

**NEW PATIENT EVALUATION
HISTORY & PRE-SCREENING FORM**

Instructions: Please complete the following information thoroughly and as detailed as possible. This will be respected *as confidential information to be used only for the purpose of gathering valuable history, and making decisions regarding diagnosis and treatment* in the event you are seen by the psychiatrist. Withholding information or failure to offer accurate responses to this inquiry may compromise our ability to treat you effectively. Please complete the entire form using N/A (non-applicable) appropriately.

1. What is the purpose of your visit today? _____

2. List medication allergies: _____

3. List all prescription medications and how taken (i.e. levothyroxine 75mcg once daily)

4. List all herbal supplements and/or over the counter medications

(FEMALES ONLY)

Are you pregnant or do you have reason to believe you are? **YES NO**

If so, how many weeks? _____

Are you taking folic acid and prenatal vitamins? **YES NO**

Are you breastfeeding or plan to do so in the near future? **YES NO**

If so, but not currently, when? _____

To the best of your knowledge are you currently able to bear children? **YES NO**

If not, please explain _____

Are you currently taking any method of birth control? **YES NO**

If so, what method(s) _____

Have you taken OR are you taking other measures to avoid pregnancy? **YES NO**

If so, what measure(s) _____

Are you currently planning pregnancy or in the near future? **YES NO**

If so, but not currently, when? _____

(please turn over and complete)

Have you ever been admitted to an inpatient psychiatric or substance abuse facility?

YES NO

If so, please provide details below

Facility Name and Location	Year/Length of Stay	Reason for Admission
	/	
	/	
	/	
	/	
	/	
	/	
	/	

Have you ever received electro-convulsive (shock) therapy?

YES NO

Have you ever experienced any of the below while taking any past or currently prescribed medications?

YES NO

If YES, check apply and give name of the medication(s)

- Tremors _____
- Seizures _____
- Insomnia _____
- Dizziness/light headedness _____
- Involuntary muscular movements _____
- Skin Rash _____
- Sexual Dysfunction _____
- Elevated blood pressure _____
- Heart Palpitations _____
- Severe anxiety _____
- Severe nausea _____
- Diarrhea _____
- Constipation _____
- Nightmares _____
- Toxicity _____
- Abnormal labs (i.e. liver enzymes) _____

PERSONAL NEUROLOGICAL MEDICAL HISTORY *(Please check all that apply)*

- | | |
|---|---|
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Huntington's Disease |
| <input type="checkbox"/> Tension Headaches | <input type="checkbox"/> Pick's Disease |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Brain Tumor |
| <input type="checkbox"/> Head/Brain Trauma | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> Other _____ | |
-

PERSONAL MEDICAL HISTORY *(Please check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer (type _____) | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> GERD/Heartburn/Stomach Ulcers |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Iron Deficiency Anemia | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Porphyria | <input type="checkbox"/> HTV/AIDS |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Glaucoma/Cataracts |
| <input type="checkbox"/> Other _____ | |
-

FAMILY MEDICAL HISTORY *(Please check all that apply)*

- | | |
|---|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Huntington's Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Pick's Disease | |
| <input type="checkbox"/> Other _____ | |
-

PERSONAL PSYCHIATRIC HISTORY *(Please check all that apply)*

- | | |
|---|---|
| <input type="checkbox"/> Clinical depression | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bipolar (manic-depression) | <input type="checkbox"/> Schizoaffective Disorder |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Obsessive-Compulsive Disorder |
| <input type="checkbox"/> Agoraphobia | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Social Anxiety Disorder | <input type="checkbox"/> Generalized Anxiety Disorder |
| <input type="checkbox"/> Anorexia Nervosa | <input type="checkbox"/> Bulimia Nervosa |
| <input type="checkbox"/> Suicide Attempt(s) | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Dissociative Identity Disorder |
| <input type="checkbox"/> Borderline Personality | (Multiple Personality Disorder) |
| <input type="checkbox"/> Other _____ | |
-

FAMILY PSYCHIATRIC HISTORY (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Clinical depression | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bipolar (manic-depression) | <input type="checkbox"/> Schizoaffective Disorder |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Obsessive-Compulsive Disorder |
| <input type="checkbox"/> Agoraphobia | <input type="checkbox"/> Alzheimer's Dementia |
| <input type="checkbox"/> Social Anxiety Disorder | <input type="checkbox"/> Generalized Anxiety Disorder |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Completed Suicide |
- Other _____

ALCOHOL/DRUG CONSUMPTION INQUIRY

1a. Have you consumed alcohol in the past? **YES NO**
If so, when was your last drink? _____

Describe your frequency below:

- | | |
|---|---|
| <input type="checkbox"/> Daily | <input type="checkbox"/> 1-2 days / week |
| <input type="checkbox"/> Weekends | <input type="checkbox"/> 3-4 days / week |
| <input type="checkbox"/> Binge Drinking | <input type="checkbox"/> 5-6 days / week . |
| <input type="checkbox"/> Occasionally, no more than twice / month | <input type="checkbox"/> Rarely, holidays/special occasions |

1b. Describe the amount, type of alcohol, and proof (*i.e two mixed drinks w/80 proof Vodka*)

1c. Do you sometimes have a drink when you wake from sleeping? **YES NO**

1d. Do you get annoyed when friends/family encourage you to stop drinking? **YES NO**

1e. Have you tried to cut back without much success? **YES NO**

1f. Do you feel guilt sometimes when you drink? **YES NO**

2. Have you ever experienced withdrawal from alcohol or any other drug that caused shakes, anxiety, palpitations, insomnia, cold sweats, muscle cramps, excessive sweating or a seizure while either decreasing your consumption or quitting abruptly ('cold turkey')? **YES NO**

3. When and how long was your longest period of sobriety? _____

4. In you opinion, what helped you stay sober? _____

5. Do you attend AA and/or some other type of rehab currently? **YES NO**
If so, give details _____

6. Have you consumed any of the below in the past? **YES NO**

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Heroin |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Inhalants ('huffing or sniffing') |
| <input type="checkbox"/> Amphetamine | <input type="checkbox"/> PCP/LSD |
| <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Xanax/Xanax bars* |

Other _____

If so, describe your frequency below:

- | | |
|---|---|
| <input type="checkbox"/> Daily | <input type="checkbox"/> 1-2 days / week |
| <input type="checkbox"/> Weekends | <input type="checkbox"/> 3-4 days / week |
| <input type="checkbox"/> Binge Drinking | <input type="checkbox"/> 5-6 days / week |
| <input type="checkbox"/> Occasionally, no more than twice / month | <input type="checkbox"/> Only as prescribed by my physician |

* *Xanax® (alprazolam)* is an FDA-approved drug that is often prescribed for anxiety disorders. It is highly effective in the management of acute anxiety and a safe drug that I endorse and prescribe. Unfortunately, some individuals who choose to misuse this drug either by taking unapproved prescribed doses or by obtaining it by some other means and using it for recreational use can become addicted.

HISTORY OF VICTIMIZATION

Have you ever been a victim of *physical, emotional, or sexual abuse*? **YES NO**

Have you ever been a victim of *molestation, rape, or sexual assault*? **YES NO**

Have you ever been a victim of *spousal or relationship abuse*? **YES NO**

Have you ever been involved in *military combat, gang violence, riot or a witness of any other violent acts*? **YES NO**

Have you been *traumatized by any other witnessed event*? **YES NO**

As a result of your above experience, have you experienced these? **YES NO**

If so, **check all that you experienced**

- Flashbacks
- Recurrent disturbing memories/thoughts
- Nightmares
- Panic Attacks
- Avoidance of anything that reminds you of the event(s)
- Insomnia
- Social and/or Occupational dysfunction

SYMPTOM CHECKLIST

Have you felt sad, depressed, or even anxious lately?

If so, **check all you have experienced**

- Sleep disturbance
- Poor energy
- Decreased motivation
- Poor concentration
- Short-term memory problems
- Hopelessness
- Low self-esteem
- Social isolation
- Crying spells
- Irritable
- Poor task completion
- Paranoia
- Auditory hallucinations "hearing voices"
- Visual hallucinations "seeing things"
- Thoughts of self-harm
- Suicidal thoughts
- Homicidal thoughts
- Social and/or Occupational dysfunction
- Decreased libido
- Poor appetite
- Increased appetite
- Easily fatigued
- Low interest in pleasurable things
- Negative thinking
- Guilt/shame/embarrassment
- Feelings of emptiness
- Poor frustration tolerance
- Mood swings
- Panic (anxiety) attacks
- Suspicious of others
- Racing thoughts
- Rapid speech
- Feelings of grandiosity
- Excessive energy "feeling wired"
- Impulsive/risky behaviors
- Other

How long have you experienced these above symptoms? _____

List three **recent major life stressors** that could have led to these symptoms

A. _____

B. _____

C. _____

What are your concerns about having these symptoms? _____

How have these symptoms affected your daily life lately? _____
