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INTAKE PAPERWORK

DATE OF APPOINTMENT

NAME

DATE OF BIRTH

ADDRESS

CELL PHONE

HOME PHONE

EMAIL

PREFERRED METHOD OF CONTACT

SOCIAL SECURITY NUMBER

WHO REFERRED YOU

REASON FOR APPOINTMENT

INSURANCE INFORMATION

INSURED NAME

INSURED DOB

INSURED EMPLOYER

INSURED CARRIER

INSURANCE POLICY / IDENTIFICATION NUMBER

GROUP NUMBER

INSURANCE PROVIDER SERVICES NUMBER

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CURRENT SYMPTOMS – PLEASE CHECK ALL THAT APPLY

<u>Depression</u>	<u>Mood swings</u>
<u>Loss of interest</u>	<u>Anger</u>
<u>Crying spells</u>	<u>Irritability</u>
<u>Appetite or weight increase</u>	<u>Easily frustrated</u>
<u>Appetite or weight decrease</u>	<u>Racing thoughts</u>
<u>Appetite or weight unchanged</u>	<u>Restlessness or pacing</u>
<u>Decreased concentration</u>	<u>Inflated or high self esteem</u>
<u>Hopelessness</u>	<u>Euphoria or happiness</u>
<u>Helplessness</u>	<u>Increased energy</u>
<u>Guilty thoughts</u>	<u>Don't need as much sleep</u>
<u>Low self esteem</u>	<u>Spending sprees</u>
<u>Lowered hygiene</u>	<u>Sexual promiscuity</u>
<u>Isolating yourself</u>	<u>Socializing too much</u>
<u>Thoughts of death or dying</u>	<u>Legal problems</u>
<u>Thoughts of suicide or self harm</u>	<u>Traffic problems</u>
<u>Symptoms worse during the day</u>	<u>Impulsive behaviors</u>
<u>Symptoms are worse at night</u>	<u>Easily distracted</u>
<u>Problems falling asleep</u>	<u>Disorganized thinking</u>
<u>Problems staying asleep</u>	<u>Procrastination</u>
<u>Problems waking up too early</u>	<u>ADHD</u>
<u>Problems sleeping too much</u>	<u>Interrupting others</u>
<u>Nightmares</u>	<u>Rude behavior</u>
<u>Sleep talking or other behaviors</u>	<u>Road rage</u>
<u>Fatigue or easily becoming tired</u>	<u>Violence toward others</u>
<u>Loss of energy</u>	<u>Being a victim of violence</u>
<u>Excess worry</u>	<u>Bulimia or Anorexia</u>
<u>Difficulty relaxing, feeling tense</u>	<u>Exercising too much</u>
<u>Easily startled</u>	<u>Worried about weight & body</u>
<u>Anxiety or panic attacks</u>	<u>Hearing hallucinations</u>
<u>Obsessive thinking</u>	<u>Seeing hallucinations</u>
<u>Germophobia</u>	<u>Feeling hallucinations</u>
<u>Perfectionistic tendencies</u>	<u>Smelling hallucinations</u>
<u>Social anxiety</u>	<u>Feeling scared</u>
<u>Performance anxiety</u>	<u>Feeling someone is after you</u>
<u>Compulsive behaviors</u>	
<u>Rechecking what you did</u>	
<u>Rituals</u>	
<u>Other :</u>	

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CURRENT SYMPTOMS : CONTINUED

QUESTION	DETAILS
HOW LONG HAVE THE CURRENT SYMPTOMS BEEN GOING ON	
HAS ANYTHING HELPED IMPROVE YOUR SYMPTOMS	
HAS ANYTHING MADE YOUR SYMPTOMS WORSE	
WHAT ARE YOUR CURRENT STRESSORS	
HAVE THERE BEEN ANY RECENT CHANGES TO YOUR PHYSICAL HEALTH	
DESCRIBE ANY RECENT PHYSICAL HEALTH SYMPTOMS	(LIKE HEADACHE, CONSTIPATION, ETC)
HAVE THERE BEEN ANY RECENT CHANGES TO YOUR MEDICATIONS	

PAST MEDICAL HISTORY :

ALLERGY	DETAILS ABOUT ALLERGY
MEDICATION ALLERGIES	
ENVIRONMENTAL ALLERGIES	
FOOD ALLERGIES	
OB/GYN HISTORY	DETAILS
AGE AT 1 ST MENSES	
CYCLE LENGTH	
LAST MENSTRUAL PERIOD	
NUMBER OF PREGNANCIES	
NUMBER OF MISCARRIAGES	
NUMBER OF DELIVERIES / DATES / METHOD OF DELIVERY	
PROBLEMS WITH MENSES	PAIN, IRREGULAR CYCLE
PROBLEMS WITH UTERUS	FIBROIDS, ENDOMETRIOSIS, CYSTS, PROLAPSE, BLEEDING
SEXUAL PROBLEMS	LIBIDO, ORGASM, PAIN, SPASMS
MENOPAUSE	
CURRENT CONTRACEPTION	

