Date of Appointment: _____

## Patient Information

| Patient's First Name | Middle Name | Last Name (as it appears on insurance card or ID) |
|---|---|---|
| | | |

| Sex | ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabitating ☐ Single | Date of Birth | Social Security Number |
|---|---|---|---|
| | | | |

| Patient's Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone | Mobile Phone | Email Address |
|---|---|---|
| | | |

| Referred by | Primary Care Physician/Pediatrician | Primary Care Physician/Pediatrician Phone |
|---|---|---|
| | | |

| Pharmacy | Pharmacy Phone | Pharmacy Address |
|---|---|---|
| | | |

| Therapist/Counselor's Name | Therapist/Counselor's Phone Number |
|---|---|
| | |

### Patient Employer/School Information

| Employer/School | Occupation | Employer/School Phone |
|---|---|---|
| | | |

| Employer/School Address | City | State | Zip |
|---|---|---|---|
| | | | |

### Emergency Contact Information

| Emergency Contact Name | Emergency Contact Phone | Relation to Patient |
|---|---|---|
| | | |

## Billing and Insurance

### Primary Health Insurance

| Insurance Company | Plan |
|---|---|
| | |

| Plan Number | Group Number | Insured's Employer/School |
|---|---|---|
| | | |

| Insured's Name (as it appears on insurance card or ID) | Relation to Patient | Insured's Phone Number |
|---|---|---|
| | | |

| Insured's Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Insured's Social Security Number | Insured's Birthdate | If patient is under 18, is this the primary contact? ☐ Yes ☐ No If no, provide primary contact name, phone, and email |
|---|---|---|
| | | |

### Secondary Health Insurance

| Insurance Company | Plan |
|---|---|
| | |

| Plan Number | Group Number | Insured's Employer/School | Insured's Social Security Number |
|---|---|---|---|
| | | | |

| Insured's Name (as it appears on insurance card or ID) | Relation to Patient | Insured's Phone Number |
|---|---|---|
| | | |

### Responsible Party

☐ Same as primary insurer ☐ Same as secondary insurer ☐ Same as primary contact person/parent/guardian ☐ Other (fill out below)

| Billing Name | Phone | Relation to Patient |
|---|---|---|
| | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

_____ _____

Signature of Patient or Authorized Guardian | Date

Name: _____ Age: _____ Sex: _____ Date of Appointment: _____

## Reason for Visit

What brings you to the office today?

_____

_____

Date symptoms started _____

Have you lost any days from work or school? ☐ Yes ☐ No

## Medications

Have you ever taken the following medicines?

☐ SSRI (*eg* Prozac/fluoxetine, Paxil/paroxetine, Celexa/citalopram, Lexapro/escitalopram)

☐ Effexor/venlafaxine or Cymbalta/duloxetine

☐ Tricyclics (*eg* Elavil/amitryptyline, Pamelor/nortryptyline, Tofranil/imipramine, Anafranil/clomipramine)

☐ Wellbutrin/ buproprion

☐ Desyrel/trazodone, Serzone/nefazodone

☐ Mood stabilizers (*eg* Lithium, Tegretol/carbamazepine, Topramax/toprimate, Depakote/valproate, Lamictal/lamotrogine)

☐ Antipsychotic mood stabilizers (*eg* Seroquel/quetipine, Geodon/ziprasidone, Abilify/aripiprazole, Zyprexa/olanzapine, Haldol/haloperidol, Clozaril/clozapine, Prolixin/fluphenazine)

☐ Sleeping pills (*eg* Ambien/zolpidem, Desyrel/trazodone, Sonata/zaleplon, Restoril/temazepam)

☐ Anti-anxiety medicines (*eg* Ativan/lorzepam, Klonipin/clonazepam, Xanax/alprazolam, Valium/diazepam, Buspar/buspirone)

☐ ADHD medicines (*eg* Ritalin/Concerta/methylphenidate, Adderall/amphetamine, Strattera/atomoxetine)

List other medicines you are taking:

_____

_____

## Past Psychiatric History

Check all that apply:

☐ ADHD
☐ Anxiety
☐ Bipolar
☐ Depression
☐ Eating Disorder
☐ Phobia(s)
☐ Obsessive Compulsive
☐ Pre-Menstrual Dysphoric Disorder/PMS
☐ Post Traumatic Stress
☐ Schizophrenia
☐ Schizoaffective Disorder
☐ Substance Abuse
☐ Suicide Attempt

Have you seen a psychiatrist, psychologist or therapist/counselor in the past?

