MWI Health

Name: _____ **Birthdate:** _____
First Middle Last (MM/DD/YYYY)

Address: _____ **Phone:** _____
Street City State Zip (Area Code) XXX-XXXX

Email: _____ ☐ I consent to receive text messages

What are your reasons for making this appointment?

- ○ ADHD
- ○ Anxiety
- ○ Depression
- ○ OCD
- ○ Pain
- ○ PTSD
- ○ Sexual Disorders
- ○ Sleep Problems
- ○ Substance Use
- ○ Other, please explain _____

_____

What are your current life stressors?

- ○ Financial
- ○ Health
- ○ Job
- ○ Legal
- ○ Marital/Family
- ○ Relationship

Primary Care Provider _____

At what facility do you see your provider _____

Past Psychiatric History

Have you ever had therapy or counseling? NO _____ YES _____
If yes, when _____ With whom? _____

Have you ever seen a psychiatrist? NO _____ YES _____
If yes, why and when _____

Psychiatrist name _____ Diagnosis _____

Have you ever been hospitalized in a psychiatric hospital? NO _____ YES _____

If yes, why, where, when, and for how long _____

_____

_____

Do you have a case manager, ARMHS worker, or probation officer? NO _____ YES _____

If yes, name _____ Agency _____

Have you ever been committed to a hospital? NO _____ YES _____

If yes, where and when _____

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_____

Have you ever hurt yourself or tried to commit suicide? NO _____ YES _____

If yes, when _____

Have you tried any of these treatments or therapies?

- ○ AA meetings
- ○ ACT team
- ○ CD treatment
- ○ DBT
- ○ ECT
- ○ EMDR
- ○ STEPPS
- ○ TMS
- ○ None

Medications List name, dose, and frequency. Include over-the-counter, vitamins, supplements, herbs, oils

_____

_____

_____

Allergies

Medication _____

Other _____

Check any medications you have ever tried

- _ Abilify/Aripiprazole
- _ Adderall/Adderall XR
- _ Ambien/Zolpidem
- _ Anafranil/Clomipramine
- _ Antabuse/Disulfiram
- _ Ativan/Lorazepam
- _ Benadryl/Diphenhydramine
- _ Buspar/Buspirone
- _ Camprel/Acamprosate
- _ Catapres/Clonidine
- _ Celexa/Citalopram
- _ Chantix/Varenicline
- _ Clozaril/Clozapine
- _ Concerta/Methylphenidate
- _ Cymbalta/Duloxetine
- _ Depakote/Valproic Acid
- _ Dyseril/Trazodone
- _ Effexor/Venlafaxine
- _ Elavil/Amitriptyline
- _ Emsam/Selegiline
- _ Fanapt/Iloperidone
- _ Geodon/Ziprasidone
- _ Haldol/Haloperidol
- _ Invega/Paliperidone
- _ Keppra/Levotriacetam
- _ Klonopin/Clonazepam
- _ Lamictal/Lamotrigine
- _ Latuda/Lurasidone
- _ Lexapro/Escitalopram
- _ Librium/Chlordiazepoxide
- _ Lithium
- _ Lunesta/Eszopiclone
- _ Luvox/Flovuxamine
- _ Methadone
- _ Minipress/Prazosin
- _ Navane/Thiothixene
- _ Neurontin/Gabapentin
- _ Pamelor/Nortriptyline
- _ Parnate/Tranylcypromine
- _ Paxil/Paroxetine
- _ Pristiq/Desvenlafaxine
- _ Prolixin/Fluphenazine
- _ Prozac/Fluoxetine
- _ Remeron/Mirtazapine
- _ Restoril/Temazepam
- _ Rexulti/Brexpiprazole
- _ Risperdone/Resperidal
- _ Ritalin/Methylphenidate
- _ Saphris/Asenapine
- _ Seroquel/Quetiapine
- _ Sonata/Zalepon
- _ Strattera/Atomoxetine
- _ Suboxone/Buprenorpine + Naloxone
- _ Subutex/Buprenorphine
- _ Tegretol/Carbamazipine
- _ Thorazine/Chlorpromazine
- _ Topomax/Topiramate
- _ Trilafon/Perfenazine
- _ Trileptal/Oxcarbazepine
- _ Valium/Diazepam
- _ Viibryd/Vilazodone
- _ Vistaril/Hydroxyzine
- _ Vivitrol/Naltrexone
- _ Vyvanse/Lisdexamfetamine
- _ Vraylar/Cariprazine
- _ Wellbutrin/Bupropion
- _ Xanax/Alprazolam
- _ Zoloft/Sertraline
- _ Zyprexa/Olanzapine
- _ Other _____

