Patient Registration Form

Date:_____

Patient Name: _____

Social Security #: _____

Date of Birth: _____ Age: _____

Billing Address: _____

City: _____ State:_____ Zip Code:_____

Home Address_____

City: _____ State: ____ Zip Code: _____

Home Phone#: _____ Cell #: _____ Work #: _____

Email Address: _____

Who referred you to the office? _____

Family Doctor: _____ Phone #:_____

Emergency Contact: _____ Phone #:_____

Primary Insurance: _____ ID #:_____

Insured's Name: _____ Date of Birth: _____

MEDICATION QUESTIONNAIRE

Directions: Please complete this questionnaire to the best of your recollection.

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Adverse Reaction	Patient, Parent, Guardian or Provider comments
ANTIDEPRESSANTS						
Fluoxetine	Prozac					
Paroxetine	Paxil, Paxil CR					
Sertraline	Zoloft					
Fluvoxamine	Luvox, Luvox CR					
Citalopram	Celexa					
Escitalopram	Lexapro					
Desipramine	Norpramin					
Imipramine	Tofranil					
Doxepin	Sinequan					
Clomipramine	Anafranil					
Nortriptyline	Pamelor					
Bupropion	Wellbutrin, Wellbutrin SR, Wellbutrin XL, Zyban					
Venlafaxine	Effexor, Effexor XR					
Duloxetine	Cymbalta					
Nefazodone	Serzone					
Mirtazapine	Remeron, Remeron Sol Tab					
Trazodone	Desyrel					
Selegiline Transdermal	Emsam					
Desvenlafaxine	Pristiq					
Phenelzine	Nardil					
Tranylcypromine	Parnate					
Vortioxetine	Trintellix					
Levomilnacipran	Fetzima					
Vilazodone	Viibryd					
ANTIPSYCHOTICS "major tranquilizers"						
Thioridazine	Mellaril					
Paliperidone	Invega					
Chlorpromazine	Thorazine					
Thiothixene	Navane					
Haloperidol	Haldol, Haldol Decanoate					
Perphenazine	Trilafon					
Loxapine	Loxitane					
Trifluoperazine	Stelazine					
Fluphenazine	Prolixin, Prolixin Decanoate					
Clozapine	Clozaril					
Olanzapine	Zyprexa, Zyprexa Zydis					
Quatrain	Seroquel, Seroquel XR					
Risperidone	Risperdal, Risperdal Consta					
Cariprazine	Vraylar					
Brexpiprazole	Rexulti					
Lurazidone	Latuda					

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of use	Adverse Reaction	Patient, Parent, Guardian or Provider comments
Aripiprazole	Abilify						
Cariprazine	Vraylar						
Ziprasidone	Geodon						
ANXIOLYTICS "anti-anxiety" "minor tranquilizers"							
Alprazolam	Xanax, Xanax XR						
Diazepam	Valium						
Chlordiazepoxide	Librium						
Buspirone	BuSpar						
Lorazepam	Ativan						
Clonazepam	Klonopin, Klonopin Wafers						
hydroxyzine	Vistaril, Atarax						
ANTICHOLINESTERASE/ ALZHEIMER'S AGENTS							
Tacrine	Cognex						
Donepezil	Aricept						
Rivastigmine	Exelon						
Memantine	Namenda						
ALCOHOL/DRUG/SMOKING CESSATION AGENTS							
Acamprosate	Campral						
Methadone	Dolophine						
Naltrexone	ReVia						
Disulfiram	Antabuse						
Buprenorphine/ Naloxone	Suboxone/Subutex						
Varenicline	Chantix						
MOOD STABILIZING AGENTS/AED's							
Carbamazepine	Tegretol						
Oxcarbazepine	Trileptal						
Valproate	Depakene, Depakote, Depakote ER						
Lamotrigine	Lamictal, Lamictal XR						
Gabapentin	Neurontin						
Topiramate	Topamax						
Levetiracetam	Keppra						
Olanzapine	Zyprexa, Zyprexa Zydis						
Lithium	Eskalith, Eskalith CR, Lithobid						
PSYCHOSTIMULANTS							
Methylphenidate	Ritalin, Ritalin SR, Ritalin LA, Concerta, Metadate ER/CD						
Methylphenidate Transdermal	Daytrana						
Amphetamine, Dexotroamphetamine	Adderall, Adderall XR						

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of use	Adverse Reaction	Patient, Parent, Guardian or Provider comments
Dexmethylphenidate	Focalin, Focalin XR						
Dextroamphetamine	Dexedrine, Dextrostat						
Lisdexamfetamine dimesylate	Vyvanse						
Modafinil	Provigil						
Armodafinil	Nuvigil						
Guanfacine	Intuniv, Tenex						
Clonidine	Catapres						

Medical & Psychiatric History

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.

	Yes	No
1. Are you in good physical health?	____	____
2. Has there been any change in your general physical health in the last year?	____	____
3. Date of your last physical examination (on or about) _____		
4. Have you ever had any serious illness or operation?	____	____

If so please explain:

_____

_____

_____

_____

5. Are you currently under the care of a physician for any physical condition?	____	____
6. Are you taking any prescription drugs or medications at the present time?	____	____

If so please list:

Name of Medication	Strength in MG	Date Began	Reason for Taking

Yes No

Are you taking any non-prescription drugs, including natural remedies and vitamins? ____ ____

If so please explain:

Name of Medication	Strength in MG	Date Began	Reason for Taking

Yes No

Are you aware of or has a physician ever told you of any allergies/adverse reactions ____ ____

to any medications or drugs? If so please explain:

Name of Medication	Reaction

	Yes	No
Have you ever been hospitalized?	____	____

If yes, please list and explain

Reason	Date of Hospitalization	Location (city & state)	Treatment Received

Do you have any of the following problems?

	Yes	No		Yes	No
Cancer			Anemia		
Rheumatic Fever			Blood Clotting Problems		
Lupus or Autoimmune Disorder			Tuberculosis		
Arthritis or Rheumatism			Asthma		
Chronic Pain or Complex Regional Pain			Hay Fever or Seasonal Allergies		
Disc Disease			Hives or Skin Rashes		
Stomach Ulcer			Venereal Disease/STD		
Gastroesophageal Reflux			Sexual or Erectile Dysfunction		
Irritable Bowel Syndrome			Bladder Problems		
Colitis			Kidney Disease/Kidney Stones		
Liver Disease			Migraine/Cluster/Tension Headaches		
Hepatitis or Jaundice			Fainting Spells		
Cardiovascular Disease or Heart Failure			Seizures or Convulsions		
Heart Attack/Myocardial Infarction			Parkinson's Disease		
High Blood Pressure			Dementia or Alzheimer's Disease		
Coronary Artery Disease/Arteriosclerosis			Glaucoma or Macular Degeneration		
Diabetes/ High Blood Sugar			Fibromyalgia		
Under Active Thyroid			Lyme Disease, Babesia, Ehrlichea		
Overactive Thyroid			Other(explain)		

Do you have any physical disease or condition not listed above that you think the doctors should know about?

_____

_____

Mental Health Questionnaire

1. **In chronological order, please list all psychiatrist and/or psychotherapists (psychologists, nurse practitioners, certified social workers, counselors, etc) who have attended you beginning with the most recent:**

Name	Profession/Title	Treatment (therapy, meds, ect)	Date started	Date Ended	Reason Discontinued

	Yes	No
2. During the last four (4) weeks, have you been bothered by any of the following?		
• Stomach Pain	____	____
• Back Pain	____	____
• Pain in your arms, legs or joints	____	____
• Menstrual cramps, or problems with your period	____	____
• Headaches	____	____
• Chest Pains	____	____
• Dizziness	____	____
• Fainting spell	____	____
• Feeling your heart pound or race	____	____
• Shortness of breath	____	____
• Constipation	____	____
• Loose bowel or diarrhea	____	____
• Nausea, gas, or indigestion	____	____

	Yes	No
3. Over the last two (2) weeks, have you been bothered by any of the following?		
• Little to no interest or pleasure in doing things	____	____
• Feeling down, depressed, or hopeless	____	____
• Trouble falling asleep or staying asleep	____	____
• Sleeping too much	____	____
• Feeling tired or having little energy	____	____
• Poor appetite or over-eating	____	____
• Feeling bad about yourself	____	____
• Feeling that you are a failure or have let others down	____	____
• Trouble concentrating on things such as reading, watching TV	____	____
• Moving or speaking slowly that other people have noticed	____	____
• Being so fidgety or restless that other people have noticed	____	____
• Thoughts that you would be better off dead or hurting yourself	____	____
• Persistently elevated, expansive mood (manic)	____	____
• Inflated self-esteem	____	____
• Pressured to keep talking	____	____
• Racing thoughts	____	____
• Distractibility (including being diagnosed with ADD or ADHD)	____	____
• Impulsiveness (buying sprees, sexual indiscretions, foolish investments)	____	____
• Hallucinations (Auditory, visual symptoms that others do not see)	____	____
• Paranoia (Believing that others are out to hurt or harm you)	____	____
	Yes	**No**
4. Questions about anxiety		
• In the last four (4) weeks have you had an anxiety attack? (Suddenly feeling fear or panic)	____	____
****If you checked no, go to question 6****		
• Has this ever happened before?	____	____
• Do some of these attacks come suddenly out of the blue or in situations Where you don't' expect to be nervous or uncomfortable?	____	____
• Do these attacks bother you a lot or are you worried about having another?	____	____

5. **Think about your last bad anxiety attack:**	**Yes**	**No**
• Were you short of breath?	____	____
• Did your heart race?	____	____
• Did you have chest pain or pressure?	____	____
• Did you sweat?	____	____
• Did you feel as if you were choking?	____	____
• Did you have hot flashes or chills?	____	____
• Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	____	____
• Did you feel dizzy, unsteady or faint?	____	____
• Did you tremble or shake?	____	____
• Were you afraid you were dying?	____	____
	Yes	**No**

6. **Over the last four (4) weeks have you been bothered by the following problems?**		
• Feeling nervous, on edge or worried a lot about different things?	____	____
****If you checked no, go to question 7****		
• Feeling restless so that it is hard to sit still	____	____
• Getting tired very easily	____	____
• Muscle tension, aches or soreness	____	____
• Trouble falling asleep or staying asleep	____	____
• Trouble concentrating on things such as reading, watching TV	____	____
• Obsessions (fear of contaminations, intrusive thoughts of harm, need for order or symmetry)	____	____
• Becoming easily annoyed or irritated	____	____
• Compulsions (checking doors, oven, washing hands)	____	____
• Social anxiety (center of attention, avoiding social situations)	____	____

7. **Questions about eating:**	**Yes**	**No**
• Do you often feel that you can't control what or how much you eat?	____	____
• Do you often eat within any 2 hour period what most people would regard as an unusually large amount of food?	____	____
• Do you fear gaining weight or feel fat?	____	____
• Do you frequently diet or restrict your caloric intake? (<1000 cal/d)	____	____

****If you answered no, go to question 9****

	Yes	No
8. In the last three (3) months, have you often done any of the following to avoid gaining weight?		
• Made you vomit	____	____
• Taken more than twice the recommended dose of laxatives	____	____
• Fasted (not eaten anything at all for at least 24 hours)	____	____
• Exercised for more than an hour, specifically to avoid gaining weight after binge eating	____	____
• If you checked YES to any one of these ways of avoiding gaining weight, were any as often or average of twice a week?	____	____
9. Do you ever drink alcohol, including beer and wine? ****If you answered no, go to question 11****	____	____
10. Have any of the following happened to you more than once in the last six (6) months?		
• You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health	____	____
• You drank alcohol, were intoxicated from alcohol, or were hung over while you were working, going to school, or taking care of someone else's children or other responsibilities.	____	____
• You missed or were late for work, school or other activities because you were drinking or hung over	____	____
• You had problems getting along with others while drinking	____	____
• You drove a car after having several drinks or drinking too much alcohol	____	____
	Yes	**No**
11. Do you presently use recreational drugs?	____	____

