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):

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____
____
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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:

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____

____

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

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____

____

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

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____

____

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:

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____

____

____

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:

☐ Chest Pain	☐ Heart Attack
☐ Diabetes	☐ Coronary Artery Disease
☐ Thyroid Disease	☐ Rheumatic Fever
☐ Hormone Problems	☐ High/Low Blood Pressure
☐ Fever or Sweats	☐ Stroke

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

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

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Do you take over-the-counter medications, herbal or dietary supplements, or vitamins? Circle YES or NO
If yes, please list:

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____
____

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

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____
____

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

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____
____

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:

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____
____

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):

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____
____

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:

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____

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

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____

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

____

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____

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?

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

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

If yes, please describe:

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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:

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____

ADDITIONAL INFORMATION YOU WOULD LIKE DR. AMBARDAR TO KNOW:

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