INTAKE PAPERWORK

This form is primarily intended to gather information ahead of time so we can have more time during your appointment to focus on your goals and why you are coming in. Most of this information is history gathering and helps me determine what to focus on in your initial appointment. If you prefer to wait, we can discuss these items together during your appointment.

Patient Name: ________________________________________________________________

Main issues that you would like to address at our visit:

SYMTPOM SCREENING: Please check (and circle or fill-in where applicable) all that apply currently:

☐ Depression ☐ Long-term memory problems ☐ Thoughts of death/suicide
☐ Not enjoying things in life ☐ Concentration/Focus problems ☐ Feeling guilty
☐ Sleep (too little/too much) ☐ Short-term memory problems ☐ Changes in appetite (eating too much/too little)
☐ Worry about several things ☐ Anxiety in public ☐ Panic symptoms
☐ Can’t relax/always tense ☐ Anxiety when giving a presentation ☐ Specific fear:
☐ Restless/on edge ☐ Anxiety in social groups
☐ Irritability

☐ Traumatic events/neglect ☐ Flashbacks of events ☐ Checking for safety
☐ Nightmares ☐ Feeling unsafe in crowds ☐ Easily startled
☐ Restrictive eating ☐ Binge eating ☐ Excessive exercise
☐ Excessive laxative use

☐ Unusual experiences ☐ Seeing things not there ☐ Special messages from TV/radio/social media/
☐ Hearing voices ☐ Special powers Internet/newspaper

☐ Self-harm ☐ Fear of abandonment ☐ Rapid changes in mood
☐ Intense relationships ☐ Impulsive behaviors ☐ Losing touch with reality
☐ Intense anger ☐ Recurrent suicide attempts or thoughts
☐ Chronic feelings of emptiness

Period of 4 or more days in a row with:
☐ Sleeping 1-2 hours a night ☐ Elevated/euphoric mood ☐ Rapid thoughts
☐ High energy ☐ Irritable/depressed ☐ Unusually high confidence
☐ Lots of great ideas ☐ Talking more than normal ☐ Decisions you later regret
- Impulsive behaviors
- Very distracted
- Makes careless mistakes
- Difficulty organizing
- Blurts out
- Fidgets/restless
- Constantly on the go/doesn’t stop/always doing something
- Trouble concentrating
- Often loses things (keys, wallet, school work)
- People say it feels like you are not listening
- Avoid difficult tasks
- Late or misses appointments
- Procrastinates

**Physical symptoms:**
- Nausea/Vomiting
- Headaches/Migraines
- Rapid heart beat
- Chest pains
- Shortness of breath
- Diarrhea/Constipation
- Changes in vision/tunnel
- Weakness
- Acid reflux/GERD
- Tingling sensations
- Trembling/shaking
- Flushed/hot flashes
- Feeling cold/chills
- Sweating
- Urges to go to the bathroom
- Almost or actually fainting
- Muscle spasms
- Aches all over
- Pain (list locations):
  - 
  - 

**Have you ever been diagnosed with any of the following:**
- Diabetes
- Seizures
- Tension headaches
- Heart condition
- High blood pressure
- Cancer
- Kidney disease
- High cholesterol
- Hypo/Hyper Thyroid
- Asthma
- Pancreatitis
- Iron deficiency
- Liver disease
- Acid reflux/GERD
- Celiac/gluten sensitivity
- Chronic pain
- Glaucoma
- Irritable bowel syndrome
- Head injury
- Fibromyalgia
- Migraines
- Other:
  - 

**Mental Health:**
- Bipolar disorder
- Depression
- Specific phobia:
- Adjustment disorder
- Drug use disorder
- PTSD
- Personality disorder
- Tobacco use disorder
- Anxiety
- ADHD
- Anorexia or bulimia
- Panic attacks/disorder
- Dementia
- Psychosis
- Obsessive-compulsive disorder
- Delirium
- Conversion disorder
- Social anxiety
- Delirium
- MTHFR mutation

Has anyone in your family (blood relatives) been diagnosed with any of the mental health conditions listed above? If so, please list here:

**Have you ever taken any of the medications listed below?**
- Prozac/fluoxetine
- Celexa/citalopram
- Luvox/fluvoxamine
- Zoloft/sertraline
- Lexapro/escitalopram
- Paxil/paroxetine
- Effexor/venlafaxine
- Pristiq/desvenlafaxine
- Viibryd/Vilazodone
- Brintillex/vortioxetine
- Cymbalta/Duloxetine
- Wellbutrin/bupropion
- Serzone/Nefazodone
- Fetzima/Levominapran
- Remeron/mirtazapine
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Drug Name</th>
<th>Drug Name</th>
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</thead>
<tbody>
<tr>
<td>Desyrel/Trazodone</td>
<td>Anafranil/clomipramine</td>
<td>Nardil/phenelzine</td>
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<tr>
<td>Neurontin/Gabapentin</td>
<td>Tofranil/imipramine</td>
<td>Emsam/selegeline</td>
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<tr>
<td>Elavil/Amitriptyline</td>
<td>Norpramin/desipramine</td>
<td>Parnate (tranylcypromine)</td>
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<tr>
<td>Pameler/nortriptyline</td>
<td>Sinequan/doxepin</td>
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</tr>
<tr>
<td>Ativan/orlozapam</td>
<td>Valium/diazepam</td>
<td>Librium/chlordiazepoxide</td>
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<tr>
<td>Xanax/alprazolam</td>
<td>Halcion/triazolam</td>
<td>Restoril/temazepam</td>
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<tr>
<td>Ambien/zolpidem</td>
<td>Sonata/zaleplon</td>
<td>Lunesta/eszopiclone</td>
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<tr>
<td>Rozerem/ramelteon</td>
<td>Costco Sleep Aid/Unisom/doxylamine</td>
<td>Unisom/other OTC sleep aid:</td>
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<tr>
<td>Belsomra/suvorexant</td>
<td></td>
<td></td>
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<tr>
<td>Benadryl/diphenhydramine</td>
<td></td>
<td></td>
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<tr>
<td>Lithium (Eskalith/Lithobid)</td>
<td>Lamictal/lamotrigine</td>
<td>Trileptal/oxcarbazepine</td>
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<tr>
<td>Depakote/divalproic acid</td>
<td>Tegretol/carbamazepine</td>
<td>Keppra/levetiracetam</td>
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<tr>
<td>Abilify/zipiriprazole</td>
<td>Latuda/lurasidone</td>
<td>Haldol/haloperidol</td>
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<tr>
<td>Geodon/ziprasidone</td>
<td>Seroquel/quetiapine</td>
<td>Fazaclol/clozapine</td>
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<tr>
<td>Zyprexa/olanzapine</td>
<td>Risperdal/risperidone</td>
<td>Invega/paliperidone</td>
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<tr>
<td>Adderall/amphetamine salts</td>
<td>Dexedrine/dextroamphetamine</td>
<td>Strattera/atomoxetine</td>
</tr>
<tr>
<td>Concerta/Ritalin/Focalin/Daytrana/Metadate/methylphenidate</td>
<td>Vyvanse/Lisdexamfetamine</td>
<td>Clonidine</td>
</tr>
</tbody>
</table>

Please indicate which supplements/nutraceuticals you have tried:

- Methylfolate (Deplin/EnLyte)
- L-theanine or Theanine Serine
- St. John’s Wort/hyperforin
- SAMe
- 5HTP
- Rhodiola rosea
- Tryptophan
- Melatonin
- Inositol
- SeroPlus
- O.N.E Multivitamin (Pure Encapsulations)
- Calcium
- Co-Q10
- Zinc
- Selenium
- Vitamin D
- Vitamin A
- Vitamin B6/P5P
- Vitamin B12
- Folate
- Fish oil/EPA/DHA
- Probiotics
- Magnesium/CALM
- L-methionine
- L-tyrosine
- Bacopa
- Ashwagandha
- GABA
- N-Acetyl Cysteine
- Valerian root
- Kava
- EmPower (Plus)
- Kavinace
- Probiotics
- Others:

Mental Health History:
Please list prior Mental Health Treating Providers (Psychiatrists and Therapists) & Dates of Treatment:
Have you ever been psychiatrically hospitalized?  □ No  □ Yes  → Please provide: Dates, Reason for Admission, Length of Stay and Name of Hospital:

Have you ever tried to kill yourself?  □ No  □ Yes  → Please provide: Method Used with Dates and if Hospitalized, as well as date of the most recent attempt:

Medical History:
Please list the name and phone of your primary care provider:

Please list the name and phone of others providers you are seeing currently (naturopaths, acupuncturists, therapists, etc):

Why are you seeing these providers currently (i.e., the medical issues or symptoms)?

Please list the current medications and supplements you are taking (or provide list):

Please list any allergies you have (medication, environmental, food):

Please list all past surgeries:
Women only: ☐ I am pregnant or trying to become pregnant ☐ I have regular menstrual periods
☐ I am in perimenopause ☐ I am in menopause ☐ I have mood swings or anxiety with my menstrual period
Other concerns:

Self-Care: Please indicate the activities that help you relax/get centered:
☐ Yoga ☐ Meditation ☐ Massage therapy ☐ Acupuncture
☐ Social time with friends/family ☐ Essential oils
☐ Exercise indoors ☐ Exercise in nature (hike, surf, beach walk, bike)
☐ Talking with someone ☐ Reading
☐ Art/creative activities ☐ Listening to music
☐ Other: ________________________________

What do you do when you exercise (ex: walk, run, yoga, weights)?

