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.

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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 live births? _____

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? _____				

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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 (nortrptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Other_____

Mood Stabilizers

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

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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:

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?*** _____

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Substance Use:

Have you ever been treated for alcohol or drug use or abuse? Yes No

If yes, forwhich 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	If yes, how long and when did you last use?
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? _____

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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: _____

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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: _____