Cheney Psychiatric Associates, LLC
3701 Union Dr Ste 100
Lincoln, NE 68516

Patient Name: _____ DOB: ____/____/____ Today's Date: ____/____/____
Mailing Address: _____ City: _____ ST: _____ Zip: _____
Check Appropriate: □ Minor □Single □Married □Separated □Widowed
Best Phone: _____ SSN: _____ Email: _____
Reminder Call Preference: □ Call/Voicemail □ Text □Email Sex (must match insurance): □Male □Female
Gender Identity: □ Male □ Female □ Transgender □non-Binary □ _____
If patient is a full-time student, name of school: _____ City/State _____
Highest Level of Education: _____
Primary Language Spoken: _____ Race: _____ Ethnicity: _____

GUARANTOR INFORMATION

Name: _____ Relationship to Patient: _____
DOB: ____/____/____ Social Security Number: _____ Phone: _____
Mailing Address: _____ City: _____ ST: _____ Zip: _____

***** MINORS ONLY (18 & Under) *****

Mother's Name: _____ Phone: _____ Ok to Release Info: □ Y /□ N
Father's Name: _____ Phone: _____ Ok to Release Info: □Y / □N

Emergency Contact Name: _____ Phone: _____
Relationship to Patient: _____

Insurance Information: Do you have Medicare? □Yes □No Do you have Medicaid? □Yes □No
Insurance Company: _____ Members ID #: _____ Group #: _____
Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's DOB: ____/____/____Subscriber's Social Security #: _____Phone: _____
Do you have additional insurance? □ Yes □No (If yes, please list below)
Insurance Company: _____ Members ID #: _____ Group #: _____
Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's DOB: ____/____/____Subscriber's Social Security #: _____Phone: _____

Authorization and Release

I certify that the information provided above is true and correct to the best of my knowledge and belief. I authorize the provider to release any information including the diagnosis and the records for any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the providers office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill services. I understand I am responsible for all co-pays, deductibles, co-insurance and balances. I understand and agree that I am ultimately responsible for any unpaid balances. I understand and agree that any cellular or landline phone numbers provided by myself to this office and to any of our service providers may leave messages for me manually and by using automatic systems such as by artificial prerecorded voice. I also agree that this office and any service providers may contact me by sending a text message and/or email to any number or email address I provide to this office or service providers and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

X_____
Signature of Patient/Parent or Guardian if Minor

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name: _____ Date of Birth: _____

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment. I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time, but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broke under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physical abused, or is at risk of such abuse, my provider is legally required to take steps to protect the individual, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with your provider any questions or concerns you may have.

By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment or services and authorize my provider to provide such care, treatment or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(For Minor)

INFORMED CONSENT FOR PATIENT RESPONSIBLITES

Patient Name:_____ Date of Birth: _____

By initialing the following you understand and accept these terms:

_____ The clinician I am seeing is an independent contractor, not an employee of Cheney Psychiatric associates, LLC.

_____ The clinician does not provide emergency service; I will contact the nearest hospital in case of an emergency.

_____ Copays must be paid at time of visit. All balances should be paid within thirty days of receipt of statement. I understand that I am responsible for any fees that are not paid by my insurance company. It is my responsibility to check with my insurance company to determine if these services are covered. I understand I may have a deductible which is also my responsibility to pay.

_____ If I have an insurance plan with a deductible, a $75 deposit is due before seen.

_____ If I'm not using insurance or the provider is "out-of-network", please complete the **Good Faith Estimate** Forms. Out-of-network claims may be submitted to your insurer but due to no agreement with the insurer it is the patient's responsibility to clear up any disputes or confusion with the insurer.

_____ If the insurance company that you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan.

_____ If previous arrangements have not been made with our office, any account balance outstanding greater than 28 days will be charged a $3 re-bill fee every 30 days.

_____ If I am unable to attend my appointment, I understand I must contact the office at least 24 hours prior to my appointment time. If this doesn't occur a **Late Cancel Fee of $50.00** will be charged if less than 24 hours' notice is given. I will be charged **$100 if No Call/No Show** occurs. I may also be discharged from my providers care due to either of the above.

_____ Should telephone contact with my provider be necessary my provider or nurse will respond as soon as possible. Calls must address immediate concerns and not substitute for an office visit. I understand I may be billed for telephone call as insurance does not cover these services.

Nurse Practitioner/ Medication Patients

_____ Prescription refills will be filled Monday through Thursday only and require 24-hour notice. No refills will be made during evening hours, weekends, and holidays. I will contact my pharmacy with all refill request except for ADHD/Stimulant medications. For those I will contact the office.

