INTAKE INFORMATION

DATE:	NAME:	OCCUPATION:	

LIVING SITUATION:	HOBBIES:
PERSONAL STRESS: {1 – 10 worst]	WORK STRESS: [1 – 10 worst]

STRESS REDUCTION/RELAXATION:

RELIGION/SPIRITUALITY: ***Do you (the patient) consider yourself spiritual or religious? Do you belong to a spiritual community?***

- ☐ increase/decrease in spiritual interest
- ☐ change in expectations for your health
- ☐ use prayer in your life
- ☐ a feeling that life is meaningless or empty
- ☐ participate in religious/spiritual practices
- ☐ loss of family member, friend or significant other
- ☐ change in your relationship w/ God or deity
- ☐ increased fear, anger or bitterness
- ☐ feeling of lingering sadness

MEDITATION PRACTICE:

SLEEPING HABITS:

EXERCISE HABITS:

EATING HABITS:

ALCOHOL/DRUG USE: CAGEAID

Have you ever:

- ☐ felt you ought to cut down n your drinking or drug use?
- ☐ had people annoy you by criticizing your drinking or drug use?
- ☐ felt bad or guilty about your drinking or drug use?
- ☐ had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover or to get the day started?

CURRENT HEALTH CARE PROVIDERS:

CURRENT MEDICATIONS:

SIGNIFICANT PAST MEDICAL HISTORY:

IF YOU HAD 3 WISHES ABOUT ANY CHANGES IN YOURSELF, SCHOOL, WORK, FAMILY, WHAT WOULD THEY BE:

1.

2.

3.

SEXUALITY:

Are you sexually active? Y N If so, do you practice safe sex? Y N

What method of contraception do you use? Birth Control Pill Diaphragm Condom Other:

Have you had or do you have a venereal disease? Y N If yes:

Sexual Orientation: Heterosexual ("straight") ____ Homosexual ("gay")____ Bisexual____

Transgender____ Preferred Pronoun: _____

STRENGTHS:

☐athletic ☐ physical health ☐ sense of humor

☐ sociable ☐ social support ☐ housing situation

☐ intelligent ☐ family support ☐ problem solving skills

☐ caring ☐ follow rules ☐ school/work functioning

☐ confident ☐ communicate well

Comments:

WEAKNESSES:

☐ shy ☐ argumentative ☐ social support

☐ angry ☐ frightens easily ☐ family support

☐ impulsive ☐ physical health ☐ problem solving skills

☐ impatient ☐ cognitive/intellect ☐ work functioning

☐ housing situation

Comments:

REASON FOR APPOINTMENT:

Psychiatric History

Psychiatric Hospitalizations

Where	Dates	Reason

Outpatient Services/Therapy

Where and with whom?	Dates	Reason	Did you find this helpful?

Neuropsych/Psychological Testing

Where	Tests Performed	Outcome/Diagnosis

MEDICATION HISTORY

Please list all medications taken currently as well as previously. Commonly prescribed medications are listed below.

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Medication & Dose_____ _____ Currently ___ Previously ___

Antidepressants

Amitriptyline/Elavil
Bupropion/Wellbutrin
Citalopram/Celexa
Desipramine/Norpramin
Desvelafaxine/Pristiq
Duloxetine/Cymbalta
Escitalopram/Lexapro
Fluoxetine/Prozac
Fluvoxamine/Luvox
Levomilnacipran/Fetzima
Imipramine/Norpramin
Mirtazapine/Remeron
Nortriptyline/Pamelor
Paroxetine/Paxil
Sertraline/Zoloft
Trazodone/Desyrel
Venlafaxine/Effexor
Vilazodone/Viibryd
Vortioxetine/Trintellix

Atypical/Mood Stabilizers

Ariprazole/Abilify
Asenapine/Saphris
Brexpiprazole/Rexulti
Clozapine/Clozaril
Haloperdol/Haldol
Lurasidone/Latuda
Olanzapine/Zyprexa
Paliperidone/Invega
Quetiapine/Seroquel
Risperdone/Risperdal
Ziprasidone/Geodon

Anti-epileptic/Mood Stabilizers

Carbamazepine/Tegretol
Gabapentin/Neurontin
Lamotrigine/Lamictal
Levetiracetam/Keppra
Oxcarbazepine/Trileptal
Topiramate/Topomax
Valproate/Depakote
Lithium

Anti-Anxiety Medications

Alprazolam/Xanax
Buspirone/Buspar
Clonazepam/Klonopin
Diazepam/Valium
Hydroxyzine/Vistaril
Lorazepam/Ativan

THE MOOD DISORDER

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	✂	✂
...you were so irritable that you shouted at people or started fights or arguments?	✂	✂
...you felt much more self-confident than usual?	✂	✂
...you got much less sleep than usual and found you didn't really miss it?	✂	✂
...you were much more talkative or spoke much faster than usual?	✂	✂
...thoughts raced through your head or you couldn't slow your mind down?	✂	✂
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	✂	✂
...you had much more energy than usual?	✂	✂
...you were much more active or did many more things than usual?	✂	✂
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	✂	✂
...you were much more interested in sex than usual?	✂	✂
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	✂	✂
...spending money got you or your family into trouble?	✂	✂
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	✂	✂

3. How much of a problem did any of these cause you *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	✂	✂
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	✂	✂

Quality Life

Name: _____ Date: _____

PHQ-9

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that your are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

_____ + _____ + _____

Total: _____

10. If you checked off any problems, 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?	Not difficult at all Somewhat difficult Very difficult Extremely difficult	_____ _____ _____ _____

GAD-7

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
11. Feeling nervous, anxious, or on edge	0	1	2	3
12. Not being able to stop or control worrying	0	1	2	3
13. Worrying too much about different things	0	1	2	3
14. Trouble relaxing	0	1	2	3
15. Being so restless that it is hard to sit still	0	1	2	3
16. Becoming easily annoyed or irritable	0	1	2	3
17. Feeling afraid as if something awful might happen	0	1	2	3

_____ + _____ + _____

Total: _____

18. If you checked off any problems, 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?	Not difficult at all Somewhat difficult Very difficult Extremely difficult	_____ _____ _____ _____

MoodCheck

Part A. Please place a check after the statements below that *accurately describe you*.

During times when I am not using drugs or alcohol:	
I notice that my mood and/or energy levels shift drastically from time to time.	
At times, I am moody and/or energy level is very low, and at other times, and very high.	
During my "low" phases, I often feel a lack of energy, a need to stay in bed or get extra sleep, and little or no motivation to do things I need to do.	
I often put on weight during these periods.	
During my low phases, I often feel "blue," sad all the time, or depressed.	
Sometimes, during the low phases, I feel helpless or even suicidal.	
During the low phases, my ability to function at work or socially is impaired.	
Typically, the low phases last for a few weeks, but sometimes they last only a few days.	
I also experience a period of "normal" mood in between mood swings, during which my mood and energy level feels "right" and my ability to function is not disturbed.	
I then notice a marked shift or "switch" in the way I feel.	
My energy increases above what is normal for me, and I often get many things done I would not ordinarily be able to do.	
Sometimes during those "high" periods, I feel as if I have too much energy or feel "hyper".	
During these high periods, I may feel irritable, "on edge," or aggressive.	
During the high periods, I may take on too many activities at once.	
During the high periods, I may spend money in ways that cause me trouble.	
I may be more talkative, outgoing or sexual during these periods.	
Sometimes, my behavior during the high periods seems strange or annoying to others.	
Sometimes, I get into difficulty with co-workers or police during these high periods.	
Sometimes, I increase my alcohol or nonprescription drug use during the high periods.	
Total	

Part B. The statements in Part A (not just those checked) describe me (circle one of the answers below):

Not at all (0)	A little (2)	Fairly well (4)	Very well (6)

Add the number in parentheses in Part B to your checkmark total from Part A. _____

Part C.

