MODERN PSYCHIATRY & WELLNESS LLC

INTAKE TREATMENT APPLICATION

IF YOU ARE IN DANGER OF HARMING YOURSELF OR SOMEONE ELSE, PLEASE GO IMMEDIATELY TO THE NEAREST HOSPITAL OR CALL 911

Why have you come to see us?
(Please check all that may apply)

☐**Mental Health** ☐**Addiction** ☐**Mental Health Medication Managements Only**

Last Name:		First Name:
Age:	Date of Birth:	Gender: ☐Male ☐Female ☐Transgender
Street Address:		City State Zip
Permission to contact via Mail ☐Yes ☐No		If No is checked please provide alternate address

CONTACT INFORMATION

Home Phone:	☐OK to Contact ☐OK to ID ☐OK to leave a message
Cell Phone:	☐OK to Contact ☐OK to ID ☐OK to leave a message
Work Phone:	☐OK to Contact ☐OK to ID ☐OK to leave a message
Emergency Contact:	Phone:
How did you hear about our practice?	Do you have friends or family in treatment with us? If so, Who?

INSURANCE INFORMATION

Insurance Company:	Effective Date:
Subscriber/Policy Holder Name:	Date of Birth:
Client ID#	Group #
Insurance Address:	
Deductible Amount: $	Copay Amount: $

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MEDICAL INFORMATION

Do you currently have, or have you had in the past any of the following? (Check all that apply)

☐Asthma\COPD	☐Cardiovascular (heart attack, high cholesterol, angina)	
☒Hypertension	☐Epilepsy or seizure disorder	☐Chronic Pain
☐Heat Trauma/TBI	☐HIV/AIDS	☐Diabetes
☐Liver problems	☐Hepatitis C	☐Thyroid Disease

Please list any significant surgeries/surgeries in the past 3 yrs.

_____

_____

Do you have difficulties with chronic pain? ☐YES ☐NO If yes, please describe location and previous pain treatments. _____

_____

Any other medical problems: _____

Are you currently under the care of a doctor or other medical health professional? ☐YES ☐NO
If yes, name and phone number of Physician _____

Name of Primary Care Physician_____
Group Name (if applicable)_____
Physician Phone: _____Ext. _____ Fax:_____

CURRENT MEDICATIONS

Please list **ALL** medications, vitamins, or herbal supplements you are currently taking. Be sure to include dosage, frequency, and length of time you have been taking:

Medication Allergies and Reactions: _____

_____

What pharmacy do you use to fill your prescriptions _____
Address: _____ Phone: _____

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HISTORY OF CURRENT PROBLEM

What are the reasons you have decided to seek treatment at this time?

_____

_____

_____

STRESS

Are there any major stressors in your life? ☐YES ☐NO If yes, indicate the area below in which you feel these stressors exist.

Stressor	Severity			Length of time	
	Mild	Moderate	Severe	Months	Years
Marriage/Relationship					
Family related					
School Related					
Work Related					
Friends/Social					
Housing					
Legal					
Death/Grief					
Health Problems					

TREATMENT GOALS

Breifly describe what treatment goals you hope to achieve. Try to list your goals in order of importance. (most important first)

1.
2.
3.

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PAST PSYCHIATRIC TREATMENT

Have you ever been diagnosed with a mental condition? ☐Yes ☐No If yes, please see below.

Diagnosis	Age at First Diagnosis	Age at First Treatment	Diagnosed by
☐Depression			
☐Bipolar Disorder			
☐Anxiety Disorder			
☐PTSD			
☐ADHD/ADD			
☐other: (specify)			

Have you ever been treated on an OUTPATIENT basis for psychiatric or psychological problems?
☐YES ☐NO If yes, please complete the section below.

Year	Length	Doctor or Therapist name	Diagnosis or problem at that time	Treatment you received	Did the treatment help

Have you ever been **HOSPITALIZED** for psychiatric or psychological problems? ☐Yes ☐No
If Yes, please complete the section below.

Year	Hospital	Length of Time	Was this Helpful?