_____ Follow up appointments are scheduled for 15 mins. If longer time is needed this must be requested in advance when scheduling. There may be additional charges.

Client Signature: _____ Date: _____
Parent/Guardian Name/Signature: _____
(for minor)

Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and limits on ways my provider may use or disclose personal health information to provide service.

Client Signature: _____ Date: _____
Parent/Guardian Name/Signature: _____
(for minor)

Minor Child Acknowledgement

As a parent/guardian, I understand that I have the right to information concerning my minor child, except where otherwise stated. I also understand that this provider believes that providing a minor child with a private environment in which to disclose helps facilitate treatment. I therefore give permission to the provider to use his/her discretion, in accordance with professional ethics and state and federal laws, in deciding which information is shared with me.

Parent/Guardian Name/Signature: _____ Date: _____
(for minor)

3701 Union Drive Suite 100 ~ Lincoln, NE 68516
Tel: (402) 875-9270 Fax: (402) 875-9272

Cheney Psychiatric Provider Name: _____

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete this form for each person you would like us to release your information to such as: Therapist, Primary Doctor, Family.

I understand the advantages/disadvantages and freely and voluntarily give permission to release information about me.

Patient Name (Last, First MI)	Date of Birth
Social Security Number	Date of Consent

Information will be disclosed to and/or exchanged with **Cheney Psychiatric Provider Name (fill in):** _____ And **Name of person releasing to (PCP/School/Etc.):**			Reason for Disclosure: ☐Request of patient ☐Obtaining past treatment records ☐Collaboration of care ☐Legal purposes ☐Consultation and/or treatment ☐Other (specify):
Address			
City	State	Zip Code	
Tel #	Fax #		

Specific information to be disclosed: ☐All records ☐Phone contact ☐Psychiatric Assessment & Update ☐Treatment Plan & Update ☐Psychosocial Assessment & Update ☐Psychological Evaluation	☐Physician's Orders ☐Substance Use Assessment ☐Medication Administration Record ☐History & Physical Examination ☐Laboratory (X-ray, EKG, EEG) ☐Discharge Summary ☐Other:

This Authorization (unless revoked earlier in writing) shall terminate 90 days from date of discharge or one year from date of signature, whichever is the latter. By signing this Authorization, I acknowledge that the information to be released MAY INCLUDE material that is protected by Federal Law and may be applicable to Drug/Alcohol related information. My signature authorizes release of all such information. I also understand this Authorization may be revoked at any time by submitting a written request and it will be honored with exception of information that has already been released. I also understand that, if the person/organization authorized to receive my information is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulation.

Patient Signature	Date
Personal Representative Signature (☐Parent ☐Guardian ☐PoA)	Date

Clinical History Form

Patient First Name: _____ **Patient Last Name:** _____

Date Completed: _____ **Age:** _____

Pharmacy Name/location: _____

Who referred you to this office: _____

Reason for visit: _____ **How long has this been a problem**_____

Goal for treatment: _____

Stressors: Given the list of categories below, how much stress is each area currently causing you?

	None	Mild	Moderate	Severe
Family	☐	☐	☐	☐
Friends	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Educational	☐	☐	☐	☐
Economic	☐	☐	☐	☐
Occupational	☐	☐	☐	☐
Housing	☐	☐	☐	☐
Legal	☐	☐	☐	☐
Health	☐	☐	☐	☐

Review of Systems

Please look at the list of physical symptoms below and check off any that you have experienced in the last several days. If you have NOT experienced any symptoms in an area, be sure to check "None of the above" for that area.

Constitutional

- ☐ Chronic pain
- ☐ Loss of appetite
- ☐ Increase in appetite
- ☐ Unexplained weight loss
- ☐ Weight gain
- ☐ Fatigue/Lethargy
- ☐ Unexplained fever
- ☐ Hot or Cold spells
- ☐ Night sweats
- ☐ Sleeping pattern disruption
- ☐ Malaise (Flu-like or Vague sick feeling)

Other:

☐ None of the above constitutional issues.

Eyes

- ☐ Eye pain
- ☐ Eye discharge
- ☐ Eye redness
- ☐ Blurred or double vision
- ☐ Visual change
- ☐ History of eye surgery
- ☐ Sensitivity to light
- ☐ Scotomas (Blind spots)
- ☐ Retinal hemorrhage (Floaters in vision)
- ☐ Amaurosis (Feeling like a curtain is pulled over vision)

Other:

☐ None of the above eye issues.

