THE CENTER FOR ANXIETY AND DEPRESSION
Medical History Form

Please answer these questions as completely as you can. We realize that this form is long, but tl information in this form will be extremely valuable to us in providing you the best possible care.

TodayÕs Date:_____Patient's Name:_____
Last First Middle

Patient's Date of Birth:_____ Age____ Patient's Gender: M___ F___ Race:_____
Month/Day/Year

Contact Address: _____
Street or PO Box

_____
City/State/Zip

Contact Phone Number:_____ Alternate Phone Number: _____
(Optional)

Emergency Contact:_____ Number: _____
Name Relationship

Who referred you to the clinic?_____
Doctor or Clinic name, Therapist name, ÒWord of Mouth,Ó ÒInternet,Ó ÒFamily Member,Ó et

Current Medications You Take: (<u>all medications</u>)

Name	Dosage	How often every day?	How long have you been taking it?

Medication Allergies and Reactions:_____
Please do not leave blank, write ÒnoneÓ if no allergies.

What <u>Psychiatric</u> Medications have you taken in the PAST:

Name	Dosage	When did you start it?	When did you stop it?	Why did you stop it?

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What are your current emotional or mental-health concerns?

(If you wish, you may rank them in order of severity, with 1 being most important, and 2 or 3 as a lesser concern to you.)

- ☐ ANXIETY
  - ☐ Panic attacks
  - ☐ Situational worry ("stress")
  - ☐ Preoccupations or obsessions
  - ☐ Compulsions or ritual behaviors
  - ☐ Intrusive or "taboo" thoughts
  - ☐ Avoiding people or places
  - ☐ Flashbacks of traumatic events
  - ☐ Feeling "jumpy" or easily startled

- ☐ DEPRESSION
  - ☐ Persistent sadness
  - ☐ Crying spells
  - ☐ Despondency or hopelessness
  - ☐ Loss of interest
  - ☐ Guilt
  - ☐ Low energy
  - ☐ Low motivation
  - ☐ Suicidal thoughts

- ☐ CONCENTRATION PROBLEMS
  - ☐ Forgetfulness
  - ☐ Easily distracted
  - ☐ Easily frustrated
  - ☐ Job conflicts
  - ☐ Schoolwork problems

- ☐ AGITATION
  - ☐ Restlessness
  - ☐ Irritability
  - ☐ Anger control problems
  - ☐ Racing thoughts
  - ☐ Rapid mood swings
  - ☐ High energy
  - ☐ Elevated mood or overly happy
  - ☐ Talking too much

- ☐ ALTERNATIVE THOUGHTS
  - ☐ Hearing commands/commentary
  - ☐ Seeing spirits, auras, other energy
  - ☐ Heightened suspicion
  - ☐ Paranoia
  - ☐ Feelings of being recorded
  - ☐ Broadcasting thoughts to others
  - ☐ Sensing the thoughts of others

- ☐ SLEEP PROBLEMS
  - ☐ I use a sleep aid _____
  - ☐ Difficulty falling asleep
  - ☐ Frequent awakening
  - ☐ Early morning awakening
  - ☐ Nightmares
  - ☐ Sleep/wake cycle (timing) offset

- ☐ ADDICTIONS
  - ☐ Overuse of alcohol
  - ☐ Use of street drugs
  - ☐ Abuse of prescribed medications
  - ☐ Impulsive sexual behaviors
  - ☐ Gambling compulsively

- ☐ SAFETY CONCERNS
  - ☐ Suicidal ideas
  - ☐ Thoughts of harming others
  - ☐ _____

- ☐ APPETITE CHANGE
  - ☐ Increased appetite
  - ☐ Weight gain
  - ☐ Decreased appetite
  - ☐ Weight loss
  - ☐ Anorexia
  - ☐ Purging
  - ☐ Body image problems

- ☐ PHYSICAL SYMPTOMS
  - ☐ Pain
  - ☐ Sexual problems
  - ☐ Muscle tension (jaw, neck, etc.)

Have you experienced a major stress or stresses that has been affecting your mood, or caused it to change?

Please Describe

Have you had any physical ailments that have been affecting you mood, or caused it to change?

Please Describe

Has anything been helping you feel better, or maintain your mood?

Please Describe

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Mental-Health Treatment History: Please list past psychiatric treatment providers, both outpatient and inpatient, as well as any substance abuse counseling or treatments.

Dates	Details

Major Medical/Surgical History:(History of seizures, thyroid problems, diabetes, gastric bypass, brain injuries, all others)

Please Describe

Date of last physical exam | Primary care provider name or clinic name | Contact phone number

PATIENT'S birth history:

Full-term, uncomplicated vaginal delivery	Yes/No	Neonatal Jaundice	Yes/No	Febrile Seizures	Yes/No	Other Neonatal Complication	

Women Only:

Last Menstrual Period		Number of times pregnant		Number of Live Births		Current form of contraception	

Cycles (_____days, regular/irregular) Hysterectomy (yes/no, age_____) Oopharectomy (yes/no, age_____)

Review of Physical Systems: (please check all that apply)

	Ye	N		Ye	N		Ye	N
ALLERGIES			GASTROINTESTINAL			MUSCULOSKELETAL		
Environmental Allergies			Peptic ulcer disease			Traumatic Injury		
			Hepatitis			Rheumatoid Arthritis		
HEAD AND NECK			Irritable Bowel Syndrome			Osteoarthritis		
Head trauma with blackout						Other musculoskelatal		
Other loss of consciousness			CARDIORESPIRATORY					
Seizure			Asthma			GENITOURINARY		
Migrane			Respiratory problems			Frequent UTI		
Multiple Sclerosis			Cardiac problems			Sexually transmitted disease		
CVA or Stroke						Kidney problems		
Other head problems			SKIN AND BREASTS			Other Genitourinary		
Neck problems			Eczema					
Lymph node problems			Raynauds			IMMUNOLOGIC		
Mouth problems			Stevens Johnson			Diabetes		
Tongue problems			Psoriasis			Thyroid problems		
Throat problems			Other skin problems			Lupus		
Other neck or mouth problem			Breast nodules/lumps			Cancer		

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Substance Screening Questions:

How much alcohol do you consume:

Presently:_____ In the past (if different):_____

If you drink alcohol presently, have you ever tried to cut back on your drinking? Yes___ No___

Are you annoyed if/when others comment on how much you drink? Yes___ No___

Do you feel guilty about your drinking behavior? Yes___ No___

Do you ever drink in the mornings? Yes___ No___

Have you ever been cited for driving while intoxicated? Yes___ No___

Do you currently, or Did you ever use 'street' drugs or abuse prescription medicines? Yes___ No___

_____

Please Describe

_____

_____

Do you smoke cigarettes? Yes___No___ If yes, how much?_____ Would you like to quit? _____

Do you drink caffeinated drinks? Yes___ No___ If yes, how many?_____

Social Screening Questions:

With whom do you live?	
Please describe your work history:	
Please describe your marital history:	
How many children do you have?	
What is your educational background?	
Have you ever been in the military?	
Do you practice a religion?	
Please describe any speech, learning or other developmental delays:	
Do you have a history of trauma or abuse?	
Do you have any legal problems?	

The Center for Anxiety and Depression: Medical History Form

Family History: Please list any blood-relatives you have with a history of mental health problems:

Depression_____

Anxiety_____

Bipolar Disorder_____

OCD_____

Completed Suicide_____

Schizophrenia_____

ADD/ADHD_____

Alcoholism/ Drug Abuse/Dependence_____

Dementia/Other_____

Consent for Treatment at the Center for Anxiety and Depression

I give permission for my psychiatrist, Dr. David Dunner, Dr. Christina Demopulos, Dr. Ryan Fugate, or Dr. Jorge Martinez, to conduct a psychiatric evaluation for the purpose of diagnosis and treatment planning. In addition, it is my right and responsibility to participate in treatment decisions made by my psychiatrist, and this includes providing full and accurate information regarding my medical conditions, prior treatments, substance abuse and current symptoms. It may be useful to have persons knowledgeable about my condition accompany me during the interview and subsequent treatment sessions, and I give permission for this to occur.

I have been provided with a fee schedule, and I understand that I am responsible for payment in full at the time of service unless other arrangement have been agreed upon prior to my visit. I have been informed that my psychiatrist does not participate in insurance plans or third-party payer systems, including Medicare and Medicaid. I understand that it is my responsibility to know the provisions of my health plan regarding the possibility of reimbursement if I choose to pursue it.

I understand that my psychiatrist may exchange limited information from my health record, from time to time, with other physicians within the Center for Anxiety and Depression as well as covering physicians from the call coverage group. This exchange is only as my psychiatrist deems necessary for urgent purposes or for routine practice decisions. This information may include but is not limited to my medical and psychiatric records, drug and alcohol and treatment records, information regarding HIV and AIDS, diagnosis, progress notes, psychiatric evaluations, testing results, therapy notes, sexual assault or domestic violence notes, sexually transmitted disease information, medication lists and billing information. My psychiatrist may also review my records for research.

I am aware that beginning Thursday afternoon and ending Monday morning there is a psychiatrist on call covering for my psychiatrist. I am aware that I need to call the Center for Anxiety and Depression (206 230 0330) and determine from the phone message who the covering psychiatrist is. I am also aware that the on-call psychiatrist is not likely to prescribe benzodiazepines such as Klonopin (clonazepam), Ativan (lorazepam), or Xanax (alprazolam); sleeping medications such as Ambien (zolpidem); narcotics or opioids such as Suboxone (buprenorphine); or stimulants such as Adderall (amphetamine) or Ritalin (methylphenidate). It is my responsibility to arrange prescription renewal for such medications prior to Thursday from my psychiatrist. During Christmas and New Year's holidays, the psychiatry coverage system operates for the entire two week period.

I am aware that the use of e-mail to correspond with my psychiatrist is discouraged as e-mail is not secure.

I have read the provisions above, and hereby consent to treatment.

_____ _____

Patient's full legal name Date of birth

_____ _____

Patient's Signature Today's Date