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CHRONIC MEDICAL CONDITIONS – CHECK ALL THAT APPLY

CARDIOVASCULAR SYSTEM

HEART DISEASE
 CORONARY ARTERY DISEASE
 CARDIOMYOPATHY
 ENDOCARDITIS / MYOCARDITIS
 HEART FAILURE
 HIGH BLOOD PRESSURE
 LOW BLOOD PRESSURE
 ANEURYSM
 ARRHYTHMIA / ABNORMAL BEAT
 HEART VALVE DISEASE
 STROKE
 MINI-STROKE / TIA
 CONGENITAL HEART DISEASE
 HIGH CHOLESTEROL
 VASCULITIS

RESPIRATORY SYSTEM

ASTHMA
 CHRONIC BRONCHITIS
 COPD
 EMPHYSEMA
 PULMONARY EMBOLISM

GASTROINTESTINAL SYSTEM

MOUTH SORES
 ESOPHAGUS DIFFICULTIES
 HEARTBURN / INDIGESTION
 GERD
 STOMACH ULCER
 GALLSTONES
 LIVER DISEASE OR CIRRHOSIS
 HEPATITIS
 PANCREATITIS
 MALABSORPTION
 CROHNS DISEASE
 CELIAC DISEASE
 IRRITABLE BOWEL DISEASE
 CHRONIC CONSTIPATION
 ANAL FISSURES
 HEMORRHOIDS

BLOOD PROBLEMS OR CANCERS

ANEMIA
 LOW IRON
 LOW VITAMIN B12 OR FOLATE
 BLEEDING OR CLOTTING PROBLEMS
 SICKLE CELL DISEASE
 THALASSEMIA
 HODGKINS DISEASE
 LYMPHOMA
 MYELOMA
 HEMOCHROMATOSIS
 MONONUCLEOSIS
 HIV / AIDS

MUSCULOSKELETAL

ARTHRITIS
 RHEUMATOID ARTHRITIS
 BRUXISM / TEETH GRINDING

ENDOCRINE DISORDERS

HYPOTHYROIDISM
 HYPERTHYROIDISM
 DIABETES MELLITUS
 PARATHYROID PROBLEMS

NEUROLOGICAL SYSTEM

HEAD TRAUMA
 HEAD TRAUMA WITH LOSS OF CONSCIOUSNESS
 AUTISM / SPECTRUM DISORDER
 BELL'S PALSY
 BRAIN DAMAGE / HEAD INJURY
 NEUROPATHY
 VASCULITIS
 MYOPATHY
 STROKE / TIA
 MULTIPLE SCLEROSIS
 MYASTHENIA GRAVIS
 DEMENTIA
 SEIZURE DISORDER
 TREMOR
 MENIERE'S DISEASE
 MIGRAINE
 NARCOLEPSY
 TIC DISORDER / TOURETTES
 PARKINSONS DISEASE
 HUNTINGTON'S DISEASE
 RESTLESS LEG SYNDROME
 TRIGEMINAL NEURALGIA
 LUPUS
 MENINGITIS
 FAINTING SPELLS / SYNCOPE
 LYME DISEASE
 PSEUDOTUMOR CEREBRI
 FIBROMYALGIA
 CHRONIC FATIGUE SYNDROME
 CHRONIC PAIN DISORDER

UROGENITAL SYSTEM

KIDNEY DISEASE
 KIDNEY STONES OR CYSTS
 PROLAPSED / FALLEN BLADDER
 URINARY INCONTINENCE
 URINARY TRACT INFECTIONS
 INTERSTITIAL CYSTITIS
 BENIGN PROSTATIC HYPERTROPHY
 PENILE DISEASE
 TESTICULAR DISEASE
 ERECTILE DYSFUNCTION
 LOW TESTOSTERONE
 URETHRAL DISCHARGE
 INFERTILITY
 SEXUALLY TRANSMITTED DISEASES
 PELVIC INFLAMMATORY DISEASE
 PAIN WITH INTERCOURSE
 VAGINAL SPASMS

OTHER MEDICAL PROBLEMS :

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PAST PSYCHIATRIC HISTORY : ANSWER YES/NO AND INCLUDE DETAILS PLEASE

QUESTION	DETAILS – DATES, LOCATIONS, TIMELINE
ANY PRIOR INPATIENT PSYCHIATRIC HOSPITALIZATIONS	
ANY PRIOR SUICIDE ATTEMPTS	
ANY PRIOR SELF INJURIOUS BEHAVIOR (LIKE CUTTING/BURNING)	
CURRENT OR PAST PSYCHIATRIST	
CURRENT OR PAST THERAPIST	
ANY PRIOR DIAGNOSES	
PRIOR HISTORY OF DEPRESSION SYMPTOMS	
PRIOR HISTORY OF MANIC-DEPRESSION OR BIPOLAR EPISODES OR SYMPTOMS	
PRIOR HISTORY OF ANXIETY : GENERALIZED WORRY, PANIC ATTACKS, OCD, PHOBIA, PTSD, SOCIAL ANXIETY	
PRIOR HISTORY OF EATING DISORDER	
PRIOR HISTORY OF HALLUCINATIONS	
PRIOR HISTORY OF PARANOIA OR UNUSUAL THOUGHTS	
PRIOR HISTORY OF SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER	
PRIOR HISTORY OF ADHD OR LEARNING PROBLEMS, OR AUTISTIC SPECTRUM	
PRIOR HISTORY OF ELECTROCONVULSIVE THERAPY	
OTHER IMPORTANT INFORMATION ABOUT YOUR PAST HISTORY OF SYMPTOMS OR TREATMENT	

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PAST MEDICATIONS YOU HAVE TRIED : CHECK ALL THAT APPLY

MEDICATION NAME (BRAND / GENERIC)		MEDICATION NAME (BRAND / GENERIC)		
	PAXIL	PAROXETINE	STRATTERA	ATOMOXETINE
	PROZAC	FLUOXETINE	RITALIN	METHYLPHENIDATE
	LUVOX	FLUVOXAMINE	CONCERTA	METHYLPHENIDATE
	CELEXA	CITALOPRAM	QUILLIVANT	METHYLPHENIDATE
	LEXAPRO	ESCITALOPRAM	METADATE	METHYLPHENIDATE
	ZOLOFT	SERTRALINE	METHYLIN	METHYLPHENIDATE
	BRINTILLIX	VORTIOXETINE	FOCALIN	DEXMETHYLPHENIDATE
	EFFEXOR	VENLAFAXINE	DAYTRANA PATCH	METHYLPHENIDATE
	CYMBALTA	DULOXETINE	ADDERALL	DEXTROAMPHETAMINE / AMPHETAMINE
	PRISTIQ	DESVENLAFAXINE	DEXEDRINE	DEXTROAMPHETAMINE
	FETZIMA	LEVOMILNACIPRAN	VYVANSE	LISDEXAMFETAMINE
	WELLBUTRIN	BUPROPRION	CATAPRES	CLONIDINE
	REMERON	MIRTAZEPINE	TENEX	GUANFACINE
	SERZONE	NEFAZODONE	CYLERT	PEMOLINE
	PARNATE	TRANLYCYPROMINE	PROVIGIL	MODAFINIL
	NARDIL	PHENELZINE	NUVIGIL	ARMODAFINIL
	ANAFRANIL	CLOMIPRAMINE	ARICEPT	DONEPEZIL
	ELAVIL	AMITRIPTYLINE	REMINYL	GALATAMINE
	NORPRAMIN	DESIPRAMINE	EXELON	RIVASTIGMINE
	PAMELOR	NORTRIPTYLINE	NAMENDA	MEMANTINE
	SINEQUAN	DOXEPIN	COGENTIN	BENZTROPINE
	SURMONTIL	TRIMIPRAMINE	ARTANE	TRIHEXYPHENIDYL
	BUSPAR	BUSPIRONE	REQUIP	ROPINIROLE
	NEURONTIN	GABAPENTIN	MIRAPEX	PRAMIPEXOLE
	VISTARIL	HYDROXYZINE	NEUPRO	ROTIGOTINE
	INDERAL	PROPRANOLOL	SYMMETREL	AMANTADINE
	XANAX	ALPRAZOLAM	ELDEPRYL	SELEGILINE
	ATIVAN	LORAZEPAM	COMTAN	ENTACAPONE
	VALIUM	DIAZEPAM	SINEMET	LEVODOPA/CARBIDOPA
	KLONOPIN	KLONAZEPAM	ABILIFY	ARIPIRAZOLE / ABILIFY MAINTENNA
	RESTORIL	TEMAZEPAM	FANAPT	ILOPERIDONE
	LIBRIUM	CHLORDIAZEPOXIDE	INVEGA	PALIPERIDONE / INVEGA SUSTENNA
	SERAX	OXAZEPAM	LATUDA	LURASIDONE
	TOPAMAX	TOPIRAMATE	RISPERDAL	RISPERIDONE / RISPERDAL CONSTA
	DEPAKOTE	VALPROIC ACID	SAPHRIS	ASENAPINE
	LAMICTAL	LAMOTRIGINE	SEROQUEL	QUETIAPINE
	TEGRETOL	CARBAMAZEPINE	ZYPREXA	OLANZAPINE / ZYPREXA RELPREVV
	TRILEPTAL	OXCARBAZEPINE	CLOZARIL	CLOZAPINE
	ESKALITH	LITHIUM	HALDOL	HALOPERIDOL / HALDOL DECANOATE
	GABITRIL	TIAGABINE	PROLIXIN	FLUPHENAZINE / PROLIXIN DECANOATE
	KEPPRA	LEVETIRACETAM	TRILAFON	PERPHENAZINE
	MELATONIN	MELATONIN	THORAZINE	CHLORPROMAZINE
	ROZEREM	RAMELTEON	MELLARIL	THIORIDAZINE
	BENADRYL	DIPHENHYDRAMINE	LOXITANE	LOXAPINE
	DESYREL	TRAZODONE	STELAZINE	TRIFLUOPERAZINE
	AMBIEN	ZOLPIDEM	REVIA OR VIVITROL	NALTREXONE OR NALTREXONE INJECTION
	LUNESTA	ZOPICLONE	SUBOXONE	BUPRENORPHINE/NALOXONE
	SONATA	ZALEPLON	SUBUTEX	BUPRENORPHINE
	ANTABUSE	DISULFIRAM	ZUBSOLV	BUPRENORPHINE
			METHADOSE	METHADONE

