Victoria Kelly MD LLC

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INTAKE PAPERWORK – Effective 2017

Date of Appointment:	**Reason for Appointment**:
	☐ Transfer of care from other provider ☐ Other ☐ New psychiatric patient

Referred To Office By:				
Family: ☐	**Friend:** ☐	**Internet:** ☐	**Doctor:** ☐	**If Doctor, provide name**

First Name:	**Middle:**	**Last Name:**	**Suffix:**

Nickname:	**Current Age :**	**Birth Date:**	**Sex:**	**Marital Status:**
		/ /	☐ M ☐ F	☐ S ☐ M ☐ D ☐ W

Primary Phone: ( )	☐ Cell ☐ Home ☐ Work
Secondary Phone: ( )	☐ Cell ☐ Home ☐ Work
Street Address:	**City, State, Zip Code**

Social Security Number:	**Email Address:**

Insurance Information			
Insured Name:	**Insured DOB:**	**Insured Employer:**	
Carrier:	**Identification Number:**	**Group Number:**	**Phone Number:**

Emergency Contact Information		
Emergency Contact:	**Phone Number:**	**Relationship:**
Primary Care Physician:		**Phone Number:**

CURRENT SYMPTOMS

Question		
How would you like the doctor to help you?		
Why are you seeking help now?		
If you are currently in treatment, when did you last see your doctor?		
What are your current stressors?		
Has anything helped improve your symptom?		
Has anything made your symptoms worse?		
Have there been any recent changes to your medications?		

Mood Symptoms

- ☐ Depression or sadness
- ☐ Loss of interest
- ☐ Crying spells
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Guilty thoughts
- ☐ Thoughts of death or suicide
- ☐ Irritability or anger
- ☐ Euphoria
- ☐ Mood swings
- ☐ Grandiosity
- ☐ Increased sexuality
- ☐ Talkativeness

Perceptual Problems

- ☐ Hearing hallucinations
- ☐ Seeing hallucinations
- ☐ Feeling hallucinations
- ☐ Smelling hallucinations
- ☐ Feeling scared
- ☐ Feeling someone is after you

Life or Social Problems

- ☐ Legal problems
- ☐ Traffic problems
- ☐ Rude behavior
- ☐ Road rage
- ☐ Violence toward others
- ☐ Being a victim of violence

Appetite Problems

- ☐ Appetite or weight increase
- ☐ Appetite or weight decrease
- ☐ Appetite or weight unchanged
- ☐ Bulimia or Anorexia
- ☐ Exercising too much
- ☐ Worried about weight & body

Anxiety Symptoms

- ☐ Fatigued or easily tired
- ☐ Excess worry
- ☐ Can't relax, feeling tense
- ☐ Easily startled
- ☐ Anxiety or panic attacks
- ☐ Obsessive thinking
- ☐ Compulsive behavior
- ☐ Skin picking or hair pulling
- ☐ Phobia
- ☐ PTSD
- ☐ Perfectionistic tendencies
- ☐ Social anxiety
- ☐ Performance anxiety
- ☐ Rituals

Cognitive Symptoms

- ☐ Decreased concentration
- ☐ Easily distracted
- ☐ Disorganized thinking
- ☐ Procrastination
- ☐ ADHD
- ☐ Interrupting others

Sleep Symptoms

- ☐ Problems falling asleep
- ☐ Problems staying asleep
- ☐ Problems waking up too early
- ☐ Problems sleeping too much
- ☐ Nightmares or sleep disorder
- ☐ Don't need as much sleep

What time do you lay down to sleep?

How long does it take you to fall asleep?

Once you're asleep, do you stay asleep?

- ☐ Yes
- ☐ No – If No, how many times do you wake up through the night?
- ☐ How long are you awake before falling back asleep again?

What time do you wake up to start your day?

Do you feel well rested when you wake up?

Do you take naps?

PAST PSYCHIATRIC HISTORY

- ✓ **If you checked “Yes,” please provide an explanation.**

Have you had any of the following?

Inpatient psychiatric hospitalizations	☐ No ☐Yes
Suicide attempts	☐ No ☐Yes
Self-injurious behavior (cutting/burning)	☐ No ☐Yes
Electroconvulsive therapy	☐ No ☐Yes

Have you had any of the following diagnoses?