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_____

Medical History

Current _____

_____

Past _____

_____

Surgeries _____

_____

Have you ever had a head injury? NO _____ YES _____
Have you ever had a seizure? NO _____ YES _____
History of abuse? NO _____ YES _____
History of trauma? NO _____ YES _____
Family history of mental illness _____

_____

Family history of drug or alcohol abuse? NO _____ YES _____
Family history of suicide? NO _____ YES _____
Current legal problems? NO _____ YES _____ Past legal problems? NO _____ YES _____
Current military service? NO _____ YES _____ Past military service? NO _____ YES _____
Religion _____ Highest level of education _____
Marital status _____ Children _____
Employed? NO _____ YES _____
If yes, where _____

Substance Use

Alcohol	Age of first use _____	Last time used _____	Frequency of use _____
Bath Salts	Age of first use _____	Last time used _____	Frequency of use _____
Caffeine	Age of first use _____	Last time used _____	Frequency of use _____
Cocaine/Crack	Age of first use _____	Last time used _____	Frequency of use _____
Fentanyl	Age of first use _____	Last time used _____	Frequency of use _____
Hallucinogens	Age of first use _____	Last time used _____	Frequency of use _____
Heroin	Age of first use _____	Last time used _____	Frequency of use _____
Inhalants	Age of first use _____	Last time used _____	Frequency of use _____
LSD	Age of first use _____	Last time used _____	Frequency of use _____
Marijuana	Age of first use _____	Last time used _____	Frequency of use _____
Meth	Age of first use _____	Last time used _____	Frequency of use _____
Nicotine	Age of first use _____	Last time used _____	Frequency of use _____
Other _____	Age of first use _____	Last time used _____	Frequency of use _____

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Substance Use, continued

Have you ever been involved in any alcohol or drug treatment? NO _____ YES _____

If so, when and where _____

Have you ever felt you needed to cut down on your drinking? NO _____ YES _____

Have people annoyed you by criticizing your drinking? NO _____ YES _____

Have you ever felt guilty about your drinking? NO _____ YES ____

Have you ever felt that you needed a drink first thing in the morning to steady your nerves or to get rid of a hangover?
NO _____ YES _____

FEMALES

Are you currently pregnant? NO _____ YES _____ Are you planning to get pregnant? NO _____ YES _____

Have you had a child in the past year? NO _____ YES _____

Are you breastfeeding? NO _____ YES _____

Do your symptoms happen or worsen before your menstrual cycle? NO _____ YES _____

Do you use birth control? NO _____ YES _____

If yes, what _____

In order to help you, it is important that we get a good idea about the things that are happening in your life.
Mark **P = true in the past**, **C = currently true**, or leave blank if neither apply.

