## 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 main floor in the east 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 servingyou!

PATIENT: PLEASE COMPLETE AND BRING THIS FORM TO CLINIC

# *History and Presenting Problem*

**Name:** ______________________________ **DOB:** _________________ **Gender:**_______________ **Today's Date:**_________________
*Last, First Middle*

**For what reason(s) are you seeking services from our office?**

**What is the duration of these symptoms?** ***(How long? Has the intensity varied?)***

**Have you seen a counselor or psychologist before?** **YES** **NO** **If YES, please complete the questions below.**

| Name of Doctor/Therapists | Appointment Frequency | How long since last appt.? | Reason(s) you were being seen. | Outcome/Did it help? |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | Yes No |

## *DEVELOPMENT and EDUCATION*

When your mother was pregnant with you, were there any complications during the pregnancy or birth? YES NO
*If yes, please describe.*

**Do you have any history of any of the following conditions?** *(check all that apply)*

Head Injury High Fever Chronic Medical Illness Prenatal exposure to toxins (drugs &/or alcohol)

*(Please give additional information related to the ones you checked.)*

**Please select the highest level of education you have completed:**

☐ Graduate Degree ☐ Bachelor's Degree ☐ Some college or technical school ☐ High School Graduate/GED ☐ Some high school

**How would you describe your educational experience?** (*check all that apply*)

Enjoyable/I love to learn Very stressful Didn't have any friends I was always bored

I struggled learning I learned best in "hands-on" classes I only enjoyed the social part of school

**Have you had any legal issues specifically related to your conduct or behavior?** *(past or present)* YES NO
*If yes, please explain:*

## *MEDICAL and PSYCHIATRIC*

**Primary Care Physician:** ______________________________ **Office Phone Number:** ______________

**Current health conditions:**

**Previous Medical or Psychiatric Diagnoses:**

***Select the words that best apply:***

**Handedness:** Right Left Ambidextrous

**Appetite:** Good Poor Fair Intense

**Weight:** Stable Loss Gain Binging Binging/Purging

**Thought Processing:** Racing Pressured Intrusive Obsessive Non-pressured

**Predominant Mood(s):** (Pick all that apply) Anxious Depressed Happy Sad
Fearful Manic Just so-so Flat Other:

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**In the past six months, which of the following have you experienced?** *(Pick all that apply)*
Moderate Exercise Inability to have fun Pleasurable Activities Stable, enjoyable sex life
Diminished interest in activities Pre-occupation with pleasurable activities

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**SLEEP:** **Average Number of hours/night:** _______ **Quality of Sleep:** Restful Unrestful

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**Waking up while sleeping:** Frequent Infrequent Very Frequent
Insomnia Early Waking Mid-sleep disruption

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**Frequent experience of:** Nightmares Night terrors Recurrent dreams

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**How would you rate your sleep disturbance?** Minor Not an issue
Moderate Significant Serious

**Current Symptoms ---** Rate the items with which you are currently having problems. Select the number that best indicates the severityof the problem.

**0=None 1=Minor 2=Moderate 3=Significant 4=Serious**

| Symptom | Rating | Symptom | Rating | Symptom | Rating |
|---|---|---|---|---|---|
| Thoughts of Self-harm | | Anxiety-Worry | | Anxiety-Fear | |
| Anxiety-Panic | | Anxiety-Phobia | | Feelings of Depression | |
| Feelings of Sadness | | Thoughts of Death | | Thoughts of Suicide | |
| Mood Swings | | Grief over a major loss | | Grief over the death of a loved one | |
| Abuse-Emotional | | Abuse-Physical | | Abuse-Domestic | |
| Abuse-Ritual | | Sexual Abuse-Rape | | Sexual Abuse-Incest | |
| Feelings of Despair | | Memory-Forgetfulness | | Memory-Changes | |
| Marriage Problems | | Relationship problems with children | | Problems with Parents | |
| Problems with Family | | Problems with Work/School | | Legal problems | |
| Problems with Alcohol | | Problems with Drugs | | Problems with Smoking | |
| Problems with other substances | | Feelings of Hopelessness | | Feelings of Helplessness | |
| Sexual concerns | | Sexual problems | | | |

*MEDICATION REPORT*

## CURRENT MEDICATIONS

| Name | Total Daily Dosage | Start Date | End Date | Reason for taking | Response/Side Effects |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Current Supplements and/or Vitamins (including over the counter)

| Name | Total Daily Dosage | Start Date | End Date | Reason for taking | Response/Side Effects |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## PAST MEDICATIONS

It is very helpful to know of past medications taken and how they affected you.