Ears, Nose, Mouth, and Throat

- ☐ Earache
- ☐ Tinnitus (Ringing in ears)
- ☐ Decreased hearing or hearing loss
- ☐ Frequent ear infections
- ☐ Frequent nose bleeds
- ☐ Sinus congestion
- ☐ Runny nose/Post-nasal drip
- ☐ Difficulty swallowing
- ☐ Frequent sore throat
- ☐ Prolonged hoarseness
- ☐ Pain in jaw or tooth
- ☐ Dry mouth

Other:

☐ None of the above ear, nose, mouth, or throat issues.

Cardiovascular

- ☐ Chest pain
- ☐ Pacemaker
- ☐ Palpitations (Fast or irregular heartbeat)
- ☐ Swollen feet or hands
- ☐ Fainting spells
- ☐ Shortness of breath with exercise

Other:

- ☐ None of the above cardiovascular issues.

Respiratory

- ☐ Pain with breathing
- ☐ Chronic cough
- ☐ Chronic shortness of breath
- ☐ Chronic wheezing/Asthma
- ☐ Excessive phlegm
- ☐ Coughing blood
- ☐ Nocturnal Dyspnea (Shortness of breath at night)

Other:

- ☐ None of the above respiratory issues.

Musculoskeletal

- ☐ Swelling in joints
- ☐ Redness of joints
- ☐ Other joint pains or stiffness
- ☐ Muscle pain or cramping
- ☐ Muscle weakness
- ☐ Muscle stiffness
- ☐ Decreased range of motion
- ☐ Back pain or stiffness
- ☐ History of fractures
- ☐ Past injury to spine or joints

Other:

- ☐ None of the above musculoskeletal issues.

Gastrointestinal

- ☐ Excessive flatulence or belching
- ☐ Diarrhea
- ☐ Constipation
- ☐ Persistent nausea/vomiting
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Difficulty swallowing solids or liquids
- ☐ Recent loss in appetite
- ☐ Sensitivity to milk products
- ☐ Jaundice (Yellow skin)
- ☐ Change in appearance of stool
- ☐ Blood in stool
- ☐ Dark/Tarry stool
- ☐ Loss of bowel control

Other:

- ☐ None of the above gastrointestinal issues.

Allergic/Immunologic

- ☐ Frequent infections
- ☐ Hives
- ☐ Anaphylaxis reaction

Other:

- ☐ None of the above allergic or immunologic issues.

Endocrine

- ☐ Severe menopausal symptoms
- ☐ Cold or heat intolerance
- ☐ Excessive appetite
- ☐ Excessive thirst or urination
- ☐ Excessive sweating

Other:

- ☐ None of the above endocrine issues.

Hematologic/Lymphatic

- ☐ Blood clots
- ☐ Easy bleeding after surgery or dental work
- ☐ History of blood transfusion
- ☐ Excessive bruising or bleeding
- ☐ Swollen glands (Neck, armpits, groin)

Other:

- ☐ None of the above hematologic or lymphatic issues.

Genitourinary (General)

- ☐ Loss of urine control
- ☐ Painful/Burning urination
- ☐ Blood in urine
- ☐ Increased frequency of urination
- ☐ Up more than twice/night to urinate
- ☐ Urine retention
- ☐ Frequent urine infections

Other:

- ☐ None of the above general genitourinary issues.

Genitourinary (Women)

- ☐ Unusual vaginal discharge
- ☐ Vaginal pain, bleeding, soreness, or dryness
- ☐ Genital sores
- ☐ Heavy or irregular periods
- ☐ No menses (Periods stopped)
- ☐ Currently pregnant
- ☐ Sterility/Infertility
- ☐ Any other sexual or sex organ concerns

Other:

- ☐ None of the above sex-specific genitourinary issues.

Genitourinary (Men)

- ☐ Slow urine stream
- ☐ Scrotal pain
- ☐ Lump or mass in the testicles
- ☐ Abnormal penis discharge
- ☐ Trouble getting/maintaining erections
- ☐ Inability to ejaculate/orgasm
- ☐ Any other sexual or sex organ concerns

Other:

- ☐ None of the above sex-specific genitourinary issues.