- ✓ **If you checked “Yes,” please provide your age (or year) of onset of the symptom or receiving the diagnosis, and any trigger or life events going on around that time**

Depression symptoms	☐ No ☐Yes Age or Year :
Manic-depression or bipolar symptoms	☐ No ☐Yes Age or Year :
Anxiety or Generalized worry	☐ No ☐Yes Age or Year :
Panic attacks	☐ No ☐Yes Age or Year :
Obsessive Compulsive Disorder (OCD)	☐ No ☐Yes Age or Year :
Phobia	☐ No ☐Yes Age or Year :
Post-Traumatic Stress Disorder (PTSD)	☐ No ☐Yes Age or Year :
Social Anxiety	☐ No ☐Yes Age or Year :
Eating Disorder / excess exercise behaviors	☐ No ☐Yes Age or Year :
Hallucinations, paranoia, unusual thoughts, schizophrenia or schizoaffective disorder	☐ No ☐Yes Age or Year :
ADHD, learning problems, autistic spectrum	☐ No ☐Yes Age or Year :

Past Treatment Providers

- ✓ **If you checked “Yes,” please provide your age (or year) that you began to see that treatment provider, including approximate last time seen**

Have you seen a psychiatrist before?	☐ No ☐Yes
Have you seen a therapist or counselor?	☐ No ☐Yes

PAST MEDICATIONS YOU HAVE TRIED: √ Please check all that apply

Category	√	Brand	Generic
ANTIDEPRESSANTS		PAXIL	PAROXETINE
		PROZAC	FLUOXETINE
		LUVOX	FLUVOXAMINE
		CELEXA	CITALOPRAM
		LEXAPRO	ESCITALOPRAM
		ZOLOFT	SERTRALINE
		VIIBRYD	VILAZODONE
		TRINTELLIX / BRINTELLIX	VORTIOXETINE
		EFFEXOR	VENLAFAXINE
		CYMBALTA	DULOXETINE
		PRISTIQ	DESVENLAFAXINE
		FETZIMA	LEVOMILNACIPRAN
		SAVELLA	MILNACIPRAN
		WELLBUTRIN	BUPROPRION
		REMERON	MIRTAZAPINE
		SERZONE	NEFAZODONE
		PARNATE	TRANYLCYPROMINE
		NARDIL	PHENELZINE
		TOFRANIL	IMIPRAMINE
		ANAFRANIL	CLOMIPRAMINE
		ELAVIL	AMITRIPTYLINE
		NORPRAMIN	DESIPRAMINE
		PAMELOR	NORTRIPTYLINE
		SINEQUAN	DOXEPIN
		SURMONTIL	TRIMIPROAMINE
ANXIOLYTICS		BUSPAR	BUSPIRONE
		NEURONTIN / GRALISE	GABAPENTIN
		VISTARIL	HYDROXYZINE
		XANAX	ALPRAZOLAM
		ATIVAN	LORAZEPAM
		VALIUM	DIAZEPAM
		KLONOPIN	KLONAZEPAM
		RESTORIL	TEMAZEPAM
		LIBRIUM	CHLORDIAZEPOXIDE
		SERAX	OXAZEPAM
MOOD STABILIZERS		TOPAMAX	TOPIRAMATE
		DEPAKOTE	VALPROIC ACID
		LAMICTAL	LAMOTRIGINE
		TEGRETOL	CARBAMAZEPINE
		TRILEPTAL	OXCARBAZEPINE
		ESKALITH	LITHIUM
		GABITRIL	TIAGABINE
		KEPPRA	LEVETIRACETAM
SLEEPING MEDS		MELATONIN	MELATONIN
		ROZEREM	RAMELTEON
		BENADRYL	DIPHENHYDRAMINE
		DESYREL	TRAZODONE
		AMBIEN	ZOLPIDEM
		LUNESTA	ZOPICLONE
		SONATA	ZALEPLON
		SOMA	CARISOPRODOL
		BELSOMRA	SUVOREXANT
ANTIPSYCHOTICS/MOOD STABLIZERS		ABILIFY	ARIPIPRAZOLE / MAINTENNA /ARISTADA
		FANAPT	ILOPERIDONE
		GEODON	ZIPRASIDONE
		INVEGA	PALIPERIDONE/ SUSTENNA / TRINZA
		LATUDA	LURASIDONE
		REXULTI	BREXPIPRAZOLE
		RISPERDAL	RISPERIDONE / RISPERDAL CONSTA
		SAPHRIS	ASENAPINE
		SEROQUEL	QUETIAPINE
		VRAYLAR	CARIPRAZINE
		ZYPREXA	OLANZAPINE/ZYPREXA RELPREW
		CLOZARIL	CLOZAPINE
		HALDOL	HALOPERIDOL / HALDOL DECANOATE
		PROLIXIN	FLUPHENAZINE / PROLIXIN DECANOATE
		TRILAFON	PERPHENAZINE
		THORAZINE	CHLORPROMAZINE
		MELLARIL	THIORIDAZINE
		LOXITANE	LOXAPINE
		STELAZINE	TRIFLUORERAZINE
ADDICTION		ANTABUSE	DISULFIRAM
		REVIA / VIVITROL	NALTREXONE/NALTREXONE INJECTION
		SUBOXONE /ZUBSOLV	BUPRENORPHINE/NALOXONE
		SUBUTEX, BUTRANS	BURENORPHINE, PATCH, IMPLANT
		CAMPRAL	ACAMPROSATE
COGNITIVE MEDICATIONS		ARICEPT	DONEPEZIL
		REMINYL	GALATAMINE
		EXELON	RIVASTIGMINE
		NAMENDA	MEMANTINE
		REQUIP	ROPINIROLE
		MIRAPEX	PRAMIPEXOLE
		NEUPRO	ROTIGOTINE
		SYMMETREL	AMANTADINE
		ELDEPRYL	SELEGILINE
		COMTAN	ENTACAPONE
		SINEMET	LEVODOPA/CARBIDOPA
ADHD MEDICATIONS		PROVIGIL	MODAFINIL
		NUVIGIL	ARMODAFINIL
		STRATTERA	ATOMOXETINE
		RITALIN, CONCERTA	METHYLPHENIDATE
		QUILLIVANT, APTENSIO	METHYLPHENIDATE
		METADATE, METHYLIN	METHYLPHENIDATE
		FOCALIN	DEXMETHYLPHENIDATE
		DAYRANA PATCH	METHYLPHENIDATE
		ADDERALL, ADENSYS	DEXTROAMPHETAMINE/AMPHETAMINE
		VYVANSE	LISDEXAMFETAMINE
		DEXEDRINE, DESOXYN	DEXTROAMPHETAMINE, METHAMPHET.
		CATAPRES, KAPVAY	CLONIDINE
		TENEX, INTUNIV	GUANFACINE
		CYLERT	PEMOLINE
		INDERAL	PROPRANOLOL
		COGENTIN	BENZTROPINE
		ARTANE	TRIHEXYPHENIDYL

PAST MEDICAL HISTORY

√ Please check or circle all that apply

CARDIOVASCULAR SYSTEM ☐ NO PROBLEMS

- ☐ HEART DISEASE
- ☐ CORONARY ARTERY DISEASE
- ☐ CARDIOMYOPATHY
- ☐ ENDOCARDITIS / MYOCARDITIS
- ☐ CONGESTIVE 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
- ☐ OTHER ____

RESPIRATORY SYSTEM ☐ NO PROBLEMS

- ☐ ASTHMA
- ☐ CHRONIC BRONCHITIS
- ☐ COPD
- ☐ EMPHYSEMA
- ☐ ENVIRONMENTAL ALLERGIES
- ☐ PULMONARY EMBOLISM
- ☐ OTHER ____

GASTROINTESTINAL SYSTEM ☐ NO PROBLEMS

- ☐ 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
- ☐ DIARRHEA
- ☐ OTHER ____

BLOOD PROBLEMS OR CANCERS ☐ NO PROBLEMS

- ☐ ANEMIA
- ☐ LOW IRON
- ☐ LOW VITAMIN D, B12, OR FOLATE
- ☐ BLEEDING OR CLOTTING PROBLEMS
- ☐ SICKLE CELL DISEASE
- ☐ THALASSEMIA
- ☐ HODGKINS DISEASE
- ☐ LYMPHOMA
- ☐ MYELOMA
- ☐ HEMOCHROMATOSIS
- ☐ MONONUCLEOSIS
- ☐ HIV / AIDS
- ☐ OTHER ____

MUSCULOSKELETAL ☐ NO PROBLEMS

- ☐ ARTHRITIS
- ☐ RHEUMATOID ARTHRITIS
- ☐ BRUXISM / TEETH GRINDING
- ☐ CHRONIC PAIN
- ☐ OTHER ____

ENDOCRINE DISORDERS ☐ NO PROBLEMS

- ☐ HYPOTHYROIDISM
- ☐ HYPERHYROIDISM
- ☐ HASHIMOTO'S THYROIDITIS
- ☐ ADRENAL INSUFFICIENCY
- ☐ DIABETES MELLITUS
- ☐ PARATHYROID PROBLEMS
- ☐ OTHER ____

