**Sanford Health**
**Psychiatry Department**
**1705 Anne St. NW (door #4)**
**Bemidji, MN 56601**
**Phone: 218-333-4820**

In preparation for your upcoming new patient visit with our psychiatry/medication management provider, please complete the enclosed paperwork. Bring this with you to your scheduled visit.

*The day of your appointment:*

- Bring your completed paperwork.
- Enter door #4 of the clinic located at 1705 Anne St. NW in Bemidji, where you will find the Psychiatry Department registration desk.

If you have a change to your schedule and need to cancel or reschedule your appointment, we request you contact us at least 24 hours in advance. If you have any other questions prior to your appointment please do not hesitate to give us a call at 218-333-4820.

Thank you for trusting Sanford Health with your care.

SANFORD HEALTH

## Medication Management/ Psychiatry Intake Form

**Please complete all information on this form and bring it to the first visit.** It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date_____

Date of Birth_____ Primary Care Physician (PCP)_____

Do you give permission for ongoing regular updates to be provided to your PCP? ( ) Yes ( ) No

Current Therapist/Counselor_____ Therapist's Phone_____

What are the problem(s) for which you are seeking help?
1._____
2._____
3._____

What are your treatment goals?
_____
_____
_____

**Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)**

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increased risky behavior
( ) Increased libido
( ) Decreased need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

**Suicide Risk Assessment**
Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

**Past Medical History:**

Allergies_____ Current Weight_____ Current Height_____

***List ALL current prescription medications*** and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements: _____
_____
Current medical problems: _____
_____
Past medical problems, nonpsychiatric hospitalization, or surgeries: _____
_____
Have you ever had an EKG? ( ) Yes ( ) No; If yes, when_____.
Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

**For women only:** Date of last menstrual period_____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us?
( ) Yes ( ) No
Date and place of last physical exam: _____

**Personal and Family Medical History:**

| | You | Family | Which Family Member? |
|---|---|---|---|
| Thyroid Disease_____ | ( ) | ( ) | _____ |
| Anemia_____ | ( ) | ( ) | _____ |
| Liver Disease_____ | ( ) | ( ) | _____ |
| Chronic Fatigue_____ | ( ) | ( ) | _____ |
| Kidney Disease_____ | ( ) | ( ) | _____ |
| Diabetes_____ | ( ) | ( ) | _____ |
| Asthma/respiratory problems_____ | ( ) | ( ) | _____ |
| Stomach or intestinal problems_____ | ( ) | ( ) | _____ |
| Cancer (type)_____ | ( ) | ( ) | _____ |
| Fibromyalgia_____ | ( ) | ( ) | _____ |
| Heart Disease_____ | ( ) | ( ) | _____ |
| Epilepsy or seizures_____ | ( ) | ( ) | _____ |
| Chronic Pain_____ | ( ) | ( ) | _____ |
| High Cholesterol_____ | ( ) | ( ) | _____ |
| High blood pressure_____ | ( ) | ( ) | _____ |
| Head trauma_____ | ( ) | ( ) | _____ |
| Liver problems_____ | ( ) | ( ) | _____ |
| Other_____ | ( ) | ( ) | _____ |

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

**Past Psychiatric History:**

**Outpatient treatment** ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

_____

_____

_____

**Psychiatric Hospitalization** ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

_____

**Past Psychiatric Medications:** If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Dates Dosage Response/Side-Effects

**Antidepressants**

Prozac (fluoxetine) _____
Zoloft (sertraline) _____
Luvox (fluvoxamine) _____
Paxil (paroxetine) _____
Celexa (citalopram) _____
Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Remeron (mirtazapine) _____
Serzone (nefazodone) _____
Anafranil (clomipramine) _____
Pamelor (nortrptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Other _____

**Mood Stabilizers**

Tegretol (carbamazepine) _____
Lithium _____
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Topamax (topiramate) _____
Other _____

**Antipsychotics/Mood Stabilizers**

Seroquel (quetiapine) _____
Zyprexa (olanzapine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperidone) _____
Other _____

**Past Psychiatric medications (continued)**

Dates Dosage Response/Side-Effects

**Sedative/Hypnotics**

Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon) _____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other _____

**ADHD medications**

Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Other _____

**Antianxiety medications**

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____
Other _____

**Your Exercise Level:**

Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

**Family Psychiatric History:**

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

| | | | |
|---|---|---|---|
| Bipolar disorder | ( ) Yes ( ) No | Schizophrenia | ( ) Yes ( ) No |
| Depression | ( ) Yes ( ) No | Post-traumatic stress | ( ) Yes ( ) No |
| Anxiety | ( ) Yes ( ) No | Alcohol abuse | ( ) Yes ( ) No |
| Anger | ( ) Yes ( ) No | Other substance abuse | ( ) Yes ( ) No |
| Suicide | ( ) Yes ( ) No | Violence | ( ) Yes ( ) No |

If yes, who had each problem? _____
_____
Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment? _____
_____

**Substance Use:**
Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?_____ _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long?
_____
_____

**Check if you have ever tried the following:**

| | Yes | No | If yes, how long and when did you last use? |
|---|---|---|---|
| Methamphetamine | ( ) | ( ) | _____ |
| Cocaine | ( ) | ( ) | _____ |
| Stimulants (pills) | ( ) | ( ) | _____ |
| Heroin | ( ) | ( ) | _____ |
| LSD or Hallucinogens | ( ) | ( ) | _____ |
| | Yes | No | If yes, how long and when did you last use? |
| Marijuana | ( ) | ( ) | _____ |
| Pain killers (not as prescribed) | ( ) | ( ) | _____ |
| Methadone | ( ) | ( ) | _____ |
| Tranquilizer/sleeping pills | ( ) | ( ) | _____ |
| Alcohol | ( ) | ( ) | _____ |
| Ecstasy | ( ) | ( ) | _____ |
| Other | | | _____ |

**How many caffeinated beverages do you drink a day?** Coffee _____ Sodas _____ Tea _____

**Tobacco History:**
Have you ever smoked cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No How many packs per day on average? _____ How many years? _____In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____

**Pipe, cigars, or chewing tobacco:** Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No
What kind? _____ How often per day on average? _____ How many years? _____

**Family Background and Childhood History:**
Were you adopted? ( ) Yes ( ) No Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with? _____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when? _____

**Trauma History:**
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No
Please describe when, where and by whom? _____
_____

**Educational History:**
Highest Grade Completed? _____ Where? _____
Did you attend college? _____ Where? _____ Major? _____
What is your highest educational level or degree attained? _____

**Occupational History:**
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No Other type discharge _____

**Relationship History and Current Family:**
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed
How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long?_____
Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer
What is your spouse or significant other's occupation?_____
Describe your relationship with your spouse or significant other:_____
_____
Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____
How long? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____
_____
Describe your relationship with your children: _____
List everyone who currently lives with you: _____
_____

**Legal History:**
Have you ever been arrested? _____
Do you have any pending legal problems? _____

**Spiritual Life:**
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature_____ Date _____

Guardian Signature (if applicable)_____ Date _____

Emergency Contact _____Phone #_____

**For Office Use Only:**

Reviewed by _____ Date _____

Reviewed by _____ Date _____