

THE HAPPINESS PSYCHIATRIST:

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New Patient Evaluation Form

Please fill out the following confidential intake form prior to your first appointment with Dr. Ambardar. By answering these questions accurately and thoughtfully, you will be helping set the therapeutic process in motion. If you are uncomfortable answering any of these questions, please feel free to leave them blank; we can discuss them in more detail at our initial evaluation.

PATIENT IDENTIFICATION:

Name: _____ SSN#: _____

Birthdate: _____ Age: _____ Occupation: _____

Marital Status: _____ Preferred Phone Number: _____

Email address: _____

Street Address: _____

How did you hear about Dr. Ambardar?

Please list two Emergency Contacts:

Name: _____ Phone:(_____) _____

Name: _____ Phone:(_____) _____

PURPOSE OF CONSULTATION: (Please describe your reasons for seeking treatment at this time):

PRESENTING SYMPTOMS: Please check any symptoms that may pertain to you:

- Depressed or sad mood
- Difficulty enjoying usual activities
- Unintentional weight loss or weight gain
- Sleeping too much or not enough
- Feeling agitated or sluggish
- Lacking energy/always tired

- Feeling guilty or worthless**
- Poor focus and concentration**
- Thoughts of death or suicide**
- Inflated self-esteem**
- Decreased need for sleep or going for days without sleeping**
- Excessive talking**
- Racing thoughts**
- Feeling highly distractible**
- Try to do or accomplish way too much in a day**
- Impulsive behavior**
- Seeing or hearing things that may not be real**
- Feeling like people are watching you or out to get you**
- Often tense or unable to relax**
- Excessive worrying**
- Panic Attacks**
- Afraid/unable to leave home**
- Extreme unreasonable fears**
- Intense fear of social situations**
- Cannot prevent repetitive thoughts**
- Cannot prevent repetitive behaviors**
- Intrusive, upsetting memories of past events**
- Always on guard or never feel safe**
- Body overreacts to "stress"**

LIFE PROBLEMS THAT CURRENTLY AFFECT YOU:

- Problems within my family**
- Problems among my friends/community**
- Educational problems**
- Occupational/Job problems**
- Housing problems**
- Financial/Economic problems**
- Problems with the law, legal system**
- Destructive/violent thoughts or behaviors**
- Attempts to hurt, harm, or mutilate self**
- Anger outbursts**
- Discipline problems at work**
- Careless, high-risk behavior**

PAST PSYCHIATRIC HISTORY:

Have you ever been hospitalized for psychiatric reasons? Circle YES or NO. If yes, please elaborate:

Have you ever seen a psychiatrist on an outpatient basis? Circle YES or NO. If yes, please give details:

Have you ever received counseling or psychotherapy in the past? Circle YES or NO. If yes, please elaborate:

Which psychiatric medications have you taken in the past and what were the benefits and/or side effects you experienced?

Are you currently taking any psychiatric medications? Circle YES or NO

If yes, please list all current medications along with dosages and prescribing physician name:

GENERAL MEDICAL HISTORY:

Do you have a Primary Care Physician (PCP)? Circle YES or NO

If yes, please list name of PCP and his or her phone # and address:

Date of Last Physical Exam: _____ Date of Last Lab work: _____

Do you suffer from any of the following general medical problems? Please check all that apply:

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Hormone Problems	<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Fever or Sweats	<input type="checkbox"/> Stroke

<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Palpations
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Surgery
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Pace Maker Implant
<input type="checkbox"/> Nose Bleed	<input type="checkbox"/> Cancer
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Asthma
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Unusual Diet	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Skin Rash	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Skin Ulcer/Lesion	<input type="checkbox"/> Neurological Disorders
<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> HIV	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Sexual Difficulties	<input type="checkbox"/> Fainting
<input type="checkbox"/> Gynecological Problems	<input type="checkbox"/> Vertigo/Dizziness
<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Motor Difficulties
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Serious Head Injury
<input type="checkbox"/> Visual Spots	<input type="checkbox"/> Recurring Headaches
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Muscle Cramps
<input type="checkbox"/> Speaking Problems	<input type="checkbox"/> Muscle Stiffness
<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Weakness
<input type="checkbox"/> Early Fatigue	<input type="checkbox"/> Tremors
<input type="checkbox"/> Daytime Sleepiness	<input type="checkbox"/> Numbness
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Difficulty Walking
<input type="checkbox"/> Concentration Problems	<input type="checkbox"/> Uncontrolled Movements
<input type="checkbox"/> Sinus or Nasal Problems	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Recurrent Infection of any kind	
<input type="checkbox"/> Depressed Immune System	

Do you take any prescription medications for your general medical problems? Circle YES or NO. If yes, list:

Do you take over-the-counter medications, herbal or dietary supplements, or vitamins? Circle YES or NO

If yes, please list:

Are you allergic to any medications? Circle YES or NO. If yes, please list medications and allergic reactions:

Have you undergone any surgical procedures? Circle YES or NO. If yes, please list all surgical procedures:

Do you have any problems with chronic physical pain or fibromyalgia? Circle YES or NO

If yes, please describe and rate your average pain level using the scale below:

Circle one 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (worst)

Have you ever suffered a severe head injury with loss of consciousness or a concussion? Circle YES or NO

If yes, please describe:

ALCOHOL, DRUG AND TOBACCO USE:

ALCOHOL: Would you say you are a non-drinker? are a social drinker? are a regular drinker?

have a drinking problem? are an alcoholic? Regardless of the box you checked, please describe the frequency of your alcohol use and what kind of alcohol and how much you drink, including date of last use:

Have you had any problems related to use or undergone treatment for use? Circle YES or NO

If yes, please describe (Legal, Financial, Health, or Relationship problems):

DRUG AND / OR PRESCRIPTION DRUG USE: Check if none _____

Would you say you are a recreational drug user? have a drug problem? have a drug addiction?

Please checkmark which substances below you regularly use:

- Benzodiazepines (Klonopin, Valium, Xanax, Ativan)
- Caffeine
- Marijuana/THC
- Cocaine/Crack
- Designer Drugs (such as Club Drugs: G, X)
- Hallucinogens (LSD, Mushrooms)
- Inhalants (Gasoline, Glue, Aerosol)
- Methamphetamines (Speed, Ice, Adderall)
- Opiates/Methadone (Vicodin, Oxycontin, Heroin)
- Prescription Pills (please list):

- Tobacco

Which of these have you experienced related to your drug use? Blackouts Bad reactions Withdrawal symptoms Cravings Overdoses Tolerance (“Could not get high no matter how much I used”) Preoccupation (Spent lots of time finding and using substance) Failed attempts to cut down or control use Detoxification in a hospital Other problems:

SOCIAL HISTORY:

Where were you born and where did you grow up?

Did your parents stay together while you were growing up? Circle YES or NO

If no, how old were you when they separated? _____

Father's occupation while you were growing up: _____

Mother's occupation while you were growing up: _____

How would you describe your current relationship with your father? Circle GOOD, AVERAGE or BAD

How would you describe your current relationship with your mother? Circle GOOD, AVERAGE or BAD

How many siblings do you have? None _____ Brothers _____ Sisters _____

How would you describe your relationship with your siblings? GOOD, AVERAGE, or BAD and describe:

Were there any complications at your birth (premature birth, major medical problems?) Circle YES or NO
If yes, please describe:

Any problems in your early development (learning to walk, talk, read, etc)? Circle YES or NO
If yes, please describe:

Did you suffer from any major illnesses / injuries while you were growing up? Circle YES or NO
If yes, please describe:

Are you/were you a victim of any form of abuse? Please describe below if you feel comfortable sharing:

Physical Abuse: Circle YES or NO. If yes, please describe and specify age of occurrence:

Sexual Abuse: Circle YES or NO. If yes, please describe and specify age of occurrence:

Emotional/Verbal Abuse: Circle YES or NO. If yes, please describe and specify age of occurrence:

What is the highest educational degree you have obtained? _____

What kinds of jobs and/or professions have you had in the past?

Are you currently employed? If yes, where?

Are you currently involved in a romantic relationship? Circle YES or NO
If yes, what is your partner's first name and occupation?

How long have you been together? _____

How would you describe your relationship? _____

Have you been involved in any previous significant intimate/romantic relationships? Circle YES or NO
If yes, please describe briefly:

Do you have any children? Circle YES or NO
If yes, what are their names & ages?

What are some things you enjoy doing in your spare time? (hobbies, interests, etc)?

Have you ever been convicted of any crimes, incarcerated in prison, or placed on probation? Circle YES or NO
If yes, please describe:

FAMILY HISTORY:

Is there any family history of mental illness or substance abuse among your blood relatives? Circle YES or NO
If yes, please describe as below:

Father's Side:

Mother's Side:

ADDITIONAL INFORMATION YOU WOULD LIKE DR. AMBARDAR TO KNOW:

Thank you for taking the time to fill out this confidential form accurately and thoughtfully.