☐ Yes ☐ No When? _____

## Allergies

Are you allergic to any of the following?

☐ ACE Inhibitors
☐ Adhesive Tape
☐ Anesthetics
☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Iodine (including contrast dye)
☐ Latex
☐ Penicillin
☐ NSAIDs (Ibuprofen, Naprosyn, Advil)
☐ Seizure Medicines
☐ Sulfa

Details/Reactions: _____

_____

## Lifestyle Factors

Has anyone in your home ever physically, emotionally or sexually abused you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs? (Including abuse of prescription drugs)

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

# drinks/week _____

How much caffeine do you drink per day?

# drinks/day _____

How often do you exercise?

# times/week _____

Are you currently:

☐ Working ☐ Not Working by Choice ☐ Unemployed ☐ Disabled
☐ Retired ☐ Volunteering

Have you ever served in the military?

☐ Yes ☐ No

How would you identify your sexual orientation?

☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Asexual
☐ Transsexual ☐ Other ☐ Unsure/Questioning ☐ Prefer Not to Answer

Have you ever been arrested?

☐ Yes ☐ No

Do you have any pending legal problems?

☐ Yes ☐ No

Do you belong to a particular religion or spiritual group?

☐ Yes ☐ No Please list: _____

Highest Educational Level Attained:

☐ Grade School ☐ High School ☐ Junior College
☐ Undergraduate College/University ☐ Graduate School

Name: _____ Age: _____ Sex: _____ Date of Appointment: _____

## Past Medical History

Have you ever had any of the following?

- ☐ Anemia
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Head Injury
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Stomach Problems
- ☐ Thyroid Disease
- ☐ Other: _____

## Hospitalizations & Surgeries

Reason: Date:

_____ _____

_____ _____

Have you ever had an EKG?

☐ Yes ☐ No If yes, when? _____

Was the EKG: ☐ Normal ☐ Abnormal ☐ Not Sure

## Women Only

Are you currently pregnant or think you may be pregnant?

☐ Yes ☐ No

Are you planning to get pregnant in the near future?

☐ Yes ☐ No

Birth Control Method:

☐ Condoms ☐ Pill ☐ Shot ☐ Patch ☐ Ring ☐ Under Skin

☐ IUD ☐ Tubal Ligation ☐ Vasectomy in Partner ☐ Not Applicable

Date of Last Menstrual Cycle: _____

## Family History

Has anyone in your family (mother, father, siblings, grandparents) had a history of the following:

- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anger
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Obsessive Compulsive Disorder
- ☐ Phobias
- ☐ Post Traumatic Stress
- ☐ Schizophrenia
- ☐ Suicide Attempts or Thoughts
- ☐ Thyroid Disease
- ☐ Violence

Details: _____

## Review of Systems

### Psychological

- ☐ Anxiety Attacks
- ☐ Avoidance/Avoidant Personality Disorder
- ☐ Change in Appetite
- ☐ Decreased Libido
- ☐ Decrease Need For Sleep
- ☐ Excessive Energy
- ☐ Excessive Guilt
- ☐ Excessive Worry
- ☐ Fatigue
- ☐ Forgetfulness
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Racing Thoughts
- ☐ Sleeping problems
- ☐ Increased Irritability
- ☐ Increased Libido
- ☐ Increase in Risky Behavior
- ☐ Loss of Interest in Most Things
- ☐ Suicidal thoughts
- ☐ Suspiciousness
- ☐ Thoughts of harming or killing someone
- ☐ Trouble concentrating
- ☐ Unable to enjoy activities

### General

- ☐ Chills
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

### Gastrointestinal

- ☐ Abdominal Cramping/Pain
- ☐ Acid Taste
- ☐ Bloating
- ☐ Diarrhea
- ☐ Frequent Belching
- ☐ Indigestion
- ☐ Nausea

### Neurology

- ☐ Burning Pain
- ☐ Headache
- ☐ Seizures
- ☐ Tingling
- ☐ Tremor
- ☐ Visual Changes

### Ear, Nose & Throat

- ☐ Hearing Problem
- ☐ Hoarseness
- ☐ Ringing in Ears

### Cardiovascular

- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Lightheadedness
- ☐ Palpitations

### Musculoskeletal

- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Weakness

### Respiratory

- ☐ Chest Tightness
- ☐ Coughing
- ☐ Shortness of Breath
- ☐ Wheezing

☐ Other: _____