_ Remembering painful things that have happened in the past
_ Needing everything to be perfect
_ Having thoughts that repeat themselves over and over
_ Feeling a need to repeat certain behaviors over and over
_ Depressed mood
_ Decreased appetite
_ Fatigue or low energy level
_ Low self-esteem
_ Being really upset about something that has happened in the past 6 months
_ Feeling of hopelessness
_ Difficulty concentrating/making decisions
_ Mind going blank when nervous
_ Difficulty falling or staying asleep
_ Depressed mood nearly every day for 2 weeks
_ Loss of interest or pleasure nearly every day for 2 weeks
_ Decreased appetite nearly every day for 2 weeks
_ Feeling slowed down nearly every day for 2 weeks
_ Fatigue or a loss of energy nearly every day for 2 weeks
_ Difficulty concentrating nearly every day for 2 weeks
_ Recurrent thought of death or dying
_ Reduced sexual interest
_ Feeling “on top of the world” without any special reason
_ Decreased need for sleep
_ Feeling more talkative than usual or pressure to keep talking
_ Having racing thoughts or “flight of ideas”
_ Being easily distracted by unimportant or irrelevant things
_ Being hyperactive, agitated, or “sped up”

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_ Being impulsive, overspending, sexual sprees, or reckless driving
_ Hearing a voice even when no one is around
_ Knowing special secrets, which no one else believes
_ Having someone else read my mind or tamper with my thoughts
_ Feeling shaky or trembling
_ Muscle aches, soreness, or tension
_ Restlessness
_ Sweaty or cold, clammy hands
_ Dry mouth
_ Dizziness or lightheadedness
_ Hot flashes or chills
_ Irritability
_ Pain in extremities
_ Shortness of breath
_ Amnesia
_ Difficulty swallowing
_ Painful menstruation
_ Loss of voice
_ Fainting or loss of consciousness
_ Blurred or double vision
_ Vomiting, other than during pregnancy
_ Seizure or convulsion
_ Deafness
_ Nausea, other than motion sickness
_ Diarrhea
_ Back pain
_ Impotence
_ Headaches
_ Losing control when angry
_ Job/occupational difficulties
_ Concerns about children
_ Legal problems
_ Sexual problems
_ Having an outside force control my brain or thoughts
_ Using my own thought waves to control the thoughts of others
_ Difficulty swallowing or feeling a lump in my throat
_ Feeling keyed up or on edge
_ Exaggerated startle response, feeling jumpy
_ Smothering sensation
_ Palpitations or accelerated heart rate
_ Abdominal pain or distress, other than when menstruating
_ Burning sensation in sexual organs, other than during sex
_ Difficulty keeping relationships or having lasting friendships
_ Panic attacks with shortness of breath or smothering sensations
_ Panic attacks with palpitations or rapid heart rate
_ Panic attacks with nausea or abdominal distress
_ Panic attacks with chest pain or discomfort
_ Panic attacks with a fear of going crazy or losing control
_ Panic attacks with dizziness or faintness
_ Panic attacks with trembling or shaking
_ Panic attacks with sweating
_ Panic attacks with choking
_ Panic attacks with feelings of unreality
_ Panic attacks with hot flashes or shills
_ Panic attacks with a fear of dying
_ Recurrent episodes of binge eating
_ Feeling a lack of control during episodes of binge eating
_ Self-induced vomiting, dieting, or laxatives to prevent weight gain
_ An average of 2 eating binges a week for at least 3 months
_ Persistent concern with body shape or weight
_ Significant weight loss during the past year
_ Intense fear of gaining weight or becoming overweight
_ Feeling overweight regardless of actual body weight
_ Missing at least 2 consecutive menstrual periods

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_ Drinking alcohol in larger amounts or for longer than intended
_ Unsuccessful attempts to cut down or control drinking
_ Spending a lot of time drinking or recovering from being drunk
_ Drinking at times when I should have been doing other things
_ Giving up social or recreational activities because of drinking
_ Drinking despite arguments from family and friends
_ Drinking larger amounts to get the same effect
_ Using a larger amount of a drug than intended
_ Unsuccessful attempts to cut down or control the use of a drug
_ Spending time using a drug or recovering from drug use
_ Using a drug when I should be working or driving
_ Giving up social or recreational events because of drug use

Describe the problems you are currently experiencing.

_____

_____

_____

Following therapy/counseling, what would you like to see change about your life and situation?

_____

_____

_____

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