TANNER CLINIC

Welcome and thank you for choosing Tanner Clinic Psychiatry!

Dear Patient,

The information you provide here will help your provider in identifying your needs and how to best serve your family.

If you have not completed the psychiatry packet before your appointment, please plan on arriving **30 minutes early** to complete the paperwork.

If you cannot keep this appointment please call and cancel as soon as possible. If you fail to do so, you may not be allowed to reschedule your appointment. We do have a **10 minute late** policy which will require rescheduling your appointment; along with a no-show policy with a charge of $250.

Please complete the attached assessment forms prior to your appointment.

Please bring your completed paperwork, updated insurance information and any current medications in their original bottle to your appointment.

Our office is located in the main Tanner Clinic building at 2121 N 1700 W; on the basement floor in the west wing. If you have any questions or need to reschedule, please call (801) 773-4840 Ext 3183.

Thank you for choosing Tanner Clinic for your family's healthcare needs and we look forward to serving you!

PATIENT: PLEASE COMPLETE AND BRING THIS FORM TO CLINIC

Outpatient Clinic Intake Form

Date_____

Name_____ Age_____
Address_____
Home phone_____ Work phone_____ Cell phone_____

What issue(s) bring(s) you to the Psychiatry Clinic?

_____
_____
_____
_____

What has been stressing you of late (e.g. Family, job, recent loss of loved ones, financial issues)?

_____
_____
_____
_____

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

Depression Loss of interest in activities Feeling hopeless, worthless Poor energy Poor self-esteem Change in appetite Increased or decreased Fatigue Poor focus Problems going to sleep Thoughts of not being alive Periods of euphoria or unusually good mood Having very high energy for no reason Going days without needing to sleep Thoughts racing Talking too fast Acting impulsively (spending, speeding)	Worrying excessively Having tense muscles So anxious you feel you cannot rest Having panic attacks Traumatic events that come back in nightmares, flashbacks Feeling awkward in public Thoughts that replay Repetitive or compulsive behaviors Phobias or fears Grunts, tics, or jerks Inattentiveness at work or school? If so, since what age Hyperactive or fidgety	Hearing voices Seeing things Feelings people were trying to watch or harm you Concerns about alcohol use Drug use Concerns about eating too much Eating too little Memory problems Getting lost easily Forgetting how to do tasks Problems finding words Problems caring for yourself (cooking, dressing)

Past Psychiatric Care

Have you been ever diagnosed with a mental health condition by a medical provider (e.g. Depression, bipolar, schizophrenia, ADHD)? If so, please list.

_____

_____

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

Date(s) seen? By whom?	For what problem?	What treatment (meds, ECT, therapy)?

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

Date(s)	Where and for what?	What treatment (meds, ECT, therapy)?

Have you ever been treated with any of the following medications? Circle all that apply and list any good or bad effects of the medications.

Med	Good/bad effects	Med	Good/bad effects	Med	Good/bad effects
Abilify		Haldol		Ritalin	
Ambien		Klonopin		Saphris	
Adderall		Invega		Serax	
Anafranil		Lamictal		Seroquel	
Antabuse		Latuda		Serzone	
Ascendin		Lexapro		Soma	
Atarax		Librium		Sonata	
Ativan		Lithium		Stelazine	
Buspar		Lunesta		Strattera	

Campral		Luvox		Suboxone/ subutex	
Celexa		Marplan		Symmetrel	
Chloral hydrate		Mellaril		Tegretol	
Clonidine		Methadone		Thorazine	
Clozaril		Miltown		Tofranil	
Cogentin		Nardil		Topomax	
Concerta		Norpramine		Traxene	
Cymbalta		Orap		Trazodone	
Dalmane		Pamelor		Trileptal	
Depakote		Parnate		Valium	
Dexedrine		Paxil		Vibryd	
Doral		Prosom		Vistraril	
Effexor		Pristiq		Vivitrol	
Elavil		Prolixin		Wellbutrin	
Fanapt		Remeron		Xanax	
Geodon		Restoril		Zoloft	
Halcion		Risperdal		Zyprexa	

Any other psychiatric medications you have taken?

_____

Past Medical Care

Do you have a primary care doctor? Name_____ Last Seen?_____

What medical illnesses do you have?

_____

_____

_____

What surgeries have you had?

_____

_____

_____

Please list all medications you are currenly taking, including over-the-counter medications, herbals, and supplements.

Medication	Dosage	# times per day	For what condition	Who prescribes it

Describe any allergies you have (e.g. to medications, foods).

_____

_____

Are you currently having or have you recently had any of these physical symptoms?

Fevers	Headache	Constipation	Hot/cold flashes
Chills	Chest pain	Acid reflux	Decreased sex drive
Night sweats	Shortness of breath	Joint pains	Problems reaching orgasm
Unexplained weight loss/gain	Heart palpitations	Muscle pains or tension	Easy bruising or bleeding
Weakness in arms/legs	Cough	Pain or difficulty urinating	Rashes
Numbness in arms/legs	Sore throat	Dental problems	
Episodes of passing out	Nausea or vomiting	Changes in vision	
Problems walking	Diarrhea	Changes in hearing	

For women-
Last menstrual period? _____ Usually regular? Yes/no
Do you use any birth control? Yes/no If yes, please list. _____
Have you been pregnant before? Yes/no If yes, how many times? _____
Miscarriages? Yes/no
Elective abortions? Yes/no
Any depression or unreal thoughts around pregnancies? Yes/no

Substance Use History

How often have you used the following substances?

