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PERSONAL INFORMATION - Please fill out this form as completely as you can. Please *print* your answers.

Date		Gender	
Full Name		Ethnicity	
Birthdate		Marital Status	
Social Security Number		Occupation	

Contact Information - Please give your *home* address. Please circle the appropriate letter letting me know if I can leave a full message (M), call-back number only (C), or no message (N).

Address		Home Phone		M C N
City		Cell Phone		M C N
State		Work Phone		M C N
Zip		Email		M C N

Emergency Contact - Please tell me the name of someone to contact in an emergency.

Name		Relationship	
Address		Home Phone	
City		Cell Phone	
State		Work Phone	
Zip		Email	

Insurance Information - Although I do not participate with any insurance plans, it is sometimes helpful for me to have your insurance information in case you need hospitalization.

Plan Name	
Subscriber	
Policy Number	
Group Number	
Phone	

Referral Source - Please tell me who suggested that you see me.

Name	
Phone	
Relationship to you	

Pharmacy - Please provide contact information for the primary pharmacy you use for your prescriptions.

Pharmacy Name/Location/ Phone	

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DOCTORS AND THERAPISTS - Please list *all* doctors and therapists you see regularly. Please also list any *past psychiatrists and therapists.* Continue on back if needed.

Name		Past or Current? (Circle one)
Phone		When Last Seen:
Fax		
Type of Doctor		

Name		Past or Current? (Circle one)
Phone		When Last Seen:
Fax		
Type of Doctor		

Name		Past or Current? (Circle one)
Phone		When Last Seen:
Fax		
Type of Doctor		

Name		Past or Current? (Circle one)
Phone		When Last Seen:
Fax		
Type of Doctor		

Name		Past or Current? (Circle one)
Phone		When Last Seen:
Fax		
Type of Doctor		

MEDICAL HISTORY

Medical Problems - Please list all major medical problems/injuries and treatments. Continues on next page. Continue on back if needed.

Medical Problem	When Diagnosed	Treatment(s)	When Treated

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Medical Problem	When Diagnosed	Treatment(s)	When Treated

Surgeries - Please list all surgeries you have had, when and for what conditions. Continue on back if needed.

Operation	When Performed	Reason for Procedure

Current Medications and Supplements - Please list *all* medications and supplements (prescribed and over-the-counter) you take regularly. Continue on back if needed.

Medication or Supplement	Dose	Frequency	Reason You Take It

Allergies and Adverse Reactions - Please list any medications or foods to which you have had a bad reaction, including problems with anesthesia. Continue on back if needed.

Medication or Food	Reaction

Recent Symptoms and Tests - Please check any symptoms or tests you have had in the past year. Please indicate which body part was tested where applicable (Xray of: chest, e.g.). Continues on next page. Continue on back if needed.

☐ Fatigue	☐ Swollen legs/feet	☐ Bloody/pink urine	☐ Memory problems
☐ Fever	☐ Pain on walking	☐ Cola-colored urine	☐ Coordination problems
☐ Weight loss OR gain	☐ Trouble/pain with swallowing	☐ Abnormal vaginal bleeding	☐ Seizures

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☐ Night sweats	☐ Heatburn	☐ Missed menstrual period(s)	☐ X-ray of:
☐ Enlarged lymph nodes	☐ Belly pain	☐ Vaginal OR penile discharge	
☐ Heat OR cold intolerance	☐ Bloating	☐ Anemia	☐ CT scan of:
☐ Increased urination	☐ Nausea/vomiting	☐ Easy bruising/bleeding	
☐ Increased thirst	☐ Diarrhea	☐ Rash/itching	☐ MRI of:
☐ Increased appetite	☐ Constipation	☐ Changes in moles	
☐ Hair loss	☐ Bowel habit change	☐ Lump/swelling of testicle	☐ Ultrasound scan of:
☐ Vision problems	☐ Blood in stool	☐ Breast lump/new discharge/skin change	
☐ Light hurts your eyes	☐ Black stool	☐ Joint/muscle pain	☐ EKG/stress test
☐ Hearing problems	☐ Clay-colored stool	☐ Limb weakness/ numbness	☐ EEG
☐ Ear pain/discharge	☐ Loss of appetite	☐ Headaches	☐ Others:
☐ Nosebleeds	☐ Yellow skin/eyes	☐ Dizzy spells	
☐ Mouth sores	☐ Trouble urinating	☐ Fainting/loss of consciousness	

Substance Use History- For any substances you have ever used, please indicate date of last use, the maximum amount and frequency used, and whether ever used intravenously if applicable. Continues on next page. Continue on back if needed.

Substance	When Last Used	Maxium Amount	Maximum Frequency	If Applies, Ever Used I.V.?
Alcohol				Y N
Cocaine				Y N
Ecstasy/LSD/mushrooms/ other hallucinogen				Y N
Glue/paint/other inhalant				Y N
Ketamine				Y N
Marijuana				Y N
Heroin/methadone/ prescription pain pills				Y N
Amphetamines/other stimulants				Y N

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Substance	When Last Used	Maxium Amount	Maximum Frequency	If Applies, Ever Used I.V.?
Sedatives (Xanax, e.g.)				Y N
Tobacco Products				Y N
Others:				Y N

PSYCHIATRIC HISTORY

Past Psychiatric Hospitalizations - Please list any *psychiatric* hospitalizations you have had. Continue on back if needed.

Hospital	When Hospitalized	Reason Admitted

Psychiatric Medications - Please check any medications you have taken and list any *psychiatric* medications you have taken that are not listed. Continues on next page. Continue on back if needed.

☐ Adderall/ amphetamine	☐ Cymbalta/ duloxetine	☐ Haldol/haloperidol	☐ Moban/molindone	☐ Prozac/ fluoxetine
☐ Anafranil/ clomipramine	☐ Depakene/ Depakote/divalproex sodium/valproic acid	☐ Invega/paliperidone	☐ Nardil/phenelzine	☐ Remeron/ mirtazapine
☐ Abilify/ aripiprazole	☐ Desyrel/trazodone	☐ Klonopin/ clonazepam	☐ Navane/ thiothixine	☐ Risperdal/ risperidone
☐ Asendin/ amoxapine	☐ Dexedrine/ dextroamphetamine	☐ Lamictal/lamotrigine	☐ Neurontin/ gabapentin	☐ Ritalin/ methylphenidate
☐ Ativan/ lorazepam	☐ Effexor/ venlafaxine	☐ Latuda/lurasidone	☐ Norpramin/ desipramine	☐ Saphris/ asenapine
☐ BuSpar/ buspirone	☐ Elavil/amitriptyline	☐ Librium/ chlordiazepoxide	☐ Pamelor/ nortriptyline	☐ Serax/ oxazepam
☐ Celexa/ citalopram	☐ Emsam/selegeline	☐ Lexapro/ escitalopram	☐ Parnate/ tranylcypromine	☐ Serentil/ mesoridazine
☐ Clozaril/ clozapine	☐ Eskalith/Lithobid/ Lithonate/lithium	☐ Loxitane/loxapine	☐ Paxil/paroxetine	☐ Seroquel/ quetiapine
☐ Concerta/ methylphenidate	☐ Fanapt/iloperidone	☐ Luvox/fluvoxamine	☐ Pristiq/ desvenlafaxine	☐ Saphris/ asenapine
☐ Cylert/pemoline	☐ Geodon/ ziprasidone	☐ Mellaril/thioridazine	☐ Prolixin/ fluphenazine	☐ Serax/ oxazepam

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☐ Serentil/ mesoridazine	☐ Surmontil/ trimipramine	☐ Tranxene/ chlorazepate	☐ Vivactil/ protriptyline	☐ Zyprexa/ olanzapine
☐ Seroquel/ quetiapine	☐ Tegretol/ carbamazepine	☐ Trilafon/ perphenazine	☐ Vyvanse/ lisdexamphetamine	☐ Others:
☐ Serzone/ nefazodone	☐ Thorazine/ chlorpromazine	☐ Trileptal/ oxcarbazepine	☐ Wellbutrin/ buproprion	
☐ Sinequan/ doxepin	☐ Tofranil/ imipramine	☐ Valium/diazepam	☐ Xanax/alprazolam	
☐ Stelazine/ trifluoperazine	☐ Topamax/ topiramate	☐ Viibrid/vilazodone	☐ Zoloft/sertraline	

Family Psychiatric History - Please list any *blood* relatives diagnosed with a mental illness. (*One* relative per row please.) Continue on back if needed.

Relative (one per row)	Gender (circle one)	Diagnosis (check all that apply)		Treatment (check all that apply)
	M F	☐ Depression ☐ Anxiety ☐ Bipolar disorder	☐ Schizophrenia ☐ Other:	☐ Therapy/counseling ☐ Medication ☐ Hospitalization
	M F	☐ Depression ☐ Anxiety ☐ Bipolar disorder	☐ Schizophrenia ☐ Other:	☐ Therapy/counseling ☐ Medication ☐ Hospitalization
	M F	☐ Depression ☐ Anxiety ☐ Bipolar disorder	☐ Schizophrenia ☐ Other:	☐ Therapy/counseling ☐ Medication ☐ Hospitalization
	M F	☐ Depression ☐ Anxiety ☐ Bipolar disorder	☐ Schizophrenia ☐ Other:	☐ Therapy/counseling ☐ Medication ☐ Hospitalization
	M F	☐ Depression ☐ Anxiety ☐ Bipolar disorder	☐ Schizophrenia ☐ Other:	☐ Therapy/counseling ☐ Medication ☐ Hospitalization

Family Suicide History - Please list any *blood* relatives who have committed suicide. Continue on back if needed.

Relative	Age at Suicide	Gender (circle one)
		M F
		M F
		M F
		M F
		M F
		M F
		M F

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Recent Psychiatric Symptoms - Please check any symptoms you have had during the past two weeks (or longer).

☐ Sad OR don't care	☐ Difficulty at work	☐ Cutting/hurting self	☐ Involuntary movements
☐ Trouble concentrating	☐ Interacting less	☐ Too much energy	☐ Hearing/seeing things
☐ Appetite increase OR decrease	☐ Can't make decisions	☐ Less need for sleep	☐ Need to count/check things
☐ Poor energy	☐ Don't enjoy things	☐ Impulsive/dangerous acts	☐ Generalized anxiety/ panic attacks
☐ Poor motivation	☐ Not good at things	☐ Racing thoughts/ talkative	☐ Afraid of/avoid things
☐ Trouble sleeping	☐ Guilt over bad deeds	☐ Lots of new plans	☐ Can't throw things away
☐ Sleeping too much	☐ Deserve punishment	☐ Don't trust people	☐ Binge eating
☐ Trouble getting started	☐ Worry about health	☐ Thoughts being inserted into your head	☐ Afraid to get fat
☐ Not getting out	☐ Worthless/hopeless	☐ Thoughts being blocked	☐ Starving self to control weight
☐ Irritability	☐ Life not worth living	☐ Thoughts being broadcast	☐ Vomiting/laxative use to control weight
☐ Interpersonal trouble	☐ Thoughts of suicide	☐ Getting messages from TV/radio	☐ Overexercising to control weight

WOMEN'S HISTORY QUESTIONS (for female patients only)

Family History - Please list any *female blood* relatives who suffered from an episode of mental illness within one year *after* giving birth. (*One* relative per row, please.) Continue on back if needed.

Female Relative	Post-Partum Diagnosis (check all that apply)	
	☐ Depression ☐ Anxiety ☐ Bipolar disorder	☐ Schizophrenia ☐ Other:
	☐ Depression ☐ Anxiety ☐ Bipolar disorder	☐ Schizophrenia ☐ Other:
	☐ Depression ☐ Anxiety ☐ Bipolar disorder	☐ Schizophrenia ☐ Other:
	☐ Depression ☐ Anxiety ☐ Bipolar disorder	☐ Schizophrenia ☐ Other:
	☐ Depression ☐ Anxiety ☐ Bipolar disorder	☐ Schizophrenia ☐ Other:

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Reproductive Events - Please indicate the number of events and when they occurred. Continue on back if needed.

Event	Number	When Occurred
Pregnancies resulting in live birth		
Miscarriages		
Elective abortions		
Stillbirths or loss after 20 weeks gestation		

Menstrual History

How old were you when you got your first menstrual period?	Age:
Have your cycles been regular?	Circle one: Y N
Are they regular now?	Circle one: Y N
When was your last menstrual period?	Date: _____/_____/_____

Premenstrual Symptoms - Have you experienced symptoms that *start before your period and stop with bleeding onset?* Please check severity level of each.

Symptom	None	Mild	Moderate	Severe
Depressed mood/hopelessness/self-deprecating thoughts				
Anxiety/tension/feelings of being “keyed up” or “on edge”				
Easily sad/tearful/increased sensitivity to rejection				
Anger/irritability				
Decreased interest in usual activities				
Difficulty concentrating				
Fatigue/lack of energy				
Overeating/specific food cravings				
Insomnia OR sleeping more than usual				
Feeling overwhelmed/out of control				
Breast tenderness, headache, joint/muscle pain, bloating, weight gain				
How badly have these symptoms interfered with your:	**None**	**Mild**	**Moderate**	**Severe**
Work efficiency?				
Home responsibilities?				
Social activities?				
Relationships with family, friends and coworkers?				

If yes to any of the above symptoms, **do they occur with every or most cycle(s)? Y N**

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Reproductive Treatments and Mood Effects - Please indicate whether hormone treatments have affected your mood in any way. Continue on back if needed.

Have you ever used a hormone birth control method (pills, Nuva Ring, Patch, IUD) or other hormone treatment (such as for polycystic ovarian syndrome or missed menses) or hormone replacement therapy? If yes, which treatments?	Y N
If yes, did you experience any mood changes (better or worse) with these treatments? If yes, please describe:	Y N

Post-Partum Mood Symptoms

Have you experienced any mood symptoms that started within 4 weeks of delivery or pregnancy termination? If yes, please describe:	Y N