Please indicate whether any of your (blood) relatives have had any of these concerns:

	Grandparents	Parents	Aunts/Uncles	Brothers/Sisters	Children
Suicide	☐	☐	☐	☐	☐
Alcohol/Drug Problems	☐	☐	☐	☐	☐
Mental Hospital	☐	☐	☐	☐	☐
Depression Problems	☐	☐	☐	☐	☐
Manic or Bipolar	☐	☐	☐	☐	☐

Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	Yes	No
Have you ever attempted suicide?	Yes	No

(please continue with part D, over)

MoodCheck

Part D.

How old were you when you first were depressed? (*circle one*)	As long as I can remember	Grade school	Middle school	High school	18-24	> 24
How many episodes of depression have you had?	One	2-4	5-6	>10		
Have antidepressants ever caused: (*circle all that apply)*	Excessive energy	Severe insomnia	Agitation	Irritability	Racing thoughts	Talking a lot
How many antidepressants have you tried, if any?	None	1	2	3	>3	
Has an antidepressant you took worked at first, then stopped working?	No	Yes				
Do your episodes *start* gradually, or suddenly?	Gradually	Can't say	Suddenly			
Do your episodes *stop* gradually, or suddenly?	Gradually	Can't say	Suddenly			
Did you have an episode after giving birth?	No	Within 6 months	Within 2 months	Within 2 weeks		
Are your moods much different at different times of year?	No effect of time of year	Yes, seasonal shifts				
When you are depressed, do you sleep differently?	No	Sleep less	Sleep more			
When you are depressed, do you eat differently?	No	Eat less	Eat more			
When you are depressed, what happens to your energy?	Nothing	It varies a lot	Very low	Extremely low, can hardly move		
In episodes, have you lost contact with reality? (delusions, voices, people thought you were odd)	No	Yes				

If your total score from Parts A and B is **greater than 16**; or if you have **lots of circles** in shaded boxes on this page, you may need to learn more about "mood swings without mania". See www.PsychEducation.org . This is something to learn about, not necessarily about *you*.

If your total score from Parts A and B is **less than 10**, and you have **few circles** in shaded boxes on this page, antidepressants are probably okay, if you and your doctor choose to use them. They can occasionally cause: unusual thoughts, including violent and suicidal ones; irritability; too much energy; and severe sleep problems. Contact your doctor if you think any of these might be happening to you.

Your Name_____ Date _____

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it ***happened to you*** personally, (b) you ***witnessed it*** happen to someone else, (c) you ***learned about it*** happening to someone close to you, (d) you're ***not sure*** if it fits, or (e) it ***doesn't apply*** to you.

Be sure to consider your ***entire life*** (growing up as well as adulthood) as you go through the list of events.

Event	*Happened to me*	*Witnessed it*	*Learned about it*	*Not Sure*	*Doesn't apply*
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

Wender Utah Rating Scale Name: _____ Date: _____

As a Child I Was (or Had):	Not at all or very slightly	Mildly	Moderately	Quite a Bit	Very Much
1.Active, restless, always on the go					
2.Afraid of things					
3.Concentration problems, easily distracted					
4.Anxious, worrying					
5.Nervous, fidgety					
6.Inattentive, daydreaming					
7.Hot or short temp, low boiling point					
8.Shy, sensitive					
9.Temper outbursts, tantrums					
10.Trouble with stick-to-it-tiveness, not following through, failing to finish things started					
11.Stubborn, strong-willed					
12.Sad or blue, depressed, unhappy					
13.Uncautious, dare-devilish, involved in pranks					
14.Not getting a kick out of things, dissatisfied with life					
15.Disobedient with parents, rebellious, sassy					
16.Low opinion of myself					
17.Irritable					
18.Outgoing, friendly, enjoy company of people					
19.Sloppy, disorganized					
20.Moody, have ups + downs					
21.Feel angry					
22.Have friends, popular					
23.Well organized, tidy, neat					
24.Acting without thinking, impulsive					
25.Tend to be immature					
26.Feel guilty, regretful					
27.Lose control of myself					
28.Tend to be or act irrational					
29.Unpopular with other children, didn't keep friends for long, didn't get along with other children					
30.Poorly coordinated, did not participate in sports					
31.Afraid of losing control of self					
32.Well coordinated, picked first in games					
33.(for women only) Tomboyish					
34.Ran away from home					
35.Get in fights					
36.Teased other children					
37.Leader, bossy					
38.Difficulty getting awake					
39.Follower, lead around too much					
40.Trouble seeing things from someone else's point of view					
41.Trouble with authorities, trouble with school, visits to the principal's office					
42.Trouble with the police, booked, convicted					