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DEVELOPMENTAL & SOCIAL HISTORY :

HISTORY	DETAILS
WHERE WERE YOU BORN	
ANY COMPLICATIONS WITH PREGNANCY OR DELIVERY WHEN YOU WERE BORN	
WERE YOUR PARENTS MARRIED AT THE TIME OF YOUR BIRTH	
DID THEY STAY MARRIED, OR GET DIVORCED (HOW OLD WERE YOU AT THAT TIME)	
WHAT WERE YOUR PARENTS OCCUPATION	
DO YOU HAVE ANY SIBLINGS (AND THEIR AGE & OCCUPATION COMPARED TO YOURS)	
WERE YOU THE VICTIM OF PHYSICAL, SEXUAL, OR EMOTIONAL ABUSE AS A CHILD	
HOW WOULD YOU DESCRIBE YOUR CHILDHOOD OVERALL	
HOW DID YOU DO ACADEMICALLY IN SCHOOL (LEARNING PROBLEMS, GPA, HONOR SOCIETY)	
WHAT EXTRACURRICULAR ACTIVITIES DID YOU PARTICIPATE IN (IF ANY)	
WHAT IS THE LAST GRADE COMPLETED, OR YEAR OF HIGH SCHOOL GRADUATION	
WHAT DID YOU DO AFTER FINISHING HIGH SCHOOL	
DID YOU ATTEND ANY COLLEGE OR OBTAIN FURTHER DEGREES	
WHAT JOBS HAVE YOU HAD, HOW MANY, WHAT KINDS, WHAT IS THE LONGEST TIME AT A JOB	
HAVE YOU EVER HAD ANY PROBLEMS AT WORK, OR BEEN FIRED	
WHAT IS YOUR SEXUAL ORIENTATION	
DESCRIBE YOUR MARRIAGES OR SIGNIFICANT ROMANTIC RELATIONSHIPS, DIVORCES	
WHAT DOES YOUR SPOUSE / SIGNIFICANT OTHER DO FOR A LIVING	
DO YOU HAVE ANY CHILDREN, AGES, WHAT THEY ARE LIKE	
WHO DO YOU TURN TO FOR SUPPORT	
WHO LIVES AT HOME WITH YOU	
ARE YOU RELIGIOUS	
HAVE YOU EVER BEEN IN THE MILITARY	
DO YOU OWN ANY WEAPONS, HOW ARE THEY STORED	
HAVE YOU EVER HAD ANY LEGAL PROBLEMS (SPEEDING, BANKRUPTCY, DV, ASSAULT, ETC)	
HOW WOULD YOU DESCRIBE YOUR PERSONAL STRENGTHS AND PERSONALITY	
IS THERE ANYTHING ABOUT YOURSELF THAT YOU WANT TO IMPROVE	

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SUBSTANCE USE HISTORY :

SUBSTANCE	AGE AT 1ST USE	FREQUENCY, AMOUNT USED	ANY PROBLEMS WITH USING THIS SUBSTANCE
CAFFIENE			
NICOTINE			
INHALANTS			
ALCOHOL			
CANNABIS			
LSD / HALLUCINOGENS			
ECSTASY			
PCP			
METHAMPHETAMINE			
HEROIN			
PRESCRIPTION PILLS			
OTHER :			
LEGAL PROBLEMS DUE TO ALCOHOL/DRUGS :			
ANY HISTORY OF REHAB TREATMENT :			

WHAT ARE YOUR GOALS OF TREATMENT :
