of your scheduled appointment, we will attempt to charge the card on file. If the card on file is not able to be charged, and we are unable to reach you, your appointment time may be forfeit.

☐ Please check if you have read and agree to the above statement.

Explanation of Fees and Charges

- We must emphasize that we are a cash-pay practice and our relationship is with you, our patient, and not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company and we are not currently in network with any insurance providers.
- As a courtesy to you we will send superbills to you, by request, and help process prior authorizations for your prescriptions. However, any and all appointment fees or office-related charges will be billed directly to you, the patient.
- Payment is required in order for an appointment to be confirmed. Payment for new patient appointments is requested 48 hours in advance and payment for all other appointment types are requested 24 hours in advance. Failure to complete your payment before this time frame may result in your appointment being rescheduled.
- Our 2024 appointment rates are as follows: $475 for a 90-minute New Patient Appointment, $375 for a 60-minute Appointment, $250 for a 40-minute First Follow-Up/Extended Follow-Up Appointment, and $185 for a 20-minute Standard Follow-Up Appointment.
- Our cancellation policy is: 48 hours notice required for a New Patient Appointment, 24 hours notice required for all other appointment types. Late Cancellations may result in the forfeit of 100% of the appointment charge.
- Other charges and fees include: $100 per 30 minutes for consultation calls and coordination of care calls with other providers, $40 per medication for medication refills, transfers, early refills, or bridge refills requested outside of a scheduled appointment, $25 per page for forms, letters, and other such paperwork that cannot be completed during a scheduled appointment, $20 for detailed email responses from Dr. Thomas regarding requested changes in patient plan or questions requiring a detailed email response, $15 for copies of medical records (first 25 pages) plus a per sheet charge of $0.15 thereafter.
- At this time, it is not customary in our practice to provide services related to short or long term disability paperwork.
- Rates and fees are subject to change. If changes are made, ample notice will be given to all patients.

☐ Please check if you have read and agree to the above statements.

Consent:

I have read, understand and agree to the above terms and conditions. I have reviewed the fees and charges and understand that payment is required for any appointment to be confirmed or services to be rendered. I understand that responsibility for payment for service provided in this office are due and payable at the time services are rendered unless financial arrangements have been made. By signing below, you are agreeing to any fees or charges that you may incur from your treatment and services provided by our office.

Responsible party's information

Who is the responsible party for payments? *

Responsible Party Signature *

Today's Date

01/02/2024

CLARITY
INTEGRATIVE PSYCHIATRY

Mood Disorder Questionnaire (MDQ)

Screens for bipolar symptoms linked to bipolar spectrum disorders.

First Name *

Last Name *

Date

01/02/2024

Part I

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

1. 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

2. you were so irritable that you shouted at people or started fights or arguments? *

○ Yes ○ No

3. you felt much more self-confident than usual? *

○ Yes ○ No

4. you got much less sleep than usual and found you didn't really miss it? *

○ Yes ○ No

5. you were much more talkative or spoke faster than usual? *

○ Yes ○ No

6. thoughts raced through your head or you couldn't slow your mind down? *

○ Yes ○ No

7. you were so easily distracted by things around you that you had troubleconcentrating or staying on track? *

○ Yes ○ No

8. you had much more energy than usual? *

○ Yes ○ No

9. you were much more active or did many more things than usual? *

○ Yes ○ No

10. you were much more social or outgoing than usual; for example, you telephonedfriends in the middle of the night? *

○ Yes ○ No

11. you were much more interested in sex than usual? *

○ Yes ○ No

Part II

14. If you checked YES to more than one of the above, have several of these ever happened during at least a four day period of time? *

○ Yes ○ No

15. Did any of the issues above cause significant problems - such as being unable to work; having family, money, or legal troubles; getting into arguments or fights? *

○ Yes ○ No

Final Scoring:

Each "Yes" response is +1. Each "No" response is +0. Please add up all "Yes" responses and indicate the total in the box below.

TOTAL SCORE	

Signature *

Date

01/02/2024

MDQ explained

Mood Disorder Questionnaire (MDQ) is a self-report screening tool that focuses on the recognition and prevalence of bipolar disorder signs.

This is used in the evaluation of outpatient psychiatric populations and refers to all the bipolar spectrum disorders (bipolar I, II and cyclothymia).

Bipolar disorder is a mental condition characterized by the alternation of periods of elation (manic episodes) with periods of depression and associated psychotic symptoms.

The MDQ consists of 15 questions divided in two parts. Part I contains 13 questions that refer to most common bipolar disorder symptoms whilst part II questions refer to family history of mental disease, past personal diagnoses and to perceived disease severity.

The questionnaire is straightforward and takes about 5 minutes to administer. The patients should be advised to reflect upon each question and to aim for answers that areas accurate as possible.

The questionnaire can be used in subsequent evaluation as well.

Result interpretation

The outcome of the MDQ screening method is classed as either positive or negative screen. Positive screening cases need to satisfy all three criteria:

- 7 positive answers out of the 13 questions in part I;
- Positive response to the first question of part II (question 14);
- Moderate or severe response to the second question of part II (question 15).

Patients who are rapidly and correctly screened can benefit from faster access to treatment if their symptoms are in the bipolar spectrum of mental diseases.

National DMDA studies have shown that when it comes to mental health disorders, up to70% of patients are initially misdiagnosed and may wait up to years to receive the correct diagnosis and a personalized treatment plan.

The sooner the diagnosis is put for patients with bipolar disorder and the sooner mood stabilizers and therapy are introduced, the more positive the outcomes.

Because this is also a mental illness with high rates of suicide, early screening and rapid initiation of treatment end up being the more important for patients at risk.

About the original study

The MDQ was created following a study by Hirschfeld

The self-report questionnaire was aimed at screening bipolar spectrum disorders. A separate research conducted telephone diagnostic interviews based on the bipolar module of the Structured Clinical Interview for DSM-IV.

Results have been compared and showed that a score of 7 or more in the MDQ yielded good sensitivity (0.73) and very good specificity (0.90).

The MDQ is recommended to be used in the screening of psychiatric out patient population.

Original source

Hirschfeld, R. et al. Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire

(https://www.ncbi.nlm.nih.gov/pubmed/11058490). American Journal of Psychiatry157:11 (November 2000) 1873-1875

Other references

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2. Lish JD, Dime-Meenan S, Whybrow PC, et al.

The National Depressive and Manic-Depressive Association (DMDA) survey of bipolar members

(https://www.ncbi.nlm.nih.gov/pubmed/7989643). J Aff ect Disord. 1994; 31:281–294.

3. Akiskal HS, Pinto O.

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(https://www.ncbi.nlm.nih.gov/pubmed/10550853). Psychiatr Clin North Am. 1999;22:517–524.