Rebecca Gladding, MD
Medical Director

233 S Market Street
Wailuku, HI 96793

95 E Lipoa Street #209
Kihei, HI 96753

T: 808-740-8425
F: 844-729-4773

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
☐Not enjoying things in life
☐Sleep (too little/too much)
☐Short-term memory problems

☐Long-term memory problems
☐Concentration/Focus problems
☐Low energy/tired/fatigue

☐Thoughts of death/suicide
☐Feeling guilty
☐Changes in appetite (eating too much/too little)

☐Worry about several things
☐Can't relax/always tense
☐Restless/on edge
☐Irritability

☐Anxiety in public
☐Anxiety when giving a presentation
☐ Anxiety in social groups

☐Panic symptoms
☐Specific fear: _____

☐Traumatic events/neglect
☐Nightmares

☐Flashbacks of events
☐Feeling unsafe in crowds

☐Checking for safety
☐Easily startled

☐Restrictive eating
☐Excessive laxative use

☐Binge eating

☐Excessive exercise

☐Unusual experiences
☐Hearing voices

☐Seeing things not there
☐Special powers

☐Special messages from TV/radio/social media/ Internet/newspaper

☐Self-harm
☐Intense relationships
☐Intense anger
☐Chronic feelings of emptiness

☐Fear of abandonment
☐Impulsive behaviors
☐Recurrent suicide attempts or thoughts

☐Rapid changes in mood
☐Losing touch with reality

Period of 4 or more days in a row with:

☐Sleeping 1-2 hours a night
☐High energy
☐Lots of great ideas

☐Elevated/euphoric mood
☐Irritable/depressed
☐Talking more than normal

☐Rapid thoughts
☐Unusually high confidence
☐Decisions you later regret

☐Impulsive behaviors
☐Impulsive behaviors
☐Blurts out information/interrupts people
☐Often loses things (keys, wallet, school work)
☐Late or misses appointments
☐Very distracted
☐Makes careless mistakes
☐Fidgets/restless
☐Constantly on the go/doesn't stop/always doing something
☐People say it feels like you are not listening
☐Difficulty organizing
☐Trouble concentrating
☐Avoid difficult tasks
☐Procrastinates

Physical symptoms:

☐Nausea/Vomiting
☐Headaches/Migraines
☐Rapid heart beat
☐Chest pains
☐Shortness of breath
☐Diarrhea/Constipation
☐Changes in vision/tunnel vision/blurry vision
☐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
☐Heart condition
☐Kidney disease
☐Asthma
☐Liver disease
☐Chronic pain
☐Sleep Apnea
☐Fibromyalgia
☐Seizures
☐High blood pressure
☐High cholesterol
☐Pancreatitis
☐Acid reflux/GERD
☐Glaucoma
☐Irritable bowel syndrome
☐Migraines
☐Tension headaches
☐Cancer
☐Hypo/Hyper Thyroid
☐Iron deficiency
☐Celiac/gluten sensitivity
☐Head injury
☐Other:
_____
_____

<u>Mental Health:</u>

☐Bipolar disorder
☐Depression
☐PTSD
☐Anxiety
☐Panic attacks/disorder
☐Obsessive-compulsive disorder
☐Social anxiety
☐Specific phobia:
_____
☐Adjustment disorder
☐Personality disorder
☐ADHD
☐Dementia
☐Delirium
☐Alcohol use disorder
☐Drug use disorder
☐Tobacco use disorder
☐Anorexia or bulimia
☐Psychosis
☐Conversion disorder
☐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
☐Zoloft/sertraline
☐Celexa/citalopram
☐Lexapro/escitalopram
☐Luvox/fluvoxamine
☐Paxil/paroxetine

☐Effexor/venlafaxine
☐Pristiq/desvenlafaxine
☐Cymbalta/Duloxetine
☐Fetzima/Levomilnacipran
☐Savella/milnacipran
☐Viibryd/Vilazodone
☐Wellbutrin/bupropion
☐Remeron/mirtazapine
☐Brintillex/vortioxetine
☐Serzone/Nefazodone

☐Desyrel/Trazodone
☐Neurontin/Gabapentin
☐Elavil/Amitriptyline
☐Pamelor/nortriptyline

☐Anafranil/clomipramine
☐Tofranil/imipramine
☐Norpramin/desipramine
☐Sinequan/doxepin

☐Nardil/phenelzine
☐Emsam/selegeline
☐Parnate (tranylcypromine)

☐Ativan/lorazepam
☐Xanax/alprazolam

☐Valium/diazepam
☐Halcion/triazolam

☐Librium/chlordiazepoxide
☐Restoril/temazepam

☐Ambien/zolpidem
☐Rozerem/ramelteon
☐Belsomra/suvorexant
☐Benadryl/diphenhydramine

☐Sonata/zaleplon
☐Costco Sleep Aid/Unisom/ doxylamine

☐Lunesta/eszopiclone
☐Unisom/other OTC sleep aid:
_____
_____

☐Lithium (Eskalith/Lithobid)
☐Depakote/divalproic acid

☐Lamictal/lamotrigine
☐Tegretol/carbamazepine

☐Trileptal/oxcarbazepine
☐Keppra/levetiracetam

☐Abilify/aripiprazole
☐Geodon/ziprasidone
☐Zyprexa/olanzapine

☐Latuda/lurasidone
☐Seroquel/quetiapine
☐Risperdal/risperidone

☐Haldol/haloperidol
☐Fazaclo/clozapine
☐Invega/paliperidone

☐Adderall/amphetamine salts
☐ Concerta/Ritalin/Focalin/ Daytrana/Metadate/ methylphenidate

☐Dexedrine/ dextroamphetamine
☐Vyvanse/Lisdexamfetamine
☐Intuniv/guanfacine

☐Strattera/atomoxetine
☐Clonidine

Please indicate which supplements/nutraceuticals you have tried:

☐Methylfolate (Deplin/EnLyte)
☐l-theanine orTheanine 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:
_____
_____
_____
_____
_____
_____

<u>Mental Health History:</u>
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:

<u>Self-Care:</u> 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
☐ moderate: 3-5 times per week ☐ almost every meal

Diet: ☐ Vegan ☐ Vegetarian ☐ Gluten-free ☐ Additional information:

Please rate your <u>satisfaction</u> with the following areas of life:

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

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

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 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?

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

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: _____

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