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Have you ever or are you currently engaging in self harm? (i.e cutting, stabbing, burning, etc.)
☐Yes ☐No ☐Current ☐Past Approx. Dates _____

Have you ever contemplated harming another person? ☐Yes ☐No If Yes, please describe Who, How, and When: _____
_____

Have you ever attempted suicide? ☐Yes ☐No If Yes, please detail below.

Year	Method

PAST MEDICATIONS

Medication Name	Used in the past	Currently Using	Response
ANTIDEPRESSANTS			
Anafranil (Clomipramine)			
Celexa (Citalopram)			
Desyrel (Trazodone)			
Effexor (Venlafaxine)			
Lexapro (Escitalopram)			
Luvox (Fluvoxamine)			
Nardil (Phenelzine)			
Norpramin (Desipramine)			
Parnate (Tranyclypromine)			
Paxil (Paroxetine)			
Pristiq (Desvenlafaxine)			
Prozac (Fluoxetine)			
Remeron (Mirtazapine)			
Serzone(Nefazodone)			
Sinequan (Doxepin)			
Tofranil (Imipramine)			
Trintellix (Vortioxetine)			
Viibyrd (Vilazodone)			
Wellbutrin (Bupropion)			
Zoloft (Sertraline)			

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PAST MEDICATIONS

Medication Name	Used in the past	Currently Using	Response
ANTIPSYCHOTICS			
Abilify (Aripiprazole)			
Fanapt (Iloperidone)			
Geodon (Ziprasidone)			
Haldol (Haloperidol)			
Latuda (Lurasidone)			
Prolixin(Perphenazine)			
Rexulti(Brexpiprazole)			
Risperdal (Risperidone)			
Saphris (Asenapine)			
Seroquel (Quetiapine)			
Stelazine (Trifluoperazine)			
Thorazine (Chlorpromazine)			
Trilafon (Fluphenazine)			
Vraylor (Cariprazine)			
Zyprexa (Olanzapine)			
SEDATIVES			
Ambien (Zolpidem)			
Buspar (Buspirone)			
Dalmane (Fluazepam)			
Halcion(Triazolam)			
Klonopin (Clonazepam)			
Librium (Chloriazpoxide)			
Restoril (Temazepam)			
Serax (Oxazepam)			
Sonata (Zaleplon)			
Tranxene (Clorazepam)			
Valium (Diazepam)			
Xanax (Alprazolam)			
Belsomra(Suvorexant)			
MOOD STABILIZERS			
Depakote (valproate)			
Lithium			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Trileptal (oxcarbamazepine)			

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Medication Name	Used in the past	Currently Using	Response
Stimulants			
Adderall (Amphetamine)			
Concerta (Methyphenidate)			
Cylert (Pemoline)			
Provigil (Modafinil)			
Ritalin (Methyphenidate)			
Vyvanse (amphetamine and dextroamphetamine)			
Adipex or any other Diet Drugs			

What medications have worked the best for you in the past and what were you taking them for? _____
_____
_____

SUBSTANCE ABUSE

Have you ever believed your substance use was a problem for you? ☐Yes ☐No

Has anyone ever told you they believed your substance use was a problem? ☐Yes ☐No

Have you used drugs other than those required for medical reasons? ☐Yes ☐No

Do you abuse more than one drug at a time? ☐Yes ☐No

Have you ever had blackouts or flashbacks as a result of drug usage? ☐Yes ☐No

Do you feel bad or guilty about your drug usage? ☐Yes ☐No

Does your spouse or significant other ever complain about your use or drugs?
☐Yes ☐No

Have you ever missed work or neglected your family due to your use of drugs?
☐Yes ☐No

Have you ever engaged in illegal activity to obtain drugs? ☐Yes ☐No

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Have you ever had withdrawal symptoms (felt sick) when you stopped taking drugs?
☐Yes ☐No

Have you ever had medical problems as a result of drug use (i.e. memory loss, hepatitis, convulsions, bleeding)? ☐Yes ☐No

Have ever participated in an alcohol and drug treatment program? ☐Yes ☐No
If yes, fill in the information below.

Type	Length of time	Age
☐Residential Treatment		
☐Individual Treatment		
☐Intensive Outpatient (IOP)		
☐Court Ordered Treatment		

Please indicate the substances you have used (over the past 6 months). Fill in the chart below.

	None	Age of first use	Route(IV, Nasal, etc.)	How much	How often	Date/time of last use	Quantity last used
Alcohol							
Caffeine pills or beverages							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Tobacco							
Acid(LSD) or other hallucinogens							
Marijuana							
Methadone							
Pain Killers (narcotic)							
PCP							
Stimulants (pills)							
Tranquilizers/Sleeping Pills							
Ecstasy							
Other (please list)							

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Do you currently attend or have previously attended Alcoholics Anonymous? ☐Yes ☐No

If yes, Do you have a sponsor? ☐Yes ☐No

SPIRITUALITY

Have you ever or do you currently engage in a personal faith practice? ☐Yes ☐No
If yes, please describe: _____
_____
_____

Have you ever or do you currently belong to a faith community (Church, Synagogue, Temple, Mosque, etc.). if yes please describe your current level of involvement.
_____
_____

Do you want to incorporate your faith/spirituality into the therapeutic process? ☐Yes ☐No
If yes, please describe how you would like to do so, and if you are specifically seeking spiritual guidance or direction. _____
_____

LIVING SITUATION

Do you currently reside in a: ☐Home that you own? ☐Home that you rent?
☐Residential Care Facility? ☐Homeless Shelter? ☐ Other, please describe_____
_____
Facility or Person's name of where you live? _____

Do you feel that you live in a healthy environment? ☐Yes ☐No

Do you feel safe in the environment in which you live? ☐Yes ☐No

Do you collect disability income? ☐Yes ☐No

Do you have reliable transportation? ☐Yes ☐No

RELATIONSHIP INFORMATION

Status: ☐Single ☐Married ☐Romantic Relationship ☐Separated ☐Divorced ☐ Widowed

Number of Marriages_____ Number of Divorces_____

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Household Members Names	Relationship to You	Age	Quality of Relationship?

Significant People Not mentioned above	Relationship to You	Age	Quality of Relationship?

FAMILY INFORMATION

Do you have children ☐Yes ☐No If yes, how many? _____

Has Child Protective Services ever been involved in your family? ☐No ☐As a child ☐As an adult

Were you adopted? ☐Yes ☐No If yes, at what age were you adopted? _____

With whom did you live until the age of 18? _____

Were you parents ever divorced? ☐Yes ☐No If yes, YOUR age at the time of the Divorce? ____

Were you ever in foster care? ☐Yes ☐No How many siblings do you have? _____

What is your birth order? _____

Has anyone in your family ever been diagnosed with a mental condition or suffered from drug abuse/addiction? ☐Yes ☐No if yes, please see below.

Family member	Condition
Mother	
Father	
Sibling	
Other: (please describe)	

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Has anyone in your family ever attempted or completed suicide? ☐Yes ☐No if yes, Please list relationship. _____

EDUCATIONAL INFORMATION

Number of years of school completed: _____ Degree or diploma received? ☐Yes ☐No
Check all that apply:
☐High School ☐Vocational/Trade School ☐G.E.D. ☐Associates Degree
☐Bachelors Degree ☐Masters Degree ☐Doctorate Degree ☐Other:_____

EMPLOYMENT INFORMATION

Are you currently employed? ☐Yes ☐No If yes, please list position title, type of work, and length of time of employment._____
_____

If you are not currently working, how long have you been unemployed? _____

What type of jobs have you typically held? _____

Have you ever served in the military? ☐Yes ☐No Branch _____ Rank _____
Duty Status? ☐Active ☐Discharged

LEGAL HISTORY
Not for reporting purposes

Have you ever been arrested? ☐Yes ☐No If yes, please describe. _____
_____
_____
_____

What is the longest you have been incarcerated? _____years _____months _____days

Are you currently on parole or probation? ☐Yes ☐No

Please indicate any legal charges you have incurred past or present.
☐Traffic Violations ☐DUI/DWI ☐Public Disturbance ☐Domestic Violence ☐Theft
☐Illegal Weapons ☐Drug trafficking ☐Drug Paraphernalia ☐Drug Possession ☐Assualt
☐Other: _____
_____

Are you currently involved in any court proceedings? ☐Yes ☐No If yes, please briefly describe:_____