	Last time used?	Approximately how often (# of times per week, month or year)?	How much do you use in a sitting if/when you do use?
Tobacco			
Alcohol			
Marijuana or K2/"spice"			
Cocaine			
Opiates (e.g. Heroin, morphine, Percocet,			

oxycodone, Tylenol #3, Dilaudid/hydromorphone)			
Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)			
PCP or LSD			
Mushrooms			
Others			

FAMILY HISTORY: Have you or any family members been treated for any of the following? Check all that apply.

ILLNESS	SELF	MOTHER	FATHER	AUNT	UNCLE	SISTER	BROTHER	CHILDREN	OTHER
ADHD/ADD									
ALZHEIMER'S									
ANXIETY									
BIPOLAR									
DEPRESSION									
HEART DISEASE									
SCHIZOPHRENIA									
SEIZURES									
STROKE									
SUBSTANCE ABUSE									
SUICIDE ATTEMPTS									

Social History

Where do you live? _____
Who lives with you? _____

How far did you go in school/highest level of education? _____

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

_____
_____

Are you married? Yes/no If so, for how long? _____

Have you been married in the past? Yes/no # of times? _____
Do you have children? Yes/no If so, how many, what are their ages?_____

What do you do in your free time to relax?

_____

Do you have any religious beliefs? Yes/ No
How important are your religious/spiritual beliefs to your life?_____

Have you had any legal issues (arrests, charges, time in jail)? If so, please describe.

_____
_____
_____

Have you ever been the victim of a violent crime? Yes/No
Have you ever been a victim of physical abuse? Emotional? Sexual abuse or rape? If so, please explain.

_____
_____
_____
_____

Safety

Do currently have thoughts of hurting yourself? Yes/no Please explain.

_____

Have you tried to hurt yourself in the past? If so, please explain.

_____
_____
_____

Do you currently have thoughts of hurting anyone else? Yes/no Please explain.

_____

Have you tried to hurt anyone in the past? If so, please explain.

_____
_____
_____

Do you own any guns or knives? _____

CHECKLIST: Review of Systems

Patient Name: _____ Date of visit: _____

CONSTITUTIONAL:
Yes No
☐ ☐ Weight Loss
☐ ☐ Fatigue
☐ ☐ Fever

EYES:
Yes No
☐ ☐ Glasses/Contacts
☐ ☐ Eye Pain
☐ ☐ Double Vision
☐ ☐ Cataracts

EAR,NOSE,THROAT:
Yes No
☐ ☐ Difficulty Hearing
☐ ☐ Ringing in Ears
☐ ☐ Vertigo
☐ ☐ Sinus Trouble
☐ ☐ Nasal Stuffiness
☐ ☐ Frequent Sore Throat

CARDIOVASCULAR:
Yes No
☐ ☐ Murmur
☐ ☐ Chest Pain
☐ ☐ Palpitations
☐ ☐ Dizziness
☐ ☐ Fainting Spells
☐ ☐ Shortness of Breath
☐ ☐ Difficulty lying Flat
☐ ☐ Swelling Ankles

ENDOCRINE:
Yes No
☐ ☐ Loss of Hair
☐ ☐ Heat/Cold Intolerance

RESPIRATORY:
Yes No
☐ ☐ Cough Easy
☐ ☐ Coughing Blood
☐ ☐ Wheezing
☐ ☐ Chills

GASTROINTESTINAL:
Yes No
☐ ☐ Heartburn/Reflux
☐ ☐ Nausea/Vomiting
☐ ☐ Constipation
☐ ☐ Change in BMs
☐ ☐ Diarrhea
☐ ☐ Jaundice
☐ ☐ Abdominal Pain
☐ ☐ Black or Bloody BM

GENITOURINARY:
Yes No
☐ ☐ Burning/Frequency
☐ ☐ Nighttime
☐ ☐ Blood in Urine
☐ ☐ Erectile Dysfunction
☐ ☐ Abnormal Discharge
☐ ☐ Bladder Leakage

ALLERGIC/IMMUNOLOGIC:
Yes No
☐ ☐ Hives/Eczema
☐ ☐ Hay Fever

PSYCHIATRIC:
Yes No
☐ ☐ Anxiety/Depression
☐ ☐ Mood Swings
☐ ☐ Difficult Sleeping

HEMATOLOGY/LYMPH:
Yes No
☐ ☐ Easy Bruising
☐ ☐ Gums Bleed Easily
☐ ☐ Enlarged Glands

MUSCULOSKELETAL:
Yes No
☐ ☐ Joint Pain/Swelling
☐ ☐ Stiffness
☐ ☐ Muscle Pain
☐ ☐ Back Pain

SKIN:
Yes No
☐ ☐ Rash/Sores
☐ ☐ Lesions
☐ ☐ Itching/Burning

NEUROLOGICAL:
Yes No
☐ ☐ Loss of Strength
☐ ☐ Numbness
☐ ☐ Headaches
☐ ☐ Tremors
☐ ☐ Memory Loss

FEMALES ONLY:
Date Last Mammogram_____
Normal_____Abnormal_____
Date last PAP_____
Normal_____Abnormal_____
Age Onset Periods_____
Age Onset Menopause_____
Periods Regular?
Yes_____No____
Number
Pregnancies_____