Nurture Psychiatry & Psychotherapy – New Patient Intake Form

Please complete all information on this form and send to Dr. Masifi in advance of your first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Basic Information

Name_____ Date_____

Date of Birth _____

Street Address _____

City _____ State _____ Zip Code _____

Primary Phone # _____ Secondary Phone #_____

Email address _____

Emergency Contact _____ Telephone # _____

Relationship of emergency contact to self _____

Primary Care Physician_____ Telephone # _____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor_____Telephone #_____

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

What are your treatment goals?

_____
_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood ( ) Unable to enjoy activities ( ) Sleep pattern disturbance ( ) Loss of interest

( ) Concentration/forgetfulness ( ) Change in appetite ( ) Excessive guilt ( ) Fatigue ( ) Decreased libido

Suicide Risk Assessment

( ) Racing thoughts ( ) Impulsivity ( ) Increase risky behavior ( ) Increased libido ( ) Decrease need for sleep
( ) Excessive energy ( ) Increased irritability ( ) Crying spells ( ) Excessive worry ( ) Anxiety attacks ( ) Avoidance
( ) Hallucinations ( ) Suspiciousness ( ) _____ ( ) _____

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No

If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

Past Medical History:

Allergies_____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____
_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements:

_____
_____

Current medical problems: _____
_____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____
_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ .
Was the EKG ( ) normal ( ) abnormal or ( ) unknown**?**

If applicable: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No

How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss? ( ) Yes ( ) No

Date and place of last physical exam: _____

Personal Medical History:

Thyroid Disease ---------- () Anemia---------- ()
Liver Disease ---------- () Chronic Fatigue ---------- ()
Kidney Disease ---------- () Diabetes ---------- ()
Asthma/respiratory problems ------ () Stomach or intestinal problems ------ ()
Cancer (type) ---------- () Fibromyalgia ---------- ()
Heart Disease ---------- () Epilepsy or seizures ---------- ()
Chronic Pain ---------- () High Cholesterol ---------- ()
High blood pressure---------- () Head trauma ---------- ()
Liver problems ---------- () Other ---------- ()

Family Medical History:

Thyroid Disease ---------- () Anemia---------- ()
Liver Disease ---------- () Chronic Fatigue ---------- ()
Kidney Disease ---------- () Diabetes ---------- ()
Asthma/respiratory problems ------ () Stomach or intestinal problems ------ ()
Cancer (type) ---------- () Fibromyalgia ---------- ()
Heart Disease ---------- () Epilepsy or seizures ---------- ()
Chronic Pain ---------- () High Cholesterol ---------- ()
High blood pressure---------- () Head trauma ---------- ()
Liver problems ---------- () Other ---------- ()

Specify which family member below:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:
_____
_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No

If yes, Please describe when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

Psychiatric Hospitalization ( ) Yes ( ) No

If yes, describe for what reason, when and where.

Reason	Date Hospitalized	Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

	Dates	Dosage Response/Side-Effects

Antidepressants

Prozac (fluoxetine) _____
Zoloft (sertraline) _____
Luvox (fluvoxamine) _____
Paxil (paroxetine) _____
Celexa (citalopram) _____
Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Remeron (mirtazapine) _____
Serzone (nefazodone) _____
Anafranil (clomipramine) _____
Pamelor (nortrptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Other _____

Mood Stabilizers

Tegretol (carbamazepine)_____
Lithium_____
Depakote (valproate) _____ _____
Lamictal (lamotrigine) _____
Tegretol (carbamazepine) _____
Topamax (topiramate) _____
Other _____

Past Psychiatric medications (continued)
Antipsychotics/Mood Stabilizers Dates Dosage Response/Side-Effects

Seroquel (quetiapine) _____
Zyprexa (olanzepine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperidone) _____
Other _____
Sedative/Hypnotics
Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon)_____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other _____
ADHD medications
Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Other _____
Antianxiety medications
Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____
Other _____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder ( ) Yes ( ) No
Depression ( ) Yes ( ) No
Anxiety ( ) Yes ( ) No
Anger ( ) Yes ( ) No
Schizophrenia ( ) Yes ( ) No
Post-traumatic stress ( ) Yes ( ) No

Alcohol abuse ( ) Yes ( ) No
Other substance abuse ( ) Yes ( ) No
Violence ( ) Yes ( ) No
Suicide ( ) Yes ( ) No
If yes, who had each problem? _____
_____
Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No
If yes, who was treated, what medications did they take, and how effective was the treatment?
_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____
_____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( )Yes( )No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Ever had a DUI or other substance related legal issues? ( ) Yes ( ) No If yes, specify: _____
_____
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? _____
_____

Check if you have ever tried the following:

Methamphetamine ( ) Yes ( ) No If yes, how long and when did you last use? _____
_____
Cocaine ( ) Yes ( ) No _____
Stimulants (pills) ( ) Yes ( ) No _____
Heroin ( ) Yes ( ) No _____
LSD/Mushrooms ( ) Yes ( ) No _____

Marijuana ( ) Yes ( ) No _____
Pain killers ( ) Yes ( ) No _____
Methadone ( ) Yes ( ) No _____
Tranquilizer
Sleeping pills ( ) Yes ( ) No _____
Alcohol ( ) Yes ( ) No _____
Ecstasy ( ) Yes ( ) No _____
Other ( ) Yes ( ) No _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? **( )** Yes **( )** No How many packs per day on average? _____ How many years? _____ In the past? **( )** Yes **( )** No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? **( )** Yes **( )** No In the past? **( )** Yes **( )** No What kind? _____
How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No
Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No
Please describe when, where and by whom: _____
_____

Educational History:

Highest Grade Completed? _____ Where? _____
Did you attend college? _____ Where? _____Major? _____
What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No Other type discharge _____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed
How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No
If yes, do you use protection and/or contraception?
( ) None ( ) Condoms ( ) Birth control pills, ring, Depo-Provera, Implanon, diaphragm, IUD (circle one and specify): _____
Have you ever been diagnosed with a sexually transmitted infection?
( ) No ( ) Yes If yes, diagnosis and treatment: _____
_____
How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual ( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer _____
What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other:
_____
Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____
How long? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____
_____
Describe your relationship with your children: _____

List everyone who currently lives with you: _____
_____

Legal History:

Have you ever been arrested? _____ If yes, specify year, charges, outcome: _____
_____
Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?
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_____

Signature_____ **Date**_____

Printed name _____

Guardian Signature (if conserved) _____ **Date** _____