Neurological

- ☐ Paralysis
- ☐ Fainting spells or blackouts
- ☐ Dizziness/Vertigo
- ☐ Drowsiness
- ☐ Slurred speech
- ☐ Speech problems (Other)
- ☐ Short term memory trouble
- ☐ Memory difficulties (loss)
- ☐ Frequent headaches
- ☐ Muscle weakness
- ☐ Numbness/Tingling sensations
- ☐ Neuropathy (Numbness in feet)
- ☐ Tremor in hands/shaking
- ☐ Muscle spasms or tremors

Other:

- ☐ None of the above neurological issues

Integumentary (Skin/Breast and Hair)

- ☐ Lesions
- ☐ Unusual mole
- ☐ Easy bruising
- ☐ Increased perspiration
- ☐ Rashes
- ☐ Chronic dry skin
- ☐ Itchy skin or scalp
- ☐ Hair or nail changes
- ☐ Hair loss
- ☐ Breast tenderness
- ☐ Breast discharge
- ☐ Breast lump or mass

Other:

- ☐ None of the above integumentary issues

Psychiatric

- ☐ In-depth review of psychiatric system appears earlier in document
- ☐ Feeling depressed
- ☐ Difficulty concentrating
- ☐ Phobias/Unexplained fears
- ☐ No pleasure from life anymore
- ☐ Anxiety
- ☐ Insomnia
- ☐ Excessive moodiness
- ☐ Stress
- ☐ Disturbing thoughts
- ☐ Manic episodes
- ☐ Confusion
- ☐ Memory loss

Other:

- ☐ None of the above psychiatric issues

***Substance Abuse History*: Do you have a history of recreational drug use/Alcohol abuse?** ☐ Yes ☐ No

If answered YES, fill out table below to the best of your knowledge:

Substance Used	Yes	No	How often used	Date last used
Amphetamines/Speed				
Barbiturates/Downers				
Opiates				
Cocaine				
Psychedelics (LSD, Ecstasy, Bath salts, etc.)				
Inhalants				
Cannabis/Marijuana				
Alcohol				
Benzodiazepines				
Other:				
Tobacco				

***History*: Did you receive any treatment for substance abuse?** ☐ Yes ☐ No

Please explain type of treatment: _____

***Consequences of Substance Abuse*: Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances? (Please check all that apply)**

___No consequences
___Felt that you needed to cut down on drinking
___Been annoyed by others criticizing your drinking
___Felt guilty about drinking
___Needing a drink first thing in the morning
___Increased tolerance
___Withdrawal (shakes, sweating, nausea, rapid heart rate)
___Seizures
___Blackouts
___Effects on physical health
___Using/consuming more than intended
___Unintentional overdose
___DUI
___Arrests
___Physical fights or assaults
___Relationship conflicts
___Problems with money
___Job loss or problems at work/school

Mental Health History:

***Prior Inpatient Treatment/ hospitalizations* (for psychiatric, emotional, or substance abuse disorder)?**

☐ Yes ☐ No

Reason	Date Hospitalized	Where

Past Mental health providers (therapist/psychiatrist/nurse practitioner)

Name	When treated

Past Psychiatric History: Suicide/Self Harm

Have you ever tried to harm or kill yourself? ☐ Yes ☐ No

If yes, please answer the following questions.

Was your intent to die? ☐ Yes ☐ No

How many times has this occurred? _____

What was the most severe episode and when?

_____

When was your most recent episode of suicidal thoughts or attempts?

_____

Have you had any history of violent behavior? ☐ Yes ☐ No

If yes, please describe:

_____

Past Medical History

Are you currently taking any medications? ☐ Yes ☐ No

If YES, please list name and dose:

_____

_____

Do you have any medication allergies? ☐ Yes ☐ No

If YES, please list medication and reaction:

_____

Are Immunizations up to date? ☐ Yes ☐ No

Primary Care Provider_____ **Date of last Physical**_____

Family Psychiatric History

Does anyone in your family have mental illness or substance abuse problems? ☐ Yes ☐ No

If YES, please list who and what their diagnosis is (ex: mother – history of depression):

_____

_____

Please check the following boxes for physical health problems you have had or currently experience.