If yes, please give details:_____

_____

_____

_____

12. Have you ever used alcohol or drugs more than you do now?	____	____

If yes, please explain to what extent_____

_____

_____

_____

13. Do you currently or have you ever vaped (e-cigarette)?	**Yes**	**No**
a. How many milligrams of nicotine do/did you use?	_____ mg	
14. Do you smoke cigarettes currently?	**Yes**	**No**
a. If yes, how many cigarettes/packs per day on average?	_____	

15. If no, have you ever smoked cigarettes in your lifetime? **Yes** **No**

16. **Do you drink more than 6 cups of coffee per day?** **Yes** **No**

    a. Do you consume 2+ caffeinated beverages per day? **Yes** **No**

17. **In the last four (4) weeks have you been bothered by any of the following problems?**

	Yes	No
• Worrying about your health	____	____
• Your weight or how you look	____	____
• Little or no sexual desire or pleasure during sex	____	____
• Difficulties with your husband/wife or significant other	____	____
• The stress of taking care of children, parents or family	____	____
• Stress at work, outside of the home or school	____	____
• Financial problems or worries	____	____
• Having no one to turn to when you have a problem	____	____
• Something bad that happened recently	____	____
• Thinking or dreaming about something terrible that happened to you in the past (like your house being destroyed, a severe accident, being physically, mentally or sexually abused), PTSD symptoms	____	____
• Learning disability (Dyslexia, ADHD, Math Disability)	____	____
• Have you experienced an unusual sensitivity to common noises such as someone eating, tapping on a computer, pen clicking, breathing, coughing, or hiccupping.	____	____

18. **In the last year have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have unwanted sexual acts?** ____ ____

19. **What is the most stressful thing in your life right now?**

    _____

    _____

    _____

20. **If you checked off any of the problems on the questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

    a. Not difficult at all
    b. Somewhat difficult
    c. Very difficult
    d. Extremely difficult

	Yes	No
21. **Has anyone in your family ever suffered from any psychiatric disorder? (i.e. Bi-polar, manic depression, anxiety disorder, schizophrenia, ADHD or alcohol or substance abuse) If yes please explain:**	____	____

For Women Only

22. Which best describes your menstrual period? (circle)

a. Periods are unchanged
b. No period because of pregnancy or recently given birth
c. Periods have become irregular or changed in frequency, duration, or amount
d. No periods for at least one (1) year (Menopause)
e. Having no periods because taking hormone replacement or contraceptive

	Yes	No
23. During the week before your period starts, do you have a serious problem with your mood, like depression, anxiety, irritability, anger or mood swings?	____	____
24. Pregnancy:		
a. Have you given birth within the last six (6) months?	____	____
b. Have you had a miscarriage within the last six (6) months?	____	____
c. Are you having difficulty getting pregnant?	____	____
25. Perimenopausal Symptoms:		
a. Have you had hot flashes	____	____
b. Have you had vaginal dryness and/or painful intercourse?	____	____
c. Have you experienced irregular periods, mood instability, anxiety, or depression?	____	____
d. Have you been prescribed hormone therapy?	____	____
e. Have you had a change in your libido or sexual interest?	____	____

For Men Only

26. Erectile or Sexual Dysfunction:		
a. Have you ever had difficulty maintaining an erection?	____	____
b. Have you had a change in your libido or sexual interest?	____	____
c. Have you ever been treated for Erectile Dyfunction?	____	____
d. Have you ever been prescribed Viagra, Cialis or Levitra?	____	____
e. Have you ever been treated for low testosterone?	____	____
f. Have you ever been treated for Peyronie's Disease?	____	____