Patient Information

Date:_____ Chart Number:_____

Name:_____ Social Security Number_____

Address: _____City_____ State _____Zip Code_____

Birthdate:_____ Age:_____ Gender: Female Male

Ethnicity: Caucasian African-American Hispanic Asian Other_____

Marital Status: Single _____Married _____Divorced _____Separated _____ Widow_____

How many children do you have? _____ How many living with you? _____

Telephone: Home ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Living Arrangements: (Who lives with you)

_____Alone _____ Spouse ____ Spouse & Children ____Friend ____ Other

Educational Level: _____Elementary ____ High School _____College _____Technical School

Place of Employment:_____ How Long? _____

Occupation or Position: _____

Spouse's/Next of Kin Name: _____

Spouse's Place of Employment: _____

Spouse's Occupation or Position: _____

Person to Notify in Case of an Emergency *(other than spouse)*

Name: _____ Relationship:_____

Address: _____

Telephone: ( ) _____ Work Phone: ( ) _____

How were you referred to Anil Parikh M.D. Inc.? _____

Insurance Information

Primary Insurance Carrier:_____

Policy #:_____ Group #:_____

Identification #:_____

Secondary Insurance Carrier:_____

Policy #:_____ Group #: _____

Identification #: _____

Medicare #:_____ Medicaid #_____

If you have an attorney for Workers' Compensation Claim please provide:

Attorney Name:_____ Telephone Number:_____

(Please provide a copy of your insurance card(s) to office personnel for copying)

For Office Use Only:

A. Dictated:_____ Typed:_____

	Name	Initials	Date
B. Records Request:	1._____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____

Reason For Evaluation

1. What is the reason for which you are seeking treatment at this time?

   _____

2. How long have you had this problem?

   _____

3. Whose idea was it to seek a psychiatric evaluation?

   _____

Review of Symptoms

1. Which of the following symptoms apply to your condition?

_____ Feeling blue, depressed, sad, or tearful	_____ Social Isolation
_____ Insomnia (inability to sleep)	_____ Feelings of guilt
_____ Hypersomnia (excessive sleep)	_____ Suicidal thoughts
_____ Poor appetite	_____ Irritability
_____ Increased appetite	_____ Decreased desire for sex
_____ Weight loss	_____ Increased desire for sex
_____ Weight gain	_____ Poor memory or concentration
_____ Crying spells	_____ Anxious or worried all the time
_____ Decreased energy	_____ Decreased motivation
_____ Increased energy	

2. Do you experience extreme mood swings? Yes No

   Do you have periods where you feel you can do anything? Yes No

   Do you have racing thoughts (unable to focus on one thought)? Yes No

   Do you feel rested after 3 or 4 hours of sleep? Yes No

   Do you often spend money on things you don't need or use? Yes No

   Do you feel that you have to keep doing something all the time? Yes No

   Do you feel that you have to do too many things at the same time? Yes No

3. A. Do you experience anxiety/nervousness Yes No

B. Do you ever get panic attacks? (Sudden onset of intense anxiety that lasts for minutes to hours) Yes No

C. Do you get any of the following symptoms of anxiety?

Please check any of the following symptoms that you may have. (symptoms may last minutes to hours)

____ Gastrointestinal (nausea, dry mouth, abdominal distress

____ Cardiovascular (palpitations, chest pain)

____ Respiratory (hyperventilation, smothering sensations)

____ Chills

____ Increased sweating

____ Trembling or shaking

____ Neurological (dizziness, unsteady feelings, faintness, tingling or numbness)

____ Fear of being in places or situations from which you want to escape

_____ Hot flashes

_____ Increased urination

_____ Decreased urination

_____ Fear of people

_____ Fear of Heights

_____ Fear of water

_____ Fear of "doing something crazy"

_____ Fear of animals

4. Do you hear voices that are not there? Yes No

Do you feel people are "out to get you? Yes No

Do you see things that are not there? Yes No

Do you feel people can read your mind? Yes No

Do you feel people can put thoughts into your mind or withdraw thoughts out of your mind? Yes No

5. Do you feel compelled to repeat activities that are not purposeful, such as handwashing, checking door locks, turning lights on and off, etc. Yes No

6. Are you excessively preoccupied about your weight, your food intake, or exercise? Yes No

Have you ever used laxatives, water pills, or diet pills to control your weight? Yes No

7. Have you had a traumatic experience in life, such as: loss of a loved one; war experience(s); accident(s); sexual or physical abuse? Yes No

8. Are you suffering pain from any work-related injury? Yes No

Please explain:_____

_____

Check any of the following from which you suffer:

1.____ headaches 2.____ backaches 3.____ Pain in extremities

4.____ Other Please specify:_____

On a scale of 1 to 10 (1 being a low amount of pain), please rate any pain that you are experiencing:

Pain Site 1 Headaches: (circle one) 1 2 3 4 5 6 7 8 9 10

What makes it better?: _____

What makes it worse?: _____

What have doctor's said about this pain?:

_____

What treatment or surgeries have you had for this pain?:

_____

Pain site 2 Backaches: (circle one) 1 2 3 4 5 6 7 8 9 10

What makes it better?: _____

What makes it worse?: _____

What have doctor's said about this pain?:

_____

What treatment or surgeries have you had for this pain?:_____

_____

10. Is you mood affected by your menstrual period (for women)? Yes No

Is your mood affected by seasons? (Winter, Spring, Summer, Fall) Yes No

11. Do you experience any of the following stresses:

a. Job related stress	Yes	No
b. Financial stress	Yes	No
c. Marital Stress	Yes	No
d. Relationship Stress	Yes	No
e. Stress from physical illness	Yes	No
f. Stress from mental illness	Yes	No
g. Stress from other source	Yes	No

Please specify_____

Drug/Alcohol Use History

1. Do you use tobacco products? Yes No

   Type_____ How frequently? _____ How much:_____

2. Do you drink alcoholic beverages? Yes No

   How frequently? _____ How Much ? _____

3. Do you now use drugs? Yes No

   How frequently?_____ How much?_____

4. Have you ever used intravenous (IV) drugs? Yes No

5. Did you ever feel you need to cut down your alcohol/tobacco/drug use? Yes No

   Did you ever feel annoyed by people's opinion regarding your alcohol/tobacco/drug use? Yes No

   Do you feel guilty about your drug/alcohol use? Yes No

   Do you ever drink alcohol first thing in the morning? Yes No

6. Do you have or have you had any legal problems related to your drug or alcohol use? Yes No

   If yes, please explain:_____

7. a. Have you ever had any legal problems? Yes No

   b. Do you have any legal problems pending? Yes No

Psychiatric Treatment History

1. Have you ever received counseling before? Yes No

   If yes, Name of Agency:_____

   Name of doctor/counselor:_____

   Dates of last treatment: From:_____ To:_____

2. Have you ever been admitted to a Psychiatric Hospital? Yes No

   If yes, please give details:

   Name of Hospital:_____

   Number of Hospital Admissions:_____

   1st Hospitalization (year):_____

   Last Hospitalization (year):_____

3. NOTES:

Family Psychiatric History

Please check if any of the listed family members received or needed treatment for a mental health disorder or any drug/alcohol abuse?

	Type of Treatment	When
____ Father	_____	_____
____ Mother	_____	_____
____ Sister	_____	_____
____ Brother	_____	_____
____ Grandfather	_____	_____
____ Grandmother	_____	_____
____ Other	_____	_____

Past Medical History

Who is your Primary Doctor? _____ Date of last visit._____

List Medical Problems:_____

_____

_____

If you are a woman of childbearing age, please answer following questions, as applicable:

When was your last menstrual period?_____

Do you use any contraceptive measures?_____

Are you currently pregnant? Yes No

Medications

Please list all known allergies to medications:_____

_____

Please list all current Medications: (Prescribed as well as over the counter drugs including vitamins/herbs)

Name	Dosage	How long have you been taking this medication?

Please list all Psychiatric medications that you have tried before.

Name	What Year	Response	Side Effects

Developmental History

1. Where were you born? _____
2. Who raised you? _____
3. How far did you go in school?_____ How did you do academically? _____
4. Did you attend college?_____
5. How would you describe your childhood?_____
6. How would your family describe you in school?_____
7. Have you had any military experience?_____

Family History

	Alive	Age	Occupation	Kind of relationship
Spouse	_____	____	_____	_____
Father	_____	____	_____	_____
Mother	_____	____	_____	_____
Brother 1	_____	____	_____	_____
Brother 2	_____	____	_____	_____
Sister 1	_____	____	_____	_____
Sister 2	_____	____	_____	_____
Child 1	_____	____	_____	_____
Child 2	_____	____	_____	_____

Please give any other information that you can give us to assist you in your evaluation and treatment program:

_____

_____

_____

Thank you for your helping us get to know you better. We hope that your experience with us is a pleasant one. If there is anything we can do to help make your experience with us more pleasant please do not hesitate to let us know. We welcome your thoughts and suggestions, after all you are our customer and we are here to be of service to you.