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 $125.

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 East Layton Tanner Clinic building at 1750 East 3100 North, Layton, UT 84040 - on the basement level. 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** **<u>If YES, please complete the questions below.</u>**

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

<u>DEVELOPMENT and EDUCATION</u>

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:

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

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

Waking up while sleeping:	☐ Frequent	☐ Infrequent	☐ Very Frequent
	☐ Insomnia	☐ Early Waking	☐ Mid-sleep disruption
Frequent experience of:	☐ Nightmares	☐ Night terrors	☐ Recurrent dreams
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

Thoughts of Self-harm	4	Anxiety-Worry	4	Anxiety-Fear	4
Anxiety-Panic	4	Anxiety-Phobia	4	Feelings of Depression	4
Feelings of Sadness	4	Thoughts of Death	4	Thoughts of Suicide	4
Mood Swings	4	Grief over a major loss	4	Grief over the death of a loved one	4
Abuse-Emotional	4	Abuse-Physical	4	Abuse-Domestic	4
Abuse-Ritual	4	Sexual Abuse-Rape	4	Sexual Abuse-Incest	4
Feelings of Despair	4	Memory-Forgetfulness	4	Memory-Changes	4
Marriage Problems	4	Relationship problems with children	4	Problems with Parents	4
Problems with Family	4	Problems with Work/School	4	Legal problems	4
Problems with Alcohol	4	Problems with Drugs	4	Problems with Smoking	4
Problems with other substances	4	Feelings of Hopelessness	4	Feelings of Helplessness	4
Sexual concerns	4	Sexual problems	4		

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)				Inconcl	
Lexapro (escitalopram)				Inconcl	
Luvox (fluvoxamine)				Inconcl	
Paxil, Paxil CR, (paroxetine, paroxetine CR)				Inconcl	
Prozac (fluoxetine)				Inconcl	
Trintellix (vortioxetine)				Inconcl	
Viibryd (vilazodone)				Inconcl	
Zoloft (sertraline)				Inconcl	

Medication Type: SNRI's

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

Medication Type: Augmented

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

MEDICATION REPORT - Cont.

Medication Type: Stimulants

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

Medication Type:- TCA/Tetracyclic

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

Medication Type:- MAOI

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

Medication Type:- Hormone Replacement

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

Medication Type:- Other

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

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: