**PSYCHIATRIC CONSULTATION INTAKE FORM**

|  |  |
| --- | --- |
|  | **Providence Psychiatry Services, Ltd.****708 Division St. P.O. Box 680****Deer River, MN 56636****218-246-6286** **… *Bridging hope, healing and recovery….*** |

**Patient Contact Information**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact and Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May we leave a message on your home and/or cell phone?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY CARE PROVIDER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PSYCHOTHERAPIST NAME AND ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHARMACY NAME AND ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REFERRED BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADVANCED DIRECTIVE: ❑ Yes ❑No ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PSYCHIATRIC EVALUATION OR PSYCHOTHERAPY IN THE LAST 5 YEARS? ❑ Yes❑No**

**If yes, name of provider last seen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHAT IS YOUR PRIMARY MENTAL HEALTH CONCERN/QUESTION/PROBLEM TODAY?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOW LONG HAVE YOU BEEN DEALING WITH THIS ISSUE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOW IS THIS AFFECTING YOUR LIFE?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social History**

**Race/Ethnicity (Check one or more):**

* **American Indian/ Alaskan Native ❑Asian ❑ African-American ❑ Hispanic ❑ Caucasian**
* **Other**

**Current marital status (Check one):**

* **Single,never married ❑ Married,living together ❑ Separated ❑ Widowed ❑ Cohabiting with partner**
* **Divorced ❑ Married,not living together**

**If you are married or cohabitating with partner, how long has this been?**

**Total number of marriages?**

**How many children do you have?**

**Spouse's/Partners Name**

**Who else lives with you?**

**Are you in a relationship at this time? ❑ Yes ❑No**

**Trauma history**

**Have you ever been abused? ❑ Yes ❑ No**

**If yes: Verbal\_\_\_\_ Physical\_\_\_\_ Sexual\_\_\_\_\_**

**History of any other trauma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you feel safe at this time? ❑ Yes ❑No**

**Education/Vocation
Highest degree obtained: (Check only one)**

* **High school graduate ❑ G.E.D. ❑ 4 year college degree ❑ M.B.A./M.A./M.S./M.P.H. ❑ M.D.**
* **Junior college degree or technical school diploma ❑ J.D./LL.B. ❑ Ph.D ❑ Other
What best describes your current employment status?**
* **Unemployed, not looking for employment ❑ Unemployed, looking for employment ❑ Full-time Part-time employed ❑ Retired ❑ Self-employed ❑ On welfare ❑ Social security disability (date you were determined to be disabled)\_\_\_\_**

**What is your occupation?**

**Housing**

 **Current Residence**

* **Own my house/ condo ❑ Retirement Complex/Senior Housing ❑ Renting ❑ Apartment /Condominium**

**Spiritual:**

**Is faith an important part of your life? ❑ Yes ❑No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Military History**

**Have you ever served in the armed forces? ❑ Yes ❑No**

**Have you ever been involved in combat? ❑ Yes ❑No**

**Have you experienced any military related injuries/traumas? ❑ Yes ❑No**

**Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal History**

**Have you ever been committed before?** ❑ Yes ❑No **Dates: Please list previous convictions other than traffic violations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Currently on Parole/Probation:** ❑ Yes ❑No **Officer Name**

**Psychiatric History**

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

Depression\_\_\_ADHD\_\_\_\_\_\_\_Bipolar (Manic / Depressive) Disorder\_\_\_\_\_\_\_\_ Anxiety\_\_\_\_\_\_OCD\_\_\_\_\_\_\_ Trauma\_\_\_\_\_Schizophrenia\_\_\_\_\_ Psychosis\_\_\_\_\_\_\_\_Panic Attacks\_\_\_\_\_\_\_Alcohol Problems (including AA)

Anorexia/Bulimia\_\_\_\_Binge-eating\_\_\_\_\_Impulsive behaviors\_\_\_\_\_Compulsive behaviors\_\_\_\_Sleep issues\_\_\_\_\_ Drug Problems\_\_\_\_\_ECT treatment\_\_\_\_\_\_\_Other psychiatric issues\_\_\_\_\_\_

**Are you currently seeing a therapist?**

Name/contact #

**Have you ever seen a psychiatrist/psychotherapist before? If** yes, please
list:

**Have you ever attempted suicide: \_\_\_\_ yes\_\_\_\_\_\_no**

**Approximate date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list all prior psychiatric hospitalizations (if any), including**

**APPROXIMATE DATES, HOSPITAL NAME AND REASON FOR ADMISSION**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list any additional psychiatric treatment you have received including partial hospitalizations, intensive out pt treatments, group therapies, etc.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Answer the following questions as to how you have been feeling the last month:**

|  |  |  |  |
| --- | --- | --- | --- |
| **SYMPTOM** | **NO** | **YES** | **Comments** |
| I feel depressed most of the time |  |  |  |
| I can’t get to sleep |  |  |  |
| I have nightmares frequently |  |  |  |
| I keep awakening throughout the night |  |  |  |
| I wake up too early and can't fall back asleep |  |  |  |
| I take naps during the day |  |  |  |
| I try to go to bed and get up at the same time most days |  |  |  |
| I sleep too much |  |  |  |
| I don't have much of an appetite |  |  |  |
| My appetite is increased |  |  |  |
| I have little interest inactivities |  |  |  |
| I have little interest in being around other people |  |  |  |
| My energy level is low |  |  |  |
| I feel hopeless or helpless much of the time |  |  |  |
| I feel guilty or that **I** am a burden to others much of the time |  |  |  |
| **I** have little interest in sex |  |  |  |
| My concentration is poor |  |  |  |
| **SYMPTOM** | **NO** | **YES** | **COMMENTS** |
| **I** feel worthless much of the time |  |  |  |
| **I have thoughts I can't stop** |  |  |  |
| **I have behaviors I can't seem to stop (washing, cleaning, counting)** |  |  |  |
| **I feel anxious, nervous, or overwhelmed much of the time.** |  |  |  |
| **I worry too much** |  |  |  |
| **I feel restless much of the time** |  |  |  |
| **I often feel tired** |  |  |  |
| **I feel tense and tight in my muscles** |  |  |  |
| **I feel irritable, edgy, or crabby much of the time** |  |  |  |
| **I'm so nervous/anxious that Idon't want to leave my house** |  |  |  |
| **I'm afraid to go places by myself** |  |  |  |
| **When I get anxious/nervous my heart starts to beat too fast** |  |  |  |
| **When I get anxious/nervous I easily break out in a sweat** |  |  |  |
| **When I get anxious I feel dizzy and faint** |  |  |  |
| **When I get anxious/nervous I get shaky** |  |  |  |
| **When I get anxious/nervous I feel short of breath** |  |  |  |
| **SYMPTOM** | **NO** | **YES** | **COMMENTS:** |
| **I often have headaches and or stomach aches** |  |  |  |
| **When I get anxious/nervous I feel tingling in my hands/feet** |  |  |  |
| **When I get anxious/nervous I feel hot** |  |  |  |
| **I often feel too happy or high** |  |  |  |
| **I have a hard time controlling my temper/anger** |  |  |  |
| **People say I talk too fast** |  |  |  |
| **I don't need to sleep much and I don't feel very tired** |  |  |  |
| **My thoughts are too fast** |  |  |  |
| **People say I have too much energy** |  |  |  |
| **I often feel like I can take on the world** |  |  |  |
| **I can't control my sexual urges** |  |  |  |
| **I hear people talking to me when I am all alone** |  |  |  |
| **I think they are talking about me on the radio or TV** |  |  |  |
| **I think other people can read my thoughts** |  |  |  |
| **I think I see things that other people don't see** |  |  |  |
| **I binge on food** |  |  |  |
| **SYMPTOM** | **NO** | **YES** | **COMMENTS:** |
| **I make myself throw up if I eat too much** |  |  |  |
| **I have a history of refusing to eat** |  |  |  |
| **I have caused myself****financial problems because of gambling** |  |  |  |
| **I have suicidal thoughts** |  |  |  |
| **I feel I could act on mysuicidal thoughts** |  |  |  |

**Please List all current medications below (** include birth control pills, over the counter medication and herbal remedies ( i.e. decongestants, St. John's Wort etc) :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

:**Please review the following list of medications, and complete questions for any medications taken in the past and/or currently:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **BrandName** | **Generic** | **Check** **If yes** | **How long did you take it?** | **What Dose did you take? Mg/day** | **Did it help?****Check if yes** | **How often In a day? Write 1, 2 or 3 times a day** | **Side effects** |
| **Luvox** | **Fluvoxamine** |  |  |  |  |  |  |
| **Paxil** | **Paroxetine** |  |  |  |  |  |  |
| **Celexa** | **Citalopram** |  |  |  |  |  |  |
| **Lexapro** | **Escitalopram** |  |  |  |  |  |  |
| **Zoloft** | **Sertraline** |  |  |  |  |  |  |
| **Prozac** | **Fluoxetine** |  |  |  |  |  |  |
| **Effexor** | **Venlafaxine** |  |  |  |  |  |  |
| **Pristiq** | **Desvenlafaxine** |  |  |  |  |  |  |
| **Cymbalta** | **Duloxetine** |  |  |  |  |  |  |
| **Desyrel** | **Trazodone** |  |  |  |  |  |  |
| **Serzone** | **Nefazodone** |  |  |  |  |  |  |
| **Welibutrin** | **Bupropion** |  |  |  |  |  |  |
| **Remeron** | **Mirtazapine** |  |  |  |  |  |  |
| **Viibryd** | **Vilazodone** |  |  |  |  |  |  |
| **Adapin** | **Doxepin** |  |  |  |  |  |  |
| **Anafranil** | **Clomipramine** |  |  |  |  |  |  |
| **Elavil** | **Amitriptyline** |  |  |  |  |  |  |
| **Pamelor** | **Nortriptyline** |  |  |  |  |  |  |
| **Tofranil** | **Imipramine** |  |  |  |  |  |  |
| **BRAND NAME** | **GENERIC** | **YES** | **HOW LONG?** | **DAILY DOSE**? | **HELPFUL?** | **FREQUENCY OF DOSING** | **SIDE EFFECTS** |
| **Depakote** | **Valporic Acid** |  |  |  |  |  |  |
| **Lithium**  | **Lithium** |  |  |  |  |  |  |
| **Tegretol** | **Carbamazepine** |  |  |  |  |  |  |
| **Gabapentin** | **Neurontin** |  |  |  |  |  |  |
| **Trileptal** | **Oxcarbazepine** |  |  |  |  |  |  |
| **Lamictal** | **Lamotrogine** |  |  |  |  |  |  |
| **Topamax** | **Topiramate** |  |  |  |  |  |  |
| **Clozaril** | **Clozapine** |  |  |  |  |  |  |
| **Risperdal** | **Risperidone** |  |  |  |  |  |  |
| **Zyprexa** | **Olanzapine** |  |  |  |  |  |  |
| **Seroquel** | **Quetiapine** |  |  |  |  |  |  |
| **Geodon** | **Ziprasidone** |  |  |  |  |  |  |
| **Abilify** | **Ariprazole** |  |  |  |  |  |  |
| **Latuda** | **Lurasidone** |  |  |  |  |  |  |
| **Invega** | **Paliperidone** |  |  |  |  |  |  |
| **Saphis** | **Asenapine** |  |  |  |  |  |  |
| **Fanapt** | **Iloperidone** |  |  |  |  |  |  |
| **Thorazine** | **Chlorpromazine** |  |  |  |  |  |  |
| **Prolixin** | **Fluphenazine** |  |  |  |  |  |  |
| **Haldol** | **Haloperidol** |  |  |  |  |  |  |
| **Trilafon** | **Perphenazine** |  |  |  |  |  |  |
| **Navane** | **Thiothixene** |  |  |  |  |  |  |
| **Mellaril** | **Thioridazine** |  |  |  |  |  |  |
| **Brand name** | **Generic** | **YES** | **HOW LONG** | **DAILY DOSE** | **HELPFUL?** | **FREQUENCY** | **SIDE EFFECTS** |
| **Stelazine** | **Trifluoperazine** |  |  |  |  |  |  |
| **Loxitane** | **Loxapine** |  |  |  |  |  |  |
| **Xanax** | **Alprazolam** |  |  |  |  |  |  |
| **Ativan** | **Lorazepam** |  |  |  |  |  |  |
| **Klonopin** | **Clonazepam** |  |  |  |  |  |  |
| **Valium** | **Diazepam** |  |  |  |  |  |  |
| **Buspar** | **Buspirone** |  |  |  |  |  |  |
| **Clonidine** | **Minipress** |  |  |  |  |  |  |
| **Propranolol** | **Inderal** |  |  |  |  |  |  |
| **Ambien** | **Zolpidem** |  |  |  |  |  |  |
| **Sonata** | **Zaleplon** |  |  |  |  |  |  |
| **Restoril** | **Temazepam** |  |  |  |  |  |  |
| **Lunesta** | **Eszopiclone** |  |  |  |  |  |  |
| **Melatonin** | **Melatonin** |  |  |  |  |  |  |
| **Benadryl** |  |  |  |  |  |  |  |
| **Hydroxyzine** | **Vistaril/Atarax** |  |  |  |  |  |  |
| **Doxepin** |  |  |  |  |  |  |  |
| **Rozarem** | **Ramelteon** |  |  |  |  |  |  |
| **Naltrexone** | **Revia** |  |  |  |  |  |  |
| **Campral** | **Acamprosate** |  |  |  |  |  |  |
| **Adderall** | **Amphetamine** |  |  |  |  |  |  |
| **Ritalin/****Concerta** | **Methylphenidate** |  |  |  |  |  |  |
| **Strattera** | **Atomoxitine** |  |  |  |  |  |  |

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Father** | **Mother** | **Aunt** | **Uncle** | **Brother** | **Sister** | **Child** | **Grand parent** |
| **Depression** |  |  |  |  |  |  |  |  |
| **Anxiety** |  |  |  |  |  |  |  |  |
| **Panic Attacks** |  |  |  |  |  |  |  |  |
| **Post Traumatic Stress** |  |  |  |  |  |  |  |  |
| **Bipolar** |  |  |  |  |  |  |  |  |
| **Schizophrenia** |  |  |  |  |  |  |  |  |
| **Alcohol Problems** |  |  |  |  |  |  |  |  |
| **Drug Problems** |  |  |  |  |  |  |  |  |
| **ADHD** |  |  |  |  |  |  |  |  |
| **Suicide Attempt** |  |  |  |  |  |  |  |  |
| **Psychiatric Hospitalization** |  |  |  |  |  |  |  |  |

**Medical History:** Do you have, or have you ever had any of the following (please check all that apply)? **Please write in your medical problem in each category:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Mark X |  | Mark X |  | Mark X |
| High BloodPressure |  | GI Problems (ulcers,pancreatitis, irritablebowel, colitis) |  | Viral Illness (Herpes, Epstein Barr, 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 |  | HIV or AIDS |  |
| Seizures |  | Ear/Nose/ThroatProblems |  | Head Injury |  |
| Other: |  | High Cholesterol |  | Sleep Apnea |  |

**List all prior surgeries and hospitalizations for medical illnesses:**

**CHEMICAL DEPENDENCY HISTORY**

1. **Have you ever felt you needed to Cut down on your drinking?**
2. **Have people Annoyed you by criticizing your drinking?**
3. **Have you ever felt Guilty about drinking?**
4. **Have you ever felt you needed a drink first thing in the morning (Eye-opener) to steady your nerves or to get rid of a hangover?**[**[**](https://en.wikipedia.org/wiki/CAGE_questionnaire#cite_note-1)

Regarding alcohol, when was your last drink?

In the past 30 days, about how many of those 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? drinks

DUI DWI Public Intoxication Seizures DT's

Number of previous CD treatments- Inpatient Outpatient
**Please check the appropriate boxes that apply for the following substances:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **NeverUsed** | **Age of First Use** | **LastUsedDate** | **AgePeakUse** | **History of****Abuse** | **Current Use and Frequency** |
| Cocaine |  |  |  |  |  |  |
| Amphetamine or Meth |  |  |  |  |  |  |
| Marijuana |  |  |  |  |  |  |
| Diet Pills |  |  |  |  |  |  |
| Hallucinogens |  |  |  |  |  |  |
| Ecstasy |  |  |  |  |  |  |
| Pain Pills/Opiates |  |  |  |  |  |  |
| Tranquilizers, Sleeping Pills |  |  |  |  |  |  |
| PCP |  |  |  |  |  |  |
| Heroin |  |  |  |  |  |  |
| Benzodiazepines |  |  |  |  |  |  |
| Anabolic Steroids |  |  |  |  |  |  |

**Do you use tobacco? ❑ Yes ❑ No**

**Cigarettes/Chew(circle one) How much daily?**

**Do you use caffeine daily? ❑ Yes ❑ No**

 **How much?**

**Are there any other addictions or concerning behaviors we should be aware of? 0 Yes ❑ No**

**If yes please explain**

**Female Health History**

**Last menstrual period (if applicable)**

**Contraceptive method:**

**Number of Pregnancies**

**Number of Living Children and Age of Child (ren):**

**Previous Miscarriage ❑ Yes ❑No**

**Previous Selected Abortion ❑ Yes ❑No**

**Currently Pregnant ❑ Yes ❑No**