Grayson & Associates

Dr. Hope Intake Form

Name:_____ Date:_____

Phones: (Home) _____ (Cell) _____ (Work) _____

If you feel uncomfortable answering any of the questions, please skip.

Current Symptoms:

What problems bring you here today?

_____

_____

Please list any recent stressors (examples include work, recent loss, financial difficulties, relationships).

_____

_____

Are you **currently** having any of the following problems (please circle)?

Depression	Intense fear of abandonment	SLEEP:
Poor energy	Feelings of numbness	Going days without needing sleep
Poor self-esteem	Worrying excessively	Problems going to sleep
Change in appetite	Tense muscles	Difficulty falling to sleep
Fatigue	So anxious you cannot rest	Difficulty staying asleep
Poor focus	Panic attacks	Waking frequently though the night
Thoughts of suicide	Nightmares	Daytime napping
Thoughts of harming someone	Flashbacks to traumatic events	Excessive daytime sleepiness
Periods of unusually good mood	Feeling awkward in public	Falling asleep at work/school
Very high energy for no reason	Thoughts that replay	Snoring
Racing thoughts	Repetitive behaviors	Waking up feeling out of breath
Talking too fast	Obsessive thinking	Waking with headache
Acting impulsively	Phobias or fears	Wearing a CPAP/BIPAP
Unstable relationships	Inattentiveness at work/school	Needing a sleep study
Distorted self-image	Fidgety	
Irritability	Hearing voices	
Inappropriate anger	Seeing things others do not	
Extreme emotions	Memory problems	

Past Psychiatric Care

Have you ever been diagnosed with a mental health condition by a medical provider (examples include depression, anxiety, bipolar disorder, schizophrenia, PTSD)? If so, please list and include your age when symptoms started.

_____

_____

_____

Have you ever been seen by a psychiatrist or therapist/counselor? Please list and describe.

When?	By Whom?	For what problem?	What treatment?

Have you ever been hospitalized for psychiatric care? Please list and describe.

When?	Where?	For what problem?	What treatment?

Have you ever been treated with any of the following medications? Circle all that apply. Please note that medications in certain categories can treat symptoms of other illnesses.

SUBSTANCE USE TREATMENT:
Acamprosate, Campra
Baclofen, Lioresal
Buprenorphine, Subutex
Burenorphone/Naloxone, Suboxone
Disulfiram, Antabuse
Methadone
Naltrexone, Vivitrol
Bupropion, Zyban
Varenicline, Chantix

ADHD MEDICATIONS:
Adderall
Dexedrine
Vyvanse
Methylphenidate, Ritalin, Concerta
Focalin
Atomoxetine, Strattera
Clonidine
Guanfacine, Intuniv, Tenex

ANXIETY MEDICATIONS:
Alprazolam, Xanax
Chlordiazepoxide, Librium
Clonazepam, Klonopin
Diazepam, Valium
Lorazepam, Ativan
Oxazepam, Serax
Buspirone, Buspar
Hydroxyzine, Vistaril
Pregabalin, Lyrica

ANTIDEPRESSANTS:
Amitriptyline, Elavil
Amoxapine
Bupropion, Wellbutrin
Citalopram, Celexa
Clomipramine, Anafranil
Desipramine
Desvenlafaxine, Pristiq
Doxepin
Duloxetine, Cymbalta
Escitalopram, Lexapro
Fluoxetine, Prozac
Fluvoxamine, Luvox
Imipramine
Mirtazapine, Remeron
Nortriptyline
Paroxetine, Paxil
Phenelzine, Nardil
Sertraline, Zoloft
Venlafaxine, Effexor
Vilazodone, Viibryd
Vortioxetine, Brintellix

MOOD STABILIZERS:
Carbamazepine
Gabapentin, Neurontin
Lamotrigine, Lamictal
Lithium
Oxcarbazepine, Trileptal
Topiramate, Topamax
Valproate, Valproic Acid, Depakote

ANTIPSYCHOTICS:
Aripiprazole, Abilify
Asenapine, Saphris
Chlorpromazine, Thorazine
Clozapine, Clozaril
Fluphenazine, Prolixin
Haloperidol, Haldol
Iloperidone, Fanapt
Latuda
Olanzapine, Zyprexa
Paliperidone, Invega
Perphenazine, Trilafon
Pimozide, Orap
Quetiapine, Seroquel
Risperidone, Risperdal
Rexulti
Thioridazine
Thiothixene, Navane
Trifluoperazine, Stelazine
Vraylar
Ziprasidone, Geodon

SLEEP MEDICATIONS:
Belsomra
Cyproheptadine, Periactin
Eszopiclone, Lunesta
Melatonin
Ramelteon
Temazepam, Restoril
Trazodone
Triazolam, Halcion
Zaleplon, Sonata
Zolpidem, Ambien

Medical History:

Primary Care Doctor: _____ phone: _____

What medical illnesses do you have?

_____

_____

_____

What surgeries have you had?

_____

_____

_____

Do you have a history of head trauma? If so, please explain.

_____

Allergies: _____

For women:

Last menstrual period? _____ Usually regular? YES / NO

Do you use birth control? YES / NO If yes, please list: _____

Have you been pregnant before? YES / NO If yes, how many times: _____

Elective abortions? YES / NO

Have you ever had depression or changes in your thoughts during/after pregnancies? YES / NO

Have you recently had any of the following symptoms (please circle):

Fevers	Chest Pain	Acid Reflux	Decreased sex drive
Chills	Shortness of Breath	Joint Pains	Problems reaching orgasm
Unexpected weight change	Heart Palpitations	Muscle pains/tension	Infertility
Weakness	Cough	Pain or difficulty urinating	Easy bruising or bleeding
Numbness	Sore throat	Dental problems	Rashes
Episodes of passing out	Nausea/Vomiting	Changes in vision	
Problems walking	Diarrhea	Changes in hearing	
Headache	Constipation	Hot/cold flashes	

Have you ever used the following substances?

Tobacco	Opiates	Cocaine	Other _____
Alcohol	(heroin, pain killers, etc)	PCP or LSD	_____
Marijuana	Tranquilizers	Mushrooms	_____
K2/"spice"	(xanax, ativan, klonopin, etc)	Anabolic steroids	_____

Have you ever been to rehab for substance use? If so, please explain.

_____

_____

_____

Family History:

Please list all blood relatives who have been diagnosed with the following conditions.

Alcoholism _____
Anxiety Disorders_____
Bipolar Disorders_____
Cancer_____
Depression_____
Diabetes_____
Drug Abuse_____
Heart disease, high blood pressure, arrhythmias_____
Osteoporosis_____
Schizophrenia or psychotic disorder_____
Seizures_____
Strokes_____
Suicides_____
Thyroid Disease_____

Social History

Where do you live? _____
Who lives with you?_____
Where did you grow up?_____

How far did you go in school?_____

What is your current job/occupation?_____
What jobs have you had in the past?

_____
_____

Are you currently disabled? _____ What reason? _____
Are you married? YES / NO If so, how long? _____
Do you have any kids? YES / NO If so, what are their ages? _____
Do you have access to a gun or firearm? _____

Please list your current medications with doses and times you take them. If you have a list, please notify the front desk staff so they can make a photocopy for our records.

_____
_____
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