*(If you don't remember exact information, please provide the best information you can.)*

Medication Type: SSRI's

| Name | Total Daily Dosage | Start Date | End Date | Effective? | Side Effect(s) |
|---|---|---|---|---|---|
| **Celexa (citalopram)** | | | | | |
| **Lexapro (escitalopram)** | | | | | |
| **Luvox (fluvoxamine)** | | | | | |
| **Paxil, Paxil CR, (paroxetine, paroxetine CR)** | | | | | |
| **Prozac (fluoxetine)** | | | | | |
| **Trintellix (vortioxetine)** | | | | | |
| **Viibryd (vilazodone)** | | | | | |
| **Zoloft (sertraline)** | | | | | |

Medication Type: SNRI's

| Name | Total Daily Dosage | Start Date | End Date | Effective? | Side Effect(s) |
|---|---|---|---|---|---|
| **Cymbalta (duloxetine)** | | | | | |
| **Effexor (incl. IR & XR) (venlafaxine)** | | | | | |
| **Pristiq (desvenlafaxine)** | | | | | |
| **Strattera (atomoxetine)** | | | | | |

Medication Type: Augmented

| Name | Total Daily Dosage | Start Date | End Date | Effective? | Side Effect(s) |
|---|---|---|---|---|---|
| **Abilify (aripiprazole)** | | | | | |
| **Depakote (divalproex)** | | | | | |
| **Geodon (ziprasidone)** | | | | | |
| **Invega (paliperidone)** | | | | | |
| **Neurontin (gabapentin)** | | | | | |
| **Risperdal (risperidone)** | | | | | |
| **Saphris (asenapine)** | | | | | |
| **Seroquel (quetiapine)** | | | | | |
| **Zyprexa (olanzapine)** | | | | | |

# *MEDICATION REPORT - Cont.*

Medication Type: Stimulants

| Name | Total Daily Dosage | Start Date | End Date | Effective? | Side Effect(s) |
|---|---|---|---|---|---|
| **Adderall (d/l amphetamine)** | | | | | |
| **Dexadrine (d-amphetamine)** | | | | | |
| **Intuniv/Tunix (guanfacine)** | | | | | |
| **Ritalin (methylphenidate)** | | | | | |

Medication Type:- TCA/Tetracyclic

| Name | Total Daily Dosage | Start Date | End Date | Effective? | Side Effect(s) |
|---|---|---|---|---|---|
| **Anafranil (clomipramine)** | | | | | |
| **Elavil, Endep (amitriptyline)** | | | | | |
| **Ludiomil (maprotilene)** | | | | | |
| **Merital (nomifensine)** | | | | | |
| **Norpramin, Pertofrane (desipramine)** | | | | | |
| **Pamelor, Aventyl (nortriptyline)** | | | | | |
| **Sinequan (doxepin)** | | | | | |
| **Surmontil (trimipramine)** | | | | | |
| **Tofranil (imipramine)** | | | | | |
| **Vivactil (protriptyline)** | | | | | |

Medication Type:- MAOI

| Name | Total Daily Dosage | Start Date | End Date | Effective? | Side Effect(s) |
|---|---|---|---|---|---|
| **Eldepryl (Selegine)** | | | | | |
| **Ensam (Selegine patch)** | | | | | |
| **Nardil (phenelzine)** | | | | | |
| **Marplan (isocarboxazid)** | | | | | |
| **Parnate (tranylcypromine)** | | | | | |

Medication Type:- Hormone Replacement

| Name | Total Daily Dosage | Start Date | End Date | Effective? | Side Effect(s) |
|---|---|---|---|---|---|
| **Estrogen Hormone** | | | | | |
| **Progesterone Hormone** | | | | | |
| **Testosterone Hormone** | | | | | |
| **Thyroid Hormone** | | | | | |

Medication Type:- Other

| Name | Total Daily Dosage | Start Date | End Date | Effective? | Side Effect(s) |
|---|---|---|---|---|---|
| **Ativan (lorazepam)** | | | | | |
| **Buspar (buspirone)** | | | | | |
| **Catapres (clonidine)** | | | | | |
| **Desyrel (trazodone)** | | | | | |
| **Lithium (Carbonate)** | | | | | |
| **Mellaril (thioridazie)** | | | | | |
| **Minipress (prazocin)** | | | | | |
| **Remeron (mirtazapine)** | | | | | |
| **Serzone (nefazodone)** | | | | | |
| **Valium (diazepam)** | | | | | |
| **Wellbutrin (buproprion)** | | | | | |
| **VNS** | | | | | |
| **Light Box** | | | | | |

## *FAMILY MEDICAL HISTORY*

**Did your parent(s) have a history of alcohol or drug abuse? Yes No** *If yes, please explain below.*

**Has anyone in your family been diagnosed with or treated for:**

| Condition | What relative(s)? | Condition | What relative(s)? |
|---|---|---|---|
| Anxiety | ______________________ | Depression | ______________________ |
| Anger | ______________________ | Schizophrenia | ______________________ |
| Bipolar Disorder | ______________________ | Post-traumatic Stress | ______________________ |

## *PERSONAL HISTORY*

**Do you have a history of Self-Harm?** Yes No *If yes, please explain:*

**Do you have a history of physical, sexual, or emotional abuse?** Yes No *If yes, please explain:*

**Do you have a history of alcohol and drug use?** Yes No *If yes, please explain:*

**Have you been hospitalized for psychiatric reasons?** Yes No *If yes, please explain:*

## *PERSONAL INTERESTS*

List hobbies and leisure interests

List individual strengths/positives

Who do you have for a personal support system?

**This form was completed by:**_____________________________________________________

*Relationship to patient:* Self Spouse Parent Sibling Other: