**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?  

If so, please provide details below

<table>
<thead>
<tr>
<th>Facility Name and Location</th>
<th>Year/Length of Stay</th>
<th>Reason for Admission</th>
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Have you ever received electro-convulsive (shock) therapy?  

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

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

- [ ] Multiple Sclerosis
- [ ] Thyroid Disease
- [ ] Migraine Headaches
- [ ] Tension Headaches
- [ ] Dementia
- [ ] Head/Brain Trauma
- [ ] Other

### PERSONAL MEDICAL HISTORY

- [ ] Stroke
- [ ] Diabetes
- [ ] High Cholesterol
- [ ] Cancer (type ____________)
- [ ] Heart Attack
- [ ] Sickle Cell Anemia
- [ ] Iron Deficiency Anemia
- [ ] Porphyria
- [ ] Mitral Valve Prolapse
- [ ] Other

### FAMILY MEDICAL HISTORY

- [ ] Stroke
- [ ] Diabetes
- [ ] High Cholesterol
- [ ] Thyroid Disease
- [ ] Huntington’s Disease
- [ ] Pick’s Disease
- [ ] Other

### PERSONAL PSYCHIATRIC HISTORY

- [ ] Clinical depression
- [ ] Bipolar (manic-depression)
- [ ] Panic Attacks
- [ ] Agoraphobia
- [ ] Social Anxiety Disorder
- [ ] Anorexia Nervosa
- [ ] Suicide Attempt(s)
- [ ] Suicidal Thoughts
- [ ] Borderline Personality
- [ ] Other

- [ ] Schizophrenia
- [ ] Schizoaffective Disorder
- [ ] Obsessive-Compulsive Disorder
- [ ] Post Traumatic Stress Disorder
- [ ] Generalized Anxiety Disorder
- [ ] Bulemia Nervosa
- [ ] ADD/ADHD
- [ ] Dissociative Identity Disorder (Multiple Personality Disorder)
FAMILY PSYCHIATRIC HISTORY (Please check all that apply)

☐ Clinical depression
☐ Schizophrenia
☐ Bipolar (manic-depression)  
☐ Schizoaffective Disorder
☐ Panic Attacks  
☐ Obsessive-Compulsive Disorder
☐ Agoraphobia  
☐ Alzheimer’s Dementia
☐ Social Anxiety Disorder  
☐ Generalized Anxiety Disorder
☐ Insomnia  
☐ Completed Suicide
Other _____________________________________________________

ALCOHOL/DRUG CONSUMPTION INQUIRY

la. Have you consumed alcohol in the past?  YES  NO
   If so, when was your last drink? __________________________

Describe your frequency below:

☐ Daily  1-2 days / week
☐ Weekends  3-4 days / week
☐ Binge Drinking  5-6 days / week
☐ Occasionally, no more than twice / month  Rarely, holidays/special occasions

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

lc. Do you sometimes have a drink when you wake from sleeping?  YES  NO

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

le. Have you tried to cut back without much success?  YES  NO

lf. 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 your 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**  
   □ Marijuana  
   □ Cocaine  
   □ Amphetamine  
   □ Ectasy  
   □ Other ________________________________________________________________________

   **If so, describe your frequency below:**  
   □ Daily  
   □ Weekends  
   □ Binge Drinking  
   □ Occasionally, no more than twice / month  
   □ 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
- [ ] 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? _______________________________
______________________________________________________________________________
______________________________________________________________________________