2655 State Road 580, Suite 202 - Clearwater, Florida 33761

7011 Ridge Road – Port Richey, Florida 34668

Patient Name: _____ Date of Birth: _____

Referred by: _____

Reason for Visit: _____

_____

Current psychiatric medications and doses: _____

_____

_____

_____

_____

PHARMACY INFORMATION:

Name of Pharmacy: _____

Phone Number: _____

Fax Number: _____

Address: _____

_____

PRIMARY CARE PHYSICIAN INFORMATION:

Is it okay to contact your Primary Care Doctor?

☐ **Yes** ☐ **No** ☐ **I do not have one**

(If yes, please fill out accompanying Release of Information at the end of the packet)

Doctor's Name*:* _____

Phone Number*:* _____

Fax Number*:* _____

Address*:* _____

_____

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Please check all that apply:

- ☐ Depressed mood
- ☐ Hopeless or helpless
- ☐ Don't do pleasure or leisure activities like I use to
- ☐ Feelings of guilt
- ☐ Feelings of worthlessness
- ☐ Low self-esteem
- ☐ Decreased energy
- ☐ Decreased concentration
- ☐ Appetite or weight changes
- ☐ Moving slower or speaking slowly
- ☐ Feeling fidgety or have feeling of inner restlessness
- ☐ Sex drive changes
- ☐ Fatigued / tired most days
- ☐ Feel irritable often for no reason
- ☐ Harder to make decisions than I use to
- ☐ Sleep problems
  - Hard to get to sleep, but I stay asleep
  - Hard to stay asleep, but I get to sleep okay
  - Hard to get to sleep and hard to stay asleep
- ☐ Ideas of suicide or death
- ☐ Anxious
- ☐ Panic attacks
- ☐ Fear of social situations
- ☐ Obsessions
- ☐ Compulsions

- ☐ Do you feel threatened or scared?
- ☐ Are people out to get you?
- ☐ Can you read people's thoughts?
- ☐ Can other people read your mind or know your thoughts?
- ☐ Does the TV or radio talk to you?
- ☐ Hear voices others can't?
- ☐ See things others can't?
- ☐ I have intrusive thoughts that are not my own
- ☐ I have special abilities or powers others do not have
- ☐ Thoughts are put inside my head by others
- ☐ I sometimes have out of body experiences

- ☐ Mood swings or irritability
- ☐ Anger outbursts
- ☐ Decreased need for sleep
- ☐ More talkative
- ☐ Racing thoughts
- ☐ At times, I become overly distractible where even small things pull me away from important things.
- ☐ At times, I do more risky things than usual or I spend money of control or get involved in sex or other adventures that often turn out badly
- ☐ At times, I do more Impulsive than usual and do things that are totally out of character for me
- ☐ At times , I start many projects or get into so many activities that I can't complete and I jump from one to another rapidly
- ☐ At times, I am unusually irresponsible and take action that cause moderate to severe problems (legal, financial, relationship) for me and my family

- ☐ I have experienced a traumatic event
- ☐ I often have the same nightmare or bad dream
- ☐ Memories come into my mind when I don't want them
- ☐ Sometimes I feel numb all over when I have some memories
- ☐ I avoid certain people and places I go
- ☐ Sometimes I feel so much fear that I detach myself or feel disassociation from people or places
- ☐ I am hyper-vigilant / hyper-aware even when no danger is present
- ☐ I have many body aches and pains
- ☐ I have neck, back and other chronic pain
- ☐ I have headaches / migraines often
- ☐ I have had a head injury in the past

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Psychiatric History

Past Psychiatrist / Therapist: _____

Date Last Seen: _____

Past Psychiatric Diagnosis: _____

Past Psychiatric Medications: _____

_____

_____

_____

_____

_____

1. Have you ever been hospitalized for any psychiatric reasons? YES ☐ NO ☐

If yes, how many times? _____

What was the reason? _____

What was the date? _____

Where were you hospitalized? _____

2. Have you ever been placed under a Baker Act? YES ☐ NO ☐

If yes, why were you Baker Acted? _____

What was the date/dates? _____

3. Have you ever attempted to commit suicide? YES ☐ NO ☐

If yes, **how** did you attempt to kill yourself? _____

How many times did you attempt suicide? _____

What was the date(s)? _____

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Medical History

Current Medical Issues: _____

_____

_____

_____

_____

_____

Current Non-psychiatric Medications: _____

_____

_____

_____

_____

_____

Allergies: _____

_____

_____

Surgical History

Past Surgeries (Include date/hospital/physician): _____

_____

_____

_____

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Family Psychiatric History (*please check all that apply & list family member*):

□ Depression - family member(s): _____

□ Anxiety - family member(s): _____

□ Bi-polar - family member(s): _____

□ Schizophrenia - family member(s): _____

□ Suicidal Attempts-family member(s): _____

□ ADD / ADHD - family member(s): _____

□ Alcoholism - family member(s): _____

□ Drug abuse - family member(s): _____

□ Dementia - family members(s): _____

Social History

Smoking status (please check one that applies):

☐ Current Smoker ☐ Former Smoker ☐ Never Smoker

Alcohol consumption (please check one that applies):

☐ Non-Drinker ☐ Occasional ☐ Social ☐ Rare

Daily, Drinks per day.

I usually drink ☐ Beer ☐ Wine ☐ Liquor

Do you have a history of substance or alcohol abuse? YES ☐ NO ☐

If so, please explain: _____

_____

Have you ever been treated for substance abuse? YES ☐ NO ☐

If so, where were you treated? _____

What was the date? _____

Marital Status (please check one that applies):

Single ☐ Married ☐ Divorced ☐ Widowed ☐

How long: _____

Children: _____

Employment Status (please check one that applies):

Employment ☐ Unemployed ☐ Disability ☐ Retired ☐

Employer: _____

IF on disability, please explain why: _____

_____

Education Level: _____

Currently Residing With (please check one that applies):

☐ I am living alone

☐ I am living with a family member

☐ I am living with a spouse or significant other

Other: _____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name _____ **Date** _____

Provider _____ **Patient ID #** _____

	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 or staying 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 you 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 in some way	0	1	2	3
	Add Columns:				
	Healthcare professional: For interpretation of TOTAL) Please refer to accompanying scoring card.)		+	+	

10 If you checked off *any* problems, how *difficult* 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 _____