Shafa Psychiatry Center

New Patient Questionnaire

Thank you for trusting Shafa Psychiatry with your psychiatric care!

Kindly complete this form and return it via fax, or electronically via patient portal. If you prefer to skip a question or to instead discuss it during your office visit, please feel free to do so.

Name
Today's Date
Date of Birth
Primary Care Physician and Phone
Do you give permission for ongoing regular updates to be provided to your primary care physician?
Current Therapist and Phone
Do you give permission for us to speak with your therapist?
Prior Psychiatrist and Phone
Do you give permission for us to speak with your psychiatrist?
What is/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 ( ) Racing thoughts ( ) Excessive worry ( ) Unable to enjoy activities ( ) Impulsivity ( )
Anxiety attacks ( ) Sleep pattern disturbance ( ) Increased risky behavior ( ) Avoidance ( ) Loss of interest ( )
Fatigue ( ) Hallucinations ( ) Concentration/forgetfulness ( ) Decreased need for sleep ( ) Suspiciousness ( )
Change in appetite ( ) Excessive energy ( ) Excessive guilt ( ) Decreased libido ( ) Excessive irritability ( ) ( )
Increased libido ( ) Crying spells

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 to make you feel this way?
How strong is your desire to end your life (1-10 scale, with 10 being strongest)
Have you come up with a specific plan?
Access to guns?
Past Medical History:
Allergies to Medication?

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

Current over-the-counter(OTC) medications orsupplements:
Current medical problems:
Past medical problems, non-psychiatric hospitalization, orsurgeries:
Have you ever had an EKG? ( ) Yes ( ) No. If yes, when
Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

Women only:
Are you currently pregnant or do youthink you might be pregnant? ( ) Yes ( ) No.
Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Personal Medical History:
Please mark if you have any of the following conditions.
____Thyroid Disease
____Anemia
____Liver Disease
____Chronic Fatigue
____Kidney Disease
____Diabetes
____Asthma/Respiratory Problems
____Stomach/GI Problems
____Cancer (please specify type:)
____Fibromyalgia
____Heart Disease
____Epilepsy/Seizures
____Chronic Pain
____High Cholesterol
____High Blood Pressure
____Head Trauma
____Liver Problems
____Other Significant Medical Issue(s) (please specify:)

Family Medical History:
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 ByWhom

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).

Antidepressants/Antianxiety Dates Dosage Response/Side-Effects SSRIs :
Prozac(fluoxetine)
Zoloft(sertraline)
Luvox(fluvoxamine)
Paxil (paroxetine)
Celexa(citalopram)
Lexapro(escitalopram)
SMSs:
Viibryd (vilazodone)
Trintellix (vortioxetine)
SNRIs:
Effexor(venlafaxine)
Cymbalta (duloxetine)
Pristiq (desvenlafaxine)
NDRIs:
Wellbutrin (bupropion)_ NSRIs:
Fetzima (levomilnacipran)
NaSSAs:
Remeron (mirtazapine)
TCAs:
Anafranil (clomipramine)
Elavil(amitriptyline)
Other

Mood Stabilizers (for Bipolar Disorder)
Lithium
Depakote (valproate)
Lamictal(lamotrigine)
Tegretol (carbamazepine)
Trileptal (oxcarbazepine)
Topamax (topiramate)
Other

Antipsychotics
Seroquel(quetiapine)
Zyprexa(olanzapine)
Geodon(ziprasidone)
Abilify (aripiprazole)

Invega (paliperidone)
Clozaril(clozapine)
Haldol(haloperidol)
Prolixin (fluphenazine)
Risperdal (risperidone)
Latuda (lurasidone)
Saphris (asenapine)
Fanapt (iloperidone)
Rexulti (brexpiprazole)
Vraylar (cariprazine)
Other

Sedatives/Hypnotics
Ambien(zolpidem)

Sonata (zaleplon)
Lunesta (eszopiclone)
Rozerem (ramelteon)_ Restoril (temazepam)
Trazodone
Belsomra (suvorexant)
Other

Stimulants/ADD Meds
NRIs:
    Strattera (atomoxetine)
Methylphenidates:
    Ritalin (methylphenidate)
    Concerta (long-acting methylphenidate)_ Amphetamines:
    Adderall (amphetamine)
    Dexedrine (dextroamphetamine)
    Vyvanse (lisdexamfetamine)
Other

Antianxiety
Benzodiazepines:
    Klonopin (clonazepam)
    Xanax (alprazolam)
    Ativan (lorazepam)
    Valium(diazepam)
5-HT_{1A} Partial agonist:
    Buspar(buspirone)
Other

Family Psychiatric History:
Place a check mark if anyone in your family has been diagnosed with or treated for any of these conditions:
___Bipolar disorder
___Schizophrenia
___Depression
___PTSD
___Anxiety
___Alcohol Abuse
___Other Substance Abuse
___Suicide

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?
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 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?

Tobacco History:
How 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?

Educational History:
What is your highest level of education?

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired What is/wasyour occupation and for how long?
Where do youwork?
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 in a relationship? ( ) Yes ( ) No If yes, how long?
What is yourspouse orsignificant other's occupation?
Do you have children? ( ) Yes ( ) No If yes, list ages and gender: List everyone who currently lives with you:

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

Patient Signature

Date

Guardian Signature (if applicable)

Date

