NEW YORK MEDICAL BEHAVIORAL HEALTH, PC

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Please note that your appointment may be delayed for 30 to 45 minutes despite our best efforts to stay on time

On the day of scheduled visit, please come 15 to 30 minutes early. You may have paperwork to fill out. Your cooperation is greatly appreciated.

Section I: General Information Date_____

Name: _____ DOB: _____ SEX: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Others

Referred by: ☐ Self ☐ PCP ☐ Therapist ☐ Counselor ☐ Other

Specify the Name of the Referring Person: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Spouse/Responsible Person: _____ Phone: _____ Cell: _____

Do you have children? ☐ Y ☐ N How Many: _____ Ages: _____

Who is living in your home and what is their relationship to you? _____

Section II CURRENT SYMPTOMS

Describe your current symptoms in your own words:

Please check that applies:

Sadness	☐ YES ☐ NO	Lack of Sleep	☐ YES ☐ NO	Anger	☐ YES ☐ NO	Panic	☐ YES ☐ NO
Fatigue	☐ YES ☐ NO	Low Energy	☐ YES ☐ NO	High Energy	☐ YES ☐ NO	Worry	☐ YES ☐ NO
Tearfulness	☐ YES ☐ NO	Slowed Thinking	☐ YES ☐ NO	Fast Thinking	☐ YES ☐ NO	Social Withdrawal	☐ YES ☐ NO
Lack of Interest	☐ YES ☐ NO	Impulsivity	☐ YES ☐ NO	Paranoia	☐ YES ☐ NO	More than usual Sleep	☐ YES ☐ NO
High Motivation	☐ YES ☐ NO	Forgetfulness	☐ YES ☐ NO	Low Motivation	☐ YES ☐ NO	Helpless	☐ YES ☐ NO
Poor Organization	☐ YES ☐ NO	Short-temper	☐ YES ☐ NO	Hopeless	☐ YES ☐ NO	Lack of Focus	☐ YES ☐ NO

High Appetite	☐ YES ☐ NO	Low Appetite	☐ YES ☐ NO	Weight Gain	☐ YES ☐ NO	Joint Pains	☐ YES ☐ NO
Increased Urgency	☐ YES ☐ NO	Homicidal Ideations/Plan	☐ YES ☐ NO	Weight Loss	☐ YES ☐ NO	Muscle Aches	☐ YES ☐ NO
Seasonal Mood Changes	☐ YES ☐ NO	Seasonal Energy Change	☐ YES ☐ NO	Obsessions /Compulsions	☐ YES ☐ NO	Hallucinations	☐ YES ☐ NO
Poor Concentration	☐ YES ☐ NO	Fears of having illness	☐ YES ☐ NO	Suicidal Ideations/Plan	☐ YES ☐ NO	Headaches	☐ YES ☐ NO
Urinary Symptoms	☐ YES ☐ NO	Stomach Symptoms	☐ YES ☐ NO	Other physical Symptoms	☐ YES ☐ NO	Explain Other:	

Section III PAST HISTORY OF PSYCHIATRIC TREATMENTS

Have you been treated with medications for sleep, anxiety, nerves, depression etc?	☐ YES ☐ NO

If yes, list starting with the most current:

MEDICATION NAME	DOSAGE	TIME PERIOD	BENEFITS	SIDE EFFECTS & REASONS FOR DISCONTINUATION

Have you ever had mental health counseling/ psychotherapy?	☐ YES ☐ NO

If yes, List:

NAME OF THERAPIST	TYPE OF THERAPY	TIME PERIOD/ # OF SESSIONS	ANY COMMENTS/ DESCRIBE EXPERIENCE

Electroconvulsive Treatment (ECT)

Have you ever had Electroconvulsive Treatment (ECT)?	☐ YES ☐ NO

If yes, when, where, inpatient/outpatient and time period

What was your response to the treatment?	☐ EXCELLENT	☐ GOOD	☐ FAIR	☐ POOR
Describe your experience with ECT:				

Transcranial Magnetic Stimulation Therapy (TMS)

Have you ever had Transcranial Magnetic Stimulation Therapy (TMS)?	☐ YES ☐ NO			
If yes, when, where and time period				
What was your response to the treatment?	☐ EXCELLENT	☐ GOOD	☐ FAIR	☐ POOR
Describe your experience:				

Section IV CURRENT MENTAL HEALTH RELATED QUESTIONS

Are you currently seeing a mental health counselor or therapist?		☐ YES ☐ NO
If Yes, Name:	Phone:	Fax:
Address:		
Do you wish to continue counseling with your current counselor/therapist?		☐ YES ☐ NO
If Yes, let the doctor know. If no, would you like to receive both medication and counseling?		☐ YES ☐ NO

Section V FAMILY MENTAL HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS, CHEMICAL ABUSE, OR MENTAL HEALTH HISTORY
FATHER		
MOTHER		
SIBLINGS	☐ M ☐ F	
	☐ M ☐ F	
CHILDREN	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
GRANDFATHER (MATERNAL)		

GRANDMOTHER (MATERNAL)		
GRANDFATHER (PATERNAL)		
GRANDMOTHER (PATERNAL)		

Section VI Personal Health History

List all Physical Health Illnesses since Birth	List all Mental Health Illnesses since Birth

Hospitalizations since birth (Surgery/Medical)

Year	Reason	Hospital

Hospitalizations since birth (Mental)

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as Vitamins and Inhalers		
Name the Drug(PRESCRIBED)	**Strength**	**Frequency Taken**
Over the counter Drugs / Vitamins	**Strength**	**Frequency Taken**

Allergies to Medications

Name of the medication	Reaction You Had

Section VII SPECIFIC HEALTH QUESTIONS

Check if you have, or have had any of the following:		
☐ Seizure	☐ Brain Surgery	☐ Aneurism Surgery
☐ Epilepsy	☐ Heart Surgery	☐ Dental
☐ Head Trauma	☐ Pace Maker Placement	☐ Gunshot/metal piece in the body
Describe:		

Check if you have had metal work done in any of the following:				
☐ Mouth	☐ Face	☐ Chest	☐ Head	☐ Neck
Please list and give details of any non-removable metallic objects in or around your head and/or neck:				

Section VIII HEALTH HABITS AND PERSONAL SAFETY

CAFFINE	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# Of cups/cans per day?			

ALCOHOL	Do you drink alcohol?	☐ YES	☐ NO
	Have you ever felt you should *cut* down on your drinking?	☐ YES	☐ NO
	Have people *annoyed* you by criticizing your drinking?	☐ YES	☐ NO
	Have you ever felt bad or *guilty* about your drinking?	☐ YES	☐ NO
	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (*eye*-opener)?	☐ YES	☐ NO
	Do you drive after drinking?	☐ YES	☐ NO

TOBACCO	Do you use tobacco?		☐ YES	☐ NO
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years		☐ Or year quit	

DRUGS	Do you currently use recreational or street drugs?	☐ YES	☐ NO
	Have you ever used recreational or street drugs?	☐ YES	☐ NO
	Have you ever given yourself any recreational or street drugs with a needle?	☐ YES	☐ NO
	Have you ever felt you should *cut* down on your drug use?	☐ YES	☐ NO
	Have people *annoyed* you by criticizing your drug use?	☐ YES	☐ NO

	Have you ever felt bad or *guilty* about using drugs?	☐ YES	☐ NO
	Have you ever used drugs first thing in the morning to steady your nerves or get rid of a hangover (*eye*-opener)?	☐ YES	☐ NO
	Do you drive after using drugs?	☐ YES	☐ NO

CHEMICAL USE	Do you have a problem with chemical use?	☐ YES	☐ NO
	If yes, are you in treatment?	☐ YES	☐ NO
	If not in treatment, do you wish to pursue treatment?	☐ YES	☐ NO

SEX	Are you trying for a pregnancy?	☐ YES	☐ NO
	Are you taking any female hormones irrespective of reasons?	☐ YES	☐ NO
	Are you using any birth control measures?	☐ YES	☐ NO
	Do you have sex related issues / concerns or med side effects?	☐ YES	☐ NO

Section IX EDUCATION / WORK HISTORY

Work History	Current Employer	Date of Employment from _____ to _____
Education History		

Section X DISABILITY HISTORY

Are you currently disabled to work?	☐Yes ☐No ☐Maybe	
If you are disabled	☐ officially ☐ unofficially	
IF Yes, then answer the following question on the type of disability		
Social Security: ☐Yes ☐No Comment:	Social Service: ☐Yes ☐No Comment:	No Fault: ☐Yes ☐No Comment:
Worker's Compensation: ☐Yes ☐No	Comments:	
Have you been disabled in the past: ☐Yes ☐No		

Any Specific issues you would like to discuss with doctor?

_____

_____

NAME OF THE PATIENT SIGNATURE OF THE PATIENT/GUARDIAN_____