Medical Problems as a Child	**Not at all or very slightly**	**Mildly**	**Moderately**	**Quite a Bit**	**Very Much**
43.Headaches					
44.Stomach aches					
45.Constipation					
46.Diarrhea					
47.Food Allergies					
48.Other Allergies					
49.Bedwetting					
As a Child in School	**Not at all or very slightly**	**Mildly**	**Moderately**	**Quite a Bit**	**Very Much**
50.Overall a good student, fast					
51.Overall a poor student, slow learner					
52.Slow reader					
53.Slow in learning to read					
54.Trouble reversing letters					
55.Trouble with spelling					
56.Trouble with math or numbers					
57.Bad handwriting					
58.Though I could read pretty well, I never really enjoyed reading					
59.Did not achieve up to potential					
60.Repeated grades (which grades?)					
61.Suspended or expelled (which grades?)					

kmm 01/2008

Quality Life H & P

Name _____ SS# _____ Date_____

Drug Allergies:	**Family History:**	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
	Heart Disease	☐	☐	☐	☐	☐	☐
	High Blood Pressure	☐	☐	☐	☐	☐	☐
	Stroke	☐	☐	☐	☐	☐	☐
	Cancer	☐	☐	☐	☐	☐	☐
	Glaucoma	☐	☐	☐	☐	☐	☐
Current Medications:	Diabetes	☐	☐	☐	☐	☐	☐
	Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
	Bleeding Disorder	☐	☐	☐	☐	☐	☐
	Kidney Disease	☐	☐	☐	☐	☐	☐
	Thyroid Disease	☐	☐	☐	☐	☐	☐
	Mental Illness	☐	☐	☐	☐	☐	☐
	Osteoporosis	☐	☐	☐	☐	☐	☐

Hospitalizations or Surgery

Reason	Date	Reason	Date

Medical History

- ☐ Headaches
- ☐ Shortness of Breath
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Dizziness/Fainting
- ☐ Peripheral Vascular Disease
- ☐ Allergies/Hay Fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Ulcer
- ☐ GI Disorder
- ☐ Lactose Intolerance
- ☐ Gallbladder Disease
- ☐ Prostate Disease
- ☐ Bowel Irregularity
- ☐ Incontinence
- ☐ Sexual/Menstrual dysfunction
- ☐ Venereal Disease
- ☐ Frequent Infections
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Nervousness
- ☐ Depression
- ☐ Gout
- ☐ Scarlet Fever
- ☐ Chronic Rashes
- ☐ Rheumatic Fever
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Polio
- ☐ Diptheria
- ☐ Tetanus
- ☐ Other
- ☐ Other

Women Only

Pregnant? ❑ Yes ❑ No Planning Pregnancy? ❑ Yes ❑ No

Men Only

It's common for men to occasionally experience erection difficulties. Is this something that happens to you? ❑ Yes ❑ No

How often does this occur? ❑ Frequently ❑ Sometimes ❑ Rarely

Habits:

☐ Smoke: Packs daily _____
How long? _____
Interested in stopping? _____

☐ Marijuana Amount used _____
Frequency of use _____

☐ Coffee Cups daily _____
Other caffeine _____

☐ Alcohol Type _____

☐ Diet Amount _____
Salt Intake _____
Fat Intake _____

☐ Exercise Routine

☐ Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring_____
Early Morning Awakening _____
Daytime drowsiness _____
Other _____