NEUROLOGICAL SYSTEM ☐ NO PROBLEMS

- ☐ CONCUSSIONS
- ☐ HEAD TRAUMA (i.e. sports injuries, car accidents)
- ☐ HEAD TRAUMA WITH LOSS OF CONSCIOUSNESS
- ☐ AUTISM / SPECTRUM DISORDER
- ☐ ALS
- ☐ AUTOIMMUNE DISORDER
- ☐ BELL'S PALSY
- ☐ NEUROPATHY
- ☐ VASCULITIS
- ☐ MYOPATHY
- ☐ STROKE / TIA
- ☐ MULTIPLE SCLEROSIS
- ☐ MYASTHENIA GRAVIS
- ☐ DEMENTIA
- ☐ SEIZURE DISORDER
- ☐ TREMOR
- ☐ MENIERE'S DISEASE
- ☐ MIGRAINE
- ☐ HEADACHES
- ☐ TIC DISORDER / TOURETTES
- ☐ PARKINSONS DISEASE
- ☐ HUNTINGTON'S DISEASE
- ☐ TRIGEMINAL NEURALGIA
- ☐ LUPUS
- ☐ MENINGITIS
- ☐ FAINTING SPELLS / SYNCOPE
- ☐ LYME DISEASE
- ☐ PSEUDOTUMOR CEREBRI
- ☐ FIBROMYALGIA
- ☐ CHRONIC FATIGUE SYNDROME
- ☐ CHRONIC PAIN DISORDER
- ☐ NARCOLEPSY
- ☐ RESTLESS LEG SYNDROME
- ☐ SLEEP APNEA or SLEEP DISORDER
- ☐ OTHER ____

UROGENITAL SYSTEM ☐ NO PROBLEMS

- ☐ KIDNEY DISEASE
- ☐ KIDNEY STONES OR CYSTS
- ☐ PROLPSED / FALLEN BLADDER
- ☐ URINARY INCONTINENCE
- ☐ URINARY TRACT INFECTIONS
- ☐ INTERSTITIAL CYSTITIS
- ☐ RENAL INSUFFICIENCY
- ☐ OTHER ____

MALES - UROGENITAL SYSTEM

- ☐ BENIGN PROSTATIC HYPERTROPHY
- ☐ PENILE OR TESTICULAR DISEASE
- ☐ ERECTILE DYSFUNCTION
- ☐ LOW TESTOSTERONE
- ☐ URETHRAL DISCHARGE
- ☐ INFERTILITY
- ☐ SEXUALLY TRANSMITTED DISEASES
- ☐ OTHER ____

PAST MEDICAL HISTORY √ **Please answer the following questions regarding your past medical history.**

Female OB/Gyn History		
Age at 1st Menses		
Cycle Length (i.e. 28 days)		
First day of last menstrual period		
Problems with Menses	☐ None ☐ Pain ☐ Irregular Cycle ☐Heavy Bleeding ☐ Other	
Problems with Cervix or Uterus	☐ Fibroids ☐ Endometriosis ☐ Cysts ☐ Prolapse ☐ Bleeding ☐ PID ☐ STD	
Menopause	☐ No ☐ Yes If yes, age of onset:	
Number of: ● Pregnancies: ___________ ● Miscarriages: ___________ ● Deliveries: ___________	Date of Delivery	Method of Delivery / Any complications

Current Contraception	☐ Oral contraceptive ☐ Condom ☐ Injection or Implant ☐ None ☐ Surgical
Sexual orientation	☐ Heterosexual ☐ Homosexual ☐ Other LGBT

✓ **Please check if you have any sexual health problems currently or in the past with:**

Libido	☐ No ☐Yes
Arousal / Lubrication	☐ No ☐Yes
Orgasm	☐ No ☐Yes
Pain / Spasms	☐ No ☐Yes

SURGICAL HISTORY

Date of Surgery	Type of Surgery

PHYSICIANS **Please list all your current physicians:**

Type of Physician	Name of Physician / Practice
Primary Care Physician	

ALLERGY HISTORY

		Reaction Type (i.e. Rash, Hives,)
Medication	☐ No Known Drug Allergies	☐ Allergy to:
Environmental	☐ No Known Environmental Allergies	☐ Allergy to:
Food	☐ No Known Food Allergies	☐ Allergy to:

CURRENT MEDICATIONS

- ✓ **Please list all medications including, over the counter medicine, vitamins and/or herbal remedies.**

Medication Name	Dose/ Directions	Prescribing Doctor

When and where is the last time you had blood work drawn?____

FAMILY HISTORY

- ✓ **Please include physical health, mental health and addiction problems.**

Relationship	Age	Medical Problems
Mother		
Father		
Siblings		
Children		
Children		
Aunts/Uncles		
Cousins		
Grandparents		

DEVELOPMENTAL & SOCIAL HISTORY

- ✓ **Please answer the following questions. If you answer yes, please provide details.**

Where were you born (City, state)		
When you were born, were there any complications with the pregnancy or delivery?	☐ No ☐ Yes	
As a child, did you experience any developmental delays? (walking, talking, potty training.)	☐ No ☐ Yes	
Where you the victim of abuse as a child?	☐ No ☐ Yes	☐ Physical ☐ Mental ☐ Emotional
Overall how would you describe your childhood?		

Family Dynamics

Were your parents married at your birth?	☐ No ☐ Yes	
Parents' current marital status	☐ Married ☐ Divorced ☐ Separated ☐ Widowed	

	If Divorced, how old were you at that time?	
	Who did you grow up with?	
	How old were you if/when your parent remarried?	

Parents Occupation and Personalities	Mother	
	Father	

Do you have any Siblings?	☐ No ☐ Yes - If yes, what are their ages and occupation?		
	Age	Occupation	Relationship with sibling
☐ Brother ☐ Sister Name:			
☐ Brother ☐ Sister Name:			
☐ Brother ☐ Sister Name:			

Education

Year of high school graduation?		Did you attend College? If yes, years attended: ____________________	☐ No ☐ Yes
If not, last grade completed?		Major:	
Did you participate in any extracurriculars? If yes, which?	☐ No ☐ Yes	Did you graduate?	☐ No ☐ Yes
		If yes, degree obtained?	
How did you perform academically in school?			

Employment

Are you currently employed?	☐ No ☐ Yes	Past Employment History:	
How long at current job?		Number of past jobs:	
If yes, name of employer:		Longest time at one job:	
Have you had any problems at work? Tardy, disciplinary, fired?	☐ No ☐ Yes	Types of jobs:	

Social History

Are you currently in a relationship?	☐ No ☐ Married / engaged ☐ Partner ☐ Dating
If yes, what is your partner's occupation?	
If yes, what is your partner's personality?	
If yes, describe your relationship:	
Do you have any children?	☐ No ☐ Yes
☐ Male ☐ Female Name:	Age/Year: Job: Personality:
☐ Male ☐ Female Name:	Age/Year: Job: Personality:
☐ Male ☐ Female Name:	Age/Year: Job: Personality:
Who lives with you at home?	
Do you exercise?	☐ No ☐ Yes - what type, and frequency
Who do you turn to for support?	

Are you religious?	☐ No ☐ Yes – Denomination:
Have you been in the military?	☐ No ☐ Yes – Branch, years of service:
Do you own any weapons?	☐ No ☐ Yes
Have you ever had any legal problems?	☐ No ☐ Yes
What are your hobbies?	
How would you describe your personal strengths?	
How would you describe your personality?	

SUBSTANCE USE HISTORY:

Substance	Age at 1st Use	Problems	Details of use
Caffeine		☐ No ☐ Yes	
Nicotine		☐ No ☐ Yes	
Inhalants		☐ No ☐ Yes	
Alcohol		☐ No ☐ Yes	
Cannabis		☐ No ☐ Yes	
LSD/Hallucinogens		☐ No ☐ Yes	
Ecstasy		☐ No ☐ Yes	
PCP		☐ No ☐ Yes	
Methamphetamine		☐ No ☐ Yes	
Cocaine		☐ No ☐ Yes	
Heroin		☐ No ☐ Yes	
Rx meds - Opioids		☐ No ☐ Yes	
Rx meds - Stimulants		☐ No ☐ Yes	
Rx meds - Benzodiazepines		☐ No ☐ Yes	
Other:		☐ No ☐ Yes	

What are your goals of treatment?	**Plan:** (to be filled out by Dr. Kelly)