*Rogue Mental Health **SOLUTIONS***

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ADULT PATIENT REGISTRATION:

Name: _____ Date of Birth: _____

Address: _____

Gender at Birth: ☐ Male ☐ Female Age: _____ Social Security #: _____

Which Gender Do You Most Identify With: ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male

☐ Gender Variant/Non-Conforming ☐ Not Listed ☐ Prefer Not to Answer

Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Sie/Hir/Hirs ☐ Other _____

Best Contact Number: _____ May we leave a message for you? ☐ Yes ☐ No

Patient's Email Address: _____ May we E-Mail you? ☐ Yes ☐ No

Marital Status: _____

Partner's Name: (*If seen as a couple*): _____

Partners' Social Security Number (*if seen as a couple*): _____

Primary Care Physician: _____ Phone: _____

PCP Address: _____

Referred by: _____ Phone: _____

PHARMACY INFORMATION

Name: Phone: Location:

_____

Please list all others living in the home with the patient

Name: DOB: Relationship to patient:

_____
_____
_____
_____
_____

Emergency Contact (Name & Number): _____

ER Contact Mailing Address: _____

Were you adopted? ☐ Yes ☐ No

Where did you grow up? _____

EDUCATION:

Self: _____ Partner: _____

OCCUPATION:

Patient: _____ Phone # & Address: _____

Partner: _____ Phone # & Address: _____

ADULT INITIAL BACKGROUND QUESTIONNAIRE:

Briefly describe the problem(s) that brought you here today: _____

_____
_____
_____
_____

Primary reason for Seeking Services: ☐ Therapy ☐ Medication ☐ Both

Please check all the symptoms you are having:

☐ Distractible
☐ Impulsive
☐ High Energy
☐ Talks non-stop
☐ Problems with peers
☐ Trouble with Organization
☐ Anger outbursts
☐ Steals
☐ Annoys others
☐ Blames others
☐ Refuses to comply
☐ Aggressive/Violent
☐ Fire-setting
☐ Harms Animals
☐ Sudden feels of pain
☐ Alcohol/Drug Abuse
☐ Problems with Family
☐ Running Away
☐ Depressed
☐ Feels Hopeless
☐ Low Self-Esteem
☐ Isolation/Withdrawal
☐ Problems with Eating
☐ Easily tearful
☐ Extreme Sadness
☐ Lack of Energy
☐ Memory Problems
☐ Thoughts of Self-harm
☐ Has hurt or tried to hurt self
☐ Weight/Appetite changes
☐ Thoughts of harming others
☐ Feeling Fearful
☐ Irritability
☐ Problems with Sleep
☐ Headaches; Stomachaches
☐ Trouble Concentrating
☐ Lots of Worries
☐ Nervousness
☐ Perfectionistic
☐ Bed-wetting
☐ Feelings of Guilt
☐ Problems separating from caregiver
☐ Problems eliminating bowels/bladder
☐ Speech and language problems

Have you been in counseling in the past? ☐ Yes ☐ No

If yes, with whom:_____ Contact Number: _____

Start and End Date: _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or neglected? ☐ Yes ☐ No Age of Trauma _____
Brief description of where this trauma was? *I.E Hurricane Katrina August 2005*

_____
_____

Please list all Medications and the Dose including vitamins:

Medication: Dose: Frequency: I.E "1X daily":

_____
_____
_____
_____
_____
_____
_____

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 cannot remember all the details, just write in what you do remember.

Antidepressants: Dates: Dosage: Response/Side-Effects:

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) _____
Tegretol (Carbamazepine) _____
Topamax (Topiramate) _____
Other _____

Substance Abuse History:

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? _____

Pipes, Cigars or Chewing Tobacco:

Currently? ☐ Yes ☐ No In the Past? ☐ Yes ☐ No

What Kind? _____ How often per day on average? _____ For how many years? _____

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

How much alcohol consumed in a week? _____ ☐Beer ☐Wine ☐Liquor

Recreational Drugs? ☐ Yes ☐ No In the Past? ☐ Yes ☐ No

What Kind? _____ How often on average per day? _____ For how many years? _____

When did you quit? _____

Medical Information:

Have you seen your PCP in the past year? ☐ Yes ☐ No

Reason for visit:

_____

_____

How is your general health? ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have you had any chronic illnesses? ☐ Yes ☐ No If yes, what? _____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, what? _____

_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for the following?

Bipolar Disorder:	☐ Yes	☐ No	Who? _____
Depression:	☐ Yes	☐ No	Who? _____
Anxiety:	☐ Yes	☐ No	Who? _____
Anger:	☐ Yes	☐ No	Who? _____
Suicide:	☐ Yes	☐ No	Who? _____
Schizophrenia	☐ Yes	☐ No	Who? _____
Post-Traumatic Stress	☐ Yes	☐ No	Who? _____
Alcohol Abuse:	☐ Yes	☐ No	Who? _____
Other Substance Abuse:	☐ Yes	☐ No	Who? _____
If yes to above, what type of substance(s)? _____			
Violence:	☐ Yes	☐ No	Who? _____

Have any family member(s) been treated with a Psychiatric Medication? ☐ Yes ☐ No

If yes, who was treated? _____

What Medication did they take? _____

How effective was the treatment? _____

Family History:

	You	Family	Family Members Relation to Patient?
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 _____	☐	☐	_____