

Foothills Neurology Neurobehavioral Health Packet

15715 South 46th, Street #100, Phoenix, AZ 85048

Tel: (480)961-2365 Fax: (480)961-2382

Please complete all information on this form and bring it to the 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!

Full Name _____ Date _____

Date of Birth _____ Primary Care Physician _____

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

Current Therapist/Counselor _____ Therapist's Phone _____

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

1. _____

2. _____

3. _____

What are your treatment goals?

Current Symptoms Checklist: (check 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

Racing Thoughts

Impulsivity

Increase risky behavior

Increased libido

Decrease need for sleep

Excessive Energy

Increased irritability

Crying Spells

Excessive Worry

Anxiety Attacks

Avoidance

Hallucination

Suspiciousness

Suicide Risk Assessment

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? Yes No

If yes, please explain.

Foothills Neurology Neurobehavioral Health Packet

15715 South 46th, Street #100, Phoenix, AZ 85048

Tel: (480)961-2365 Fax: (480)961-2382

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?

For women only:

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
 Birth control method _____
 How many times have you been pregnant? _____ How many livebirths? _____
 Do you have any concerns about your physical health that you would like to discuss with us? Yes No
 Date and place of last physical exam: _____

Personal and Family Medical History:

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

Foothills Neurology Neurobehavioral Health Packet

15715 South 46th, Street #100, Phoenix, AZ 85048

Tel: (480)961-2365 Fax: (480)961-2382

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	Dates Hospitalized	By Whom

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 (nortriptyline)	_____	_____	_____
Tofranil (imipramine)	_____	_____	_____
Elavil (amitriptyline)	_____	_____	_____
Other	_____	_____	_____

Mood Stabilizers

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

Foothills Neurology Neurobehavioral Health Packet

15715 South 46th, Street #100, Phoenix, AZ 85048

Tel: (480)961-2365 Fax: (480)961-2382

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response
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:

	Yes	No		Yes	No
Bipolar disorder	Yes	No	Schizophrenia	Yes	No
Depression	Yes	No	Post-traumatic stress	Yes	No
Anxiety	Yes	No	Alcohol abuse	Yes	No
Anger	Yes	No	Other substance abuse	Yes	No
Suicide	Yes	No	Violence	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?* _____

Foothills Neurology Neurobehavioral Health Packet

15715 South 46th, Street #100, Phoenix, AZ 85048

Tel: (480)961-2365 Fax: (480)961-2382

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 |
| • 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:

	Yes	No	
Methamphetamine			_____
Cocaine			_____
Stimulants (pills)			_____
Heroin			_____
LSD or Hallucinogens			_____
Marijuana			_____
Pain killers (not as prescribed)			_____
Methadone			_____
Tranquilizer/sleeping pills			_____
Alcohol			_____
Ecstasy			_____
Other			_____

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? _____

Foothills Neurology Neurobehavioral Health Packet

15715 South 46th, Street #100, Phoenix, AZ 85048

Tel: (480)961-2365 Fax: (480)961-2382

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 yes, 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

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: _____

Foothills Neurology Neurobehavioral Health Packet

15715 South 46th, Street #100, Phoenix, AZ 85048

Tel: (480)961-2365 Fax: (480)961-2382

Legal History:

Have you ever been arrested? _____

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?

Signature _____

Date _____

Emergency Contact: _____ Telephone Number: _____