

Personal Information

Instructions Please fill out this form as completely as you can. *Print your answers.*

Identification For **Race** below, " **A** " means Asian, " **N** " means Native American.

Today's Date	<input type="text"/>	Marital Status	S M D W
First Name	<input type="text"/>	Race	W B H A N
Last Name	<input type="text"/>	Gender	M F
Date of Birth	<input type="text"/>	Occupation	<input type="text"/>

Address and Phones Please give your *home* address. Circle " **M** " if it is OK for me to leave a full message there, " **C** " if a callback message is OK, and " **N** " if it isn't OK to call or leave a callback number there.

Street Address	<input type="text"/>	Cell Phone	<input type="text"/>	M C N
	<input type="text"/>	Home Phone	<input type="text"/>	M C N
City	<input type="text"/>	Fax	<input type="text"/>	M C N
State	<input type="text"/>	Business Phone	<input type="text"/>	M C N
Zip	<input type="text"/>	Email	<input type="text"/>	M C N

Emergency Contact Please tell me the name of someone to contact in case of an emergency. If any information is the same in the table above, you can write "Same".

Name	<input type="text"/>	Relationship	<input type="text"/>
Street Address	<input type="text"/>	Cell Phone	<input type="text"/>
	<input type="text"/>	Home Phone	<input type="text"/>
City	<input type="text"/>	Fax	<input type="text"/>
State	<input type="text"/>	Business Phone	<input type="text"/>
Zip	<input type="text"/>	Email	<input type="text"/>

Continued on next page

Personal Information, Continued

Allergies and Bad Reactions

Please list any medications or foods to which you have had a bad reaction, such as an allergy or side effect that required you to stop taking the medication or eating the food. Use another sheet of paper if you have to.

Example:

Medication or Food	Reaction
<i>Penicillin</i>	<i>Rash</i>

Medication or Food	Reaction

Current Medications and Supplements

Please list **ALL** medications and supplements that you take. Include drugs that are prescribed by a doctor, any vitamins or herbal supplements, and any over-the-counter drugs that you take more than once every two weeks or so.

Example:

Medication	Dose	How Often?	Why?
<i>Asprin</i>	<i>325 mg</i>	<i>2 x week</i>	<i>Headache</i>

Medication	Dose	How Often?	Why?

Continued on next page

Personal Information, Continued

Insurance

Although I do not participate with any insurance companies, it is often helpful to me to have the following information should you need laboratory tests, an EKG, or hospitalization.

Primary Insurance		Subscriber's name	
Policy #		Group #	
Your relationship to subscriber		Subscriber's employer	
Subscriber's Employer		Phone	
Secondary Insurance		Subscriber's name	
Policy #		Group #	
Your relationship to subscriber		Subscriber's employer	
Subscriber's Employer		Phone	

Provider Information

Instructions

Please fill out this form for each of your health providers, including doctors, therapists, pharmacies, alternative health practitioners, and anyone else you see regularly, such as a physical therapist. You do not have to include dentists, or optometrists. *Print your answers.*

Example:

Name	<i>Jane Doe</i>	Phone	<i>410 123 4567</i>
Role	<i>Internist</i>	Fax	<i>410 123 4568</i>
Why do you see?	<i>Family doctor</i>		

Example:

Name	<i>Rite-Aid</i>	Phone	<i>410 423 4567</i>
Role	<i>Pharmacy</i>	Fax	<i>410 523 4568</i>
Why do you see?	<i>Neighborhood drugstore</i>		

Name		Phone	
Role		Fax	
Why do you see?			

Name		Phone	
Role		Fax	
Why do you see?			

Name		Phone	
Role		Fax	
Why do you see?			

Continued on next page

Provider Information, Continued

Name		Phone	
Role		Fax	
Why do you see?			

Name		Phone	
Role		Fax	
Why do you see?			

Name		Phone	
Role		Fax	
Why do you see?			

Name		Phone	
Role		Fax	
Why do you see?			

Name		Phone	
Role		Fax	
Why do you see?			

Name		Phone	
Role		Fax	
Why do you see?			

Medical History

Medical problems

Please mark whether you or a blood-related family member (parent, sibling, grandparent, aunt or uncle) have had this medical problem now or in the past.

Now	Past	Family	Problem	Now	Past	Family	Problem
			Alcoholism				Other genetic diseases
			Anemia				Hay fever
			Anesthesia problem				Hearing problems
			Arthritis				High cholesterol
			Asthma				High blood pressure
			Bleeding problem				Immune disease
			Cancer, Breast				Kidney diseases
			Cancer, Colon				Mental retardation
			Cancer, Melanoma				Osteoporosis
			Cancer, Ovary				Epilepsy (seizure)
			Cancer, Prostate				Stroke
			Heart Attack				Substance abuse
			Birth Defects				Thyroid disorder
			Diabetes (childhood)				Smoking
			Diabetes (adult onset)				Tuberculosis
			Eczema				Migraines
			Food allergies				Gout
			AIDS/HIV				Glaucoma
			Hepatitis				Other
			Emphysema				Other

Substances

Please mark whether you are currently using any of the following substances now or in the past, whether prescribed or not.

Now	Past	Substance	Now	Past	Substance
		Alcohol			Mescaline
		Amphetamines			Methadone
		Cocaine			Opiates
		Ecstasy			PCP
		Hallucinogens			Peyote
		Heroin			Ritalin
		Illicit prescription drugs			Sedatives
		Ketamine			Other street drugs
		LSD			Tobacco products
		Marijuana			Tranquilizers

Continued on next page

Medical History, Continued

Symptoms and tests

Please circle whether you have had any of the following problems or tests in the **LAST YEAR**.

- | | | |
|------------------------------------|--------------------------------|--------------------------------|
| Unexplained weight gain of 20 lbs | High blood pressure | Prolonged bleeding |
| Unexplained weight loss of 20 lbs | Heart murmur | Swollen lymph glands |
| Heat intolerance | Fainting episode | Anemia |
| Cold intolerance | Cardiovascular disease | Leukemia |
| Excessive appetite | Difficulty or pain swallowing | Blood disorder |
| Unusual thirst | Frequent vomiting | Persistent rash |
| Abnormal hair growth | Persistent gas, heartburn | Moles changed in size or color |
| Change in sexual drive | Frequent belly pain | Lumps or soreness of breast |
| Frequent eye pain | Persistent constipation | Bloody discharge from nipples |
| Failing vision | Change in bowel habits | Psoriasis |
| Hearing troubles | Blood in stool | Broken bone |
| Ear pain or discharge | Blood on toilet paper | Back pain |
| Severe nosebleeds | Black or tarry stools | Headaches |
| Painful teeth | Loss of appetite | Double vision |
| Persistent sores on lips or tongue | Ulcer | Dizzy spells |
| Persistent hoarseness | Jaundice or hepatitis | Blackouts |
| Loss of vision in one or both eyes | Diverticulitis | Lost ability to speak |
| Retinal detachment | Gall stones | Troubles with memory |
| Cataract | Polyp or tumor of bowel | Coordination problems |
| Eye, Ear, Nose, Throat surgery | Abdominal surgery | Stroke |
| Daily cough | Trouble passing urine | Seizure |
| Severe snoring | Bloody urine | Paralysis |
| Asthma | Kidney or bladder infection | Multiple sclerosis |
| Skipped or irregular heartbeat | Treatment for venereal disease | X-Rays |
| Chest pain or discomfort | Kidney or bladder surgery | MRI |
| Shortness of breath | Discharge from penis | CT |
| Swollen ankles or feet | Lump or swelling of testicle | EEG |
| Leg cramps brought on by walking | Decrease in erections | EKG |
-

Psychiatric History

Past Medications

The medications below are sometimes prescribed for psychiatric problems. Please circle any that you have taken in the past.

- | | | | |
|-------------------|-------------------|-----------------|-----------------|
| Abilify | diazepam | metamphetamine | Rozeram |
| Adderall | divalproex sodium | Methylin | Serax |
| alprazolam | doxepin | methylphenidate | Serentil |
| Ambien | Effexor | mirtazapine | Seroquel |
| amitriptyline | Elavil | Moban | sertraline |
| amoxapine | escitalopram | Modafanil | Serzone |
| amphetamine | Eskalith | molindone | Sinequan |
| Anafranil | fluoxetine | Nardil | Stelazine |
| Antabuse | fluphenazine | Navane | Strattera |
| Asendin | flurazepam | nefazodone | Surmontil |
| atenolol | fluvoxamine | Neurontin | Tegretol |
| Ativan | Focalin | Norpramin | temazepam |
| atomoxetine | gabapentin | nortriptyline | Tenormin |
| Aventyl | Geodon | olanzapine | thioridazine |
| bupropion | Halcion | Orap | thiothixene |
| Buspar | Haldol | oxazepam | Thorazine |
| bupirone | haloperidol | Pamelor | Tofranil |
| carbamazepine | imipramine | Parnate | Topamax |
| Carbatrol | Inderal | paroxetine | topiramate |
| Celexa | Klonopin | Paxil | Tranxene |
| Centrax | Lamictal | pemoline | tranylcypromine |
| chlordiazepoxide | lamotrigine | perphenazine | trazodone |
| chlorpromazine | Lexapro | phenelzine | triazolam |
| citalopram | Librium | Pimozide | trifluoperazine |
| clomipramine | lithium | prazepam | Trilafon |
| clonazepam | Lithobid | Prolixin | trimipramine |
| clorazepate | Lithonate | Primidone | Valium |
| clozapine | Lithotabs | propranolol | valproic acid |
| Clozaril | lorazepam | protriptyline | venlafaxine |
| Concerta | loxapine | Provigil | Vivactil |
| Cylert | Loxitane | Prozac | Wellbutrin |
| Dalmane | ludiomil | quetiapine | Xanax |
| Depakene | Lunesta | Remeron | ziprasidone |
| Depakote | Luvox | Restoril | Zoloft |
| desipramine | maprotiline | Risperdal | zopiclone |
| Desyrel | Mellaril | risperidone | Zydis |
| Dexedrine | mesoridazine | Ritalin | Zyprexa |
| dextroamphetamine | Metadate | | |

Hospitalization History

If you have ever been hospitalized for a psychiatric problem, please indicate below. Use the back of the page if you need to.

When	Where	Reason

Continued on next page

Psychiatric History, Continued

Past Therapists Please list all mental health professionals that you have seen for more than one visit.

Who	When	Where	Why

Version Jan 10, 2010

Patient-rated Level 1 Cross-cutting Measure

Note: The following questions inquire about how you have been feeling over the past **TWO (2) WEEKS**.

Please respond to each item by choosing one option per question.					
During the past TWO (2) WEEKS , how much have you been bothered by the following problems:	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day
1. No interest or pleasure in doing things?	0	1	2	3	4
2. Feeling down, depressed, or hopeless?	0	1	2	3	4
3. Feeling irritated, grouchy, angry?	0	1	2	3	4
4. Sleeping less but still have a lot of energy?	0	1	2	3	4
5. Starting lots of projects or doing more risky things?	0	1	2	3	4
6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4
7. Feeling panic or being frightened?	0	1	2	3	4
8. Avoiding situations that make you anxious?	0	1	2	3	4
9. Unexplained aches and pains (e.g. head, back, joints, abdomen, legs)?	0	1	2	3	4
10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4
11. Thoughts of actually hurting yourself?	0	1	2	3	4
12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4
13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4
14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4
15. Problems with memory (e.g., learning new information), or with location (e.g., finding your way home)?	0	1	2	3	4
16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
17. Feeling driven to perform certain behaviors or mental acts over and over?	0	1	2	3	4

over again?					
18. Feeling detached or distant from myself, my body, my physical surroundings, or my memories?	0	1	2	3	4
19. Not knowing who you really are or what you want out of life?	0	1	2	3	4
20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4
21. Drink at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4
22. Smoke any cigarettes, a cigar, or pipe or use snuff or chewing tobacco?	0	1	2	3	4
23. Use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., Painkillers (like Vicodin), Stimulants (like Ritalin or Adderall), Sedatives or tranquilizers (like sleeping pills or Valium), or drugs like Marijuana, Cocaine or crack, Club drugs (like ecstasy), Hallucinogens (like LSD), Heroin, Inhalants or solvents (like glue), or Methamphetamine (like speed)]?	0	1	2	3	4