New Patient Intake Form (Dr. Jeffrey DeSarbo / ED-180 Clinicians)

Date: _____

Patient Name:_____

Address:_____

Home Tel:_____ Cell #:_____

Email:_____ Date of Birth:_____

Emergency Contact Name/Phone:_____

Occupation:_____

Current employer/school: _____

Relationship Status: ____Single ____ Married ___yrs: _____Divorced ___yrs:
_____ In a relationship ____ Dating ____Other

Do you have children? _____ Names ages: _____

Who do you currently live with? _____

Insurance Provider(s): _____

Insurance Member ID #: _____ Insurance Phone #: _____

Pharmacy Address and Phone #: _____

Reason for today's evaluation: _____

_____

MENTAL HEALTH HISTORY

Please check next to any of the following that you have ever been diagnosed with or suspect you have suffered from:

Depressive Disorder_____ Anxiety Disorder____ Obsessive-Compulsive Disorder (OCD)____

Bipolar Disorder _____ Post-Traumatic Stress Disorder_____ Eating Disorder _____

Panic Disorder_____ Alcohol/Substance Use Disorder_____ Schizophrenia_____

Attention Deficit/Hyperactivity Disorder (ADHD) _____ Sleep Disorder _____

Personality Disorder_____ Premenstrual Mood Disorder_____

Other (please describe): _____

_____

Please list the names, specialty (i.e. psychiatrist, therapist, nutritionist, medical doctor), and dates of treatment for all clinicians you are **CURRENTLY** seeing for your treatment.

_____
_____
_____
_____

Please list the names, specialty and dates of treatment of any **PAST** treatment professionals you have seen for treatment. _____

_____
_____
_____
_____

Have you ever been hospitalized for mental health reasons? _____No _____Yes, please list hospital(s), date(s): _____

_____

Have you ever been treated in a residential facility for treatment? _____No _____Yes, please list name of center(s), date(s): _____

_____

Have you ever been treated in an IOP, partial day or full-day treatment program? _____No _____Yes, please list name, type and date(s) of any program(s): _____

_____
_____

List **ALL CURRENT** psychiatric MEDICATIONS/dose you are taking: _____

_____
_____

List **ALL PAST** psychiatric medications you have taken and any effectiveness or side effects you may have had: _____

_____
_____
_____

Have you recently had any thoughts of death and/or suicide? ____No ____Yes
Have you ever attempted suicide or come close to attempting? ____No ____Yes
Have you ever engaged in cutting behaviors or other self-mutilating behaviors? ____No ____Yes
Have you ever suffered from trauma or abuse? _____No _____Yes
Approximately how many alcoholic beverages do you have in a typical week? _____
Do you smoke marijuana? _____Never _____Occasionally _____Frequently
Have you ever had a history of any dependency on either alcohol and/or illicit substances?
_____No _____Yes, please specify _____

MEDICAL HISTORY

Height: _____ Weight: _____

Please check if you have ever been diagnosed with any of the following:

_____High Blood Pressure _____Low Blood Pressure _____Diabetes _____Thyroid Disease

_____ GERD (Reflux Disease) _____Gastroparesis _____Anemia _____Kidney Disease

_____Irregular Heart Beat _____Heart Disease _____Pulmonary Disease

_____Pre-Menstrual Mood Disorder _____Dental Disease _____Osteopenia/Osteoperosis

_____Sleep Apnea _____High Cholesterol _____STD _____Infertility

_____Polycystic Ovarian Syndrome _____Cancer:Type_____

Have you even been pregnant: _____No _____Yes

Please list any other medical conditions you have:_____

Please list any surgeries you had including cosmetic:_____

Please list any medications you are taking for medical conditions:_____

Please list any allergic reactions you have had to any medications:_____

Please list any vitamins and/or supplements you are currently taking:_____

Please list the name/town/phone number of you primary medical doctor and any specialists you see for medical treatment: _____

FAMILY HISTORY

____ Biological Parents ____ Adoptive Parents

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

List any siblings and include names/ages/school or occupations: _____

Mother's medical history: _____
Mother's psych history: _____

Father's medical history: _____
Father's psych history: _____

Sibling's medical history: _____
Sibling's psych history: _____

Are any family members on any medications for any mood, anxiety or other psychiatric conditions?
_____No _____Unknown _____Yes, please describe as best you can _____

Do any family members see a therapist for any mood, anxiety or other psychiatric conditions?
_____No _____Unknown _____Yes, please describe as best you can _____

ADDITIONAL INFORMATION – Please include below any additional information you feel is important for us to be aware for your evaluation.

_____ _____
Primary Clinician Signature *Date*

_____ _____
Clinician Signature *Date*