How many days per week do you exercise? ☐ None ☐ 1-2 days ☐ 3-4 days ☐ 5+ days
Intensity: ☐ Light ☐ Moderate ☐ Intense (can’t talk/out of breath)
Average time: ☐ Under 15 mins ☐ 15-30 mins ☐ 30+ mins

Do you meditate? ☐ Yes ☐ No
If yes, how many days per week: ☐ 1-2 days ☐ 3-4 days ☐ 5+ days
Average time: ☐ Under 10 mins ☐ 11-20 mins ☐ 21-45 mins ☐ 46+ mins
Type: ☐ Insight/Vipassana ☐ Transcendental ☐ Visualizations ☐ Qi Gong ☐ Kundalini ☐ Other: ________

Please rate your average stress level:
☐ Minimal ☐ Moderate but manageable ☐ Moderate and getting worse ☐ Severe ☐ Barely Functioning

Please indicate what your typical diet is like most days:
☐ Mostly fruits & veggies ☐ Lean meats and fish ☐ Red meat ☐ Carbohydrates

Processed food intake: ☐ very little/limited: 1-2 times per week ☐ some: 3-5 times a week
☐ moderate: every day ☐ almost every meal

Sugar intake: ☐ rare/special occasions ☐ a little sugar each day
☐ moderate: sugar with several meals/snacks ☐ almost every meal

Fast food: ☐ rare/special occasions ☐ limited: once a week
c☐ moderate: 3-5 times per week ☐ almost every meal

Diet: ☐ Vegan ☐ Vegetarian ☐ Gluten-free ☐ Additional information:
Please rate your satisfaction with the following areas of life:

0 = very dissatisfied/unsupported, 5= moderately satisfied, 10 = very satisfied/supported

<table>
<thead>
<tr>
<th>Area of Life</th>
<th>Level of Satisfaction (0-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing/where you live</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
</tr>
<tr>
<td>Finances/money</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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<tr>
<td>Career/work/studies</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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<tr>
<td>Health/Medical Issues</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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<tr>
<td>Fitness Level</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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<tr>
<td>Supportive family and friends</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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<tr>
<td>Feeling loved (romantic relationships)</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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<tr>
<td>Personal growth/interests</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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<tr>
<td>Fun/recreation</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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<tr>
<td>Spirituality</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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<td>Self-image</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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<tr>
<td>Community/contributing to others</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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<tr>
<td>Healthy Eating/Nutrition</td>
<td>□ 0 □ 1-2 □ 3-4 □ 5-6 □ 7-8 □ 9-10</td>
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</tbody>
</table>

Do you drink caffeine?  □ Yes □ No
   If yes, what do you drink?  □ Coffee □ Tea □ Soda □ Energy drinks □ Other: __________________________
   How many cups/drinks per day?  □ 1-2 □ 3-4 □ 5+ |

Do you drink alcohol?  □ Yes □ No
   If yes, what do you drink?  □ Beer □ Wine/Sake □ Liquor/Mixed drinks □ Other: __________________________
   How many days per week do you drink?  □ 1-2 □ 3-4 □ 5+ |
   How many drinks per day when you drink?  □ 1-2 □ 3-4 □ 5-8 □ 9+ |

Do you use tobacco/ smoke cigarettes?  □ Yes □ No
   If yes, what do you use?  □ Cigarettes □ Vape with Nicotine □ Cigars □ Chewing Tobacco □ Other: __________________________
   How many cigarettes (or equivalent) per day?  □ 1-5 □ 5-10 □ 10-15 □ 15-20 □ Other: _________

Do you use marijuana?  □ Yes □ No
   If yes, what is the primary reason?  □ Sleep □ Anxiety □ Pain □ Other: __________________________
   How many days per week do you use it?  □ 1-2 □ 3-4 □ 5+ |
   When do you use it?  □ Only at night □ Only in the day □ All day □ Sporadically
   □ Other: __________________________

Do you use any of the following drugs? (Check if currently using)
□ Methamphetamine/Ice □ Cocaine/crack □ Opiates/heroin □ Ecstasy/MDMA □ Inhalants
□ LSD/hallucinogens □ Kratom □ Spice □ Other: __________________________
**Substance Use Treatment History:**
Have you ever been treated for a substance use problem?  □ No  □ Yes → Please provide: Dates, Reason for Admission, Drugs Involved, Length of Stay and Name of Facility:

If drugs/alcohol have been an issue for you in the past, what are your drug(s) of choice?

What has your longest period of sobriety been?

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Do you currently attend AA/NA?  □ Yes  □ No
Do you have a sponsor?  □ Yes  □ No
Do you have a service commitment?  □ Yes  □ No
Do you sponsor others?  □ Yes  □ No

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**Social History:**
Where were you born and raised? __________________________________________________________

How far did you go in school? __________________________________________________________

Current job: __________________________________________________________________________

Marital Status: □ Single    □ Partner/Married    □ Divorced    □ Widowed

Children?
Names and ages: __________________________________________________________

Where do they live? __________________________________________________________

Siblings?
Names and ages: __________________________________________________________

Where do they live? __________________________________________________________

Who do you live with? __________________________________________________________________

Who can you rely on for emotional support? ______________________________________________

Do you have any pets? ___________________________________________________________________

Did you serve in the military?  □ No  □ Yes → Branch & Years of Service: ______________________

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Please share any other information that you would like me to be aware of here: