

THE CENTER FOR ANXIETY AND DEPRESSION

Medical History Form

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.)

<input type="checkbox"/> ANXIETY	<input type="checkbox"/> AGITATION	<input type="checkbox"/> ADDICTIONS
<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Restlessness	<input type="checkbox"/> Overuse of alcohol
<input type="checkbox"/> Situational worry ("stress")	<input type="checkbox"/> Irritability	<input type="checkbox"/> Use of street drugs
<input type="checkbox"/> Preoccupations or obsessions	<input type="checkbox"/> Anger control problems	<input type="checkbox"/> Abuse of prescribed medications
<input type="checkbox"/> Compulsions or ritual behaviors	<input type="checkbox"/> Racing thoughts	<input type="checkbox"/> Impulsive sexual behaviors
<input type="checkbox"/> Intrusive or "taboo" thoughts	<input type="checkbox"/> Rapid mood swings	<input type="checkbox"/> Gambling compulsively
<input type="checkbox"/> Avoiding people or places	<input type="checkbox"/> High energy	<input type="checkbox"/> SAFETY CONCERNS
<input type="checkbox"/> Flashbacks of traumatic events	<input type="checkbox"/> Elevated mood or overly happy	<input type="checkbox"/> Suicidal ideas
<input type="checkbox"/> Feeling "jumpy" or easily startled	<input type="checkbox"/> Talking too much	<input type="checkbox"/> Thoughts of harming others
		<input type="checkbox"/> _____
<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> ALTERNATIVE THOUGHTS	<input type="checkbox"/> APPETITE CHANGE
<input type="checkbox"/> Persistent sadness	<input type="checkbox"/> Hearing commands/commentary	<input type="checkbox"/> Increased appetite
<input type="checkbox"/> Crying spells	<input type="checkbox"/> Seeing spirits, auras, other energy	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Despondency or hopelessness	<input type="checkbox"/> Heightened suspicion	<input type="checkbox"/> Decreased appetite
<input type="checkbox"/> Loss of interest	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Guilt	<input type="checkbox"/> Feelings of being recorded	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Low energy	<input type="checkbox"/> Broadcasting thoughts to others	<input type="checkbox"/> Purging
<input type="checkbox"/> Low motivation	<input type="checkbox"/> Sensing the thoughts of others	<input type="checkbox"/> Body image problems
<input type="checkbox"/> Suicidal thoughts		
<input type="checkbox"/> CONCENTRATION PROBLEMS	<input type="checkbox"/> SLEEP PROBLEMS	<input type="checkbox"/> PHYSICAL SYMPTOMS
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> I use a sleep aid _____	<input type="checkbox"/> Pain
<input type="checkbox"/> Easily distracted	<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Easily frustrated	<input type="checkbox"/> Frequent awakening	<input type="checkbox"/> Muscle tension (jaw, neck, etc.)
<input type="checkbox"/> Job conflicts	<input type="checkbox"/> Early morning awakening	
<input type="checkbox"/> Schoolwork problems	<input type="checkbox"/> Nightmares	
	<input type="checkbox"/> Sleep/wake cycle (timing) offset	

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

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

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

Please Describe

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Medical History Form

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 _____) Oophorectomy (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 musculoskeletal		
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		

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 Demopoulos, 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 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