☐ **No problems**	☐ Fibromyalgia	☐ Iron deficiency
☐ Allergies	☐ Gall bladder disease	☐ Kidney disease
☐ Anemia	☐ Gastritis/Ulcer	☐ Kidney stones
☐ Arthritis	☐ Glaucoma	☐ Liver disease
☐ Asthma	☐ Gout	☐ Lupus
☐ Back Problems	☐ Hearing loss	☐ Migraine headaches
☐ Cancer	☐ Heart disease	☐ Multiple sclerosis
☐ Cataracts	☐ Heart defect from birth	☐ Obesity or overweight
☐ Chickenpox	☐ Heart valve problems	☐ Parkinson's disease
☐ Chronic bronchitis	☐ Hemorrhoids	☐ Polyps
☐ COPD (Emphysema)	☐ Hepatitis	☐ Seizures
☐ Diabetes	☐ Hernia	☐ Sleep apnea
☐ Diverticulitis	☐ HIV	☐ Stroke/TIA
☐ Fainting spells	☐ Hypertension (high blood pressure)	☐ Testosterone (low)
☐ High cholesterol	☐ Hypotension (low blood pressure)	☐ Thyroid problems
Other:	☐ Inflammatory bowel disease	☐ Tuberculosis

Do you have a history of head injury? ___NO ___YES please describe_____

Please check the following boxes for past surgical history.

☐ **No surgical history**	☐ Hip/Knee/Ankle/Foot	☐ Cesarean
☐ Back/Neck	☐ Hysterectomy (ovaries removed)	☐ Prostate
☐ Brain/Head	☐ Hysterectomy (ovaries retained)	☐ Kidney stones
☐ Cardiac	☐ Kidney	☐ Shoulder/Elbow/Wrist/Hand
☐ Ear/Nose/Throat	☐ Liver	☐ Tonsils
☐ Gall bladder	☐ Lung	☐ Vagina
☐ Hernia	☐ Pancreas	☐ Weight loss surgery
☐ Pelvis		
OTHER:		

Past Psychiatric Medications **(If you have ever taken any of the following medications, indicate the date, dosage, and how helpful they were)**

Antidepressants	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Prozac (fluoxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Zoloft (sertraline)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Luvox (fluvoxamine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Paxil (paroxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Celexa (citalopram)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Effexor (venlafaxine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Cymbalta (duloxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Wellbutrin (bupropion)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Remeron (mirtazapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Fetzima	☐			☐ Yes ☐ No	☐ Yes ☐ No
Anafranil (clomipramine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Pamelor (nortrptyline)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Tofranil (imipramine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Elavil (amitriptyline)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Pristiq (desvenlafaxin)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Trintellix (vortioxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Viibryd (vilazodone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Silenor (doxepin)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Norpramin (desipramine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Lexapro (escitalopram)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Antipsychotics/Mood Stabilizers	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Seroquel (quetiapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Zyprexa (olanzapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Geodon (ziprasidone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Abilify (aripiprazole)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Clozaril (clozapine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Haldol (haloperidol)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Invega	☐			☐ Yes ☐ No	☐ Yes ☐ No
Latuda	☐			☐ Yes ☐ No	☐ Yes ☐ No
Risperdal	☐			☐ Yes ☐ No	☐ Yes ☐ No
Saphris	☐			☐ Yes ☐ No	☐ Yes ☐ No
Prolixin (fluphenazine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Vraylar	☐			☐ Yes ☐ No	☐ Yes ☐ No
Rexulti	☐			☐ Yes ☐ No	☐ Yes ☐ No
Fanapt	☐			☐ Yes ☐ No	☐ Yes ☐ No
				☐	☐

Sedative/Hypnotics	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Ambien (zolpidem)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Sonata (zaleplon)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Restoril (temazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Rozerem (ramelteon)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Desyrel (trazodone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Lunesta	☐			☐ Yes ☐ No	☐ Yes ☐ No
Belsomra	☐			☐ Yes ☐ No	☐ Yes ☐ No
ADHD Medications	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Adderall (amphetamine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Concerta (methylphenidate)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Ritalin (methylphenidate)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Strattera (atomoxetine)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Vyvanse	☐			☐ Yes ☐ No	☐ Yes ☐ No
Focalin	☐			☐ Yes ☐ No	☐ Yes ☐ No
Antianxiety Medications	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
Xanax (alprazolam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Ativan (lorazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Klonopin (clonazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Valium (diazepam)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Tranxene (clorazepate)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Buspar (buspirone)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Propranolol	☐			☐ Yes ☐ No	☐ Yes ☐ No
Neurontin (gabapentin)	☐			☐ Yes ☐ No	☐ Yes ☐ No
Neuroleptics					
Tegretol	☐			☐ Yes ☐ No	☐ Yes ☐ No
Trileptal	☐			☐ Yes ☐ No	☐ Yes ☐ No
Lamictal	☐			☐ Yes ☐ No	☐ Yes ☐ No
Depakote	☐			☐ Yes ☐ No	☐ Yes ☐ No
Other Medications (specify)	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects?**
	☐			☐ Yes ☐ No	☐ Yes ☐ No
	☐			☐ Yes ☐ No	☐ Yes ☐ No

Social History: Developmental and Educational

Did you have any complications after your birth (premature, jaundice, difficulty breathing, etc.)?

☐ Yes ☐ No

Did you have any delays or difficulties in reaching the following developmental milestones?

☐ None of these
☐ Walking
☐ Talking
☐ Toilet training
☐ OTHER: _____
☐ Sleeping alone
☐ Being away from parents
☐ Making friends

Which options below best describe your childhood home atmosphere?

☐ Normal
☐ Supportive
☐ Parental fighting
☐ Parental violence
☐ Financial difficulties
☐ Frequent moving
☐ OTHER: _____

Highest level of education_____

Social History: General

Do you have a support system/ who? _____

Are you: ☐ Married ☐ Significant other ☐ Divorced (years married: ___) ☐ Single

What is your current living situation? ☐ Live alone ☐ Live with family ☐ Live with friends

Is spirituality/religion important to you? _____

Are you currently employed? ☐ Yes ☐ No

If yes, what is your occupation? _____

Have you ever been in the Military? ☐ Yes ☐ No

What are your hobbies and interest? _____

Have you ever been a victim of verbal/emotional abuse? ☐ Yes ☐ No

Have you ever been a victim of physical abuse? ☐ Yes ☐ No

Have you ever been a victim of sexual abuse? ☐ Yes ☐ No

Have you ever been in trouble with the law/details? _____

Social History: Menstruation and Pregnancy

Do you have children? _____ **If yes Ages**_____

Do you have any of the following symptoms prior to menstruation?

☐ Cramping
☐ Bloating
☐ Mood changes
☐ None of the above

Over the past 2 weeks, have you been bothered by the following problems?

	Yes	No		Yes	No
Lack of energy			Disorganization		
Anger and angry episodes			Inattention to tedious tasks		
Lack of ability to enjoy things			Loss of necessary items for tasks or activities		
Changes in appetite			Easily distracted		
Difficulty concentrating			Forgetfulness		
Crying spells			Fidgety		
Difficulty making decisions			Unnecessarily leaves seat		
Excessive worrying			Overactive or restless		
Excessive fatigue			Often being noisy		
Feeling guilty			Talks excessively		
Irritability			Blurts out answers		
Decreased sex drive			Can't wait his/her turn		
Memory difficulties			Interrupts		
Sadness			Loss of temper		
Social isolation/Decrease in socialization			Often touchy		
Feelings of worthlessness			Often angry or resentful		
Worrying too much			Easily annoyed by others		
Feelings of increased muscular tension			Often argues with adults or people in authority		
Difficulty sleeping			Often spiteful or vindictive		
Attention span is short			Often blames others for his/her mistakes or misbehavior		
Trouble listening			Often deliberately annoys people		
Ability to finish a task is poor			Often actively defies or refuses to comply with adults' requests or rules		

Have you ever experienced periods of:

	Yes	No		Yes	No
Increased physical activity			Increase in sociability		
Decreased sleep and not feeling tired			Talking too fast		
Periods of very high self esteem			Talking excessively		
Racing thoughts			Highs in mood		
Increase in sex drive					

Are any of the following symptoms currently present?

	Yes	No		Yes	No
Recurrent dreams of the traumatic event			Dizziness		
Flashbacks of the traumatic experience			Experience chest pain or discomfort		
Emotional distress when reminded of the traumatic event			Feeling things are not real		
Avoid situations that evoke memories of the traumatic event			Sensations of chills or hot flashes		
Diminished interest or participation in significant activities			Numbness and tingling		
Feeling of detachment or alienation from others has occurred			Trouble interacting, playing with or relating to others		
Sense of foreshortened future			Having little or brief eye contact with others		
Being watchful or on edge			Not pointing to objects to call attention to them		
Startle easily			Unusual or repetitive movements, such as hand flapping, spinning or tapping		
Heart palpitations, pounding or fast heart rate			Delays in developmental milestones or loss of milestones already achieved		
Anxiety causing you to tremble or shake			Playing with a toy in a way that seems odd or repetitive		
Sensations of shortness of breath or of smothering			Not exploring surroundings with curiosity or interest (a child seeming to be in his/her "own world")		
Panic attacks are accompanied by sensations of shortness of breath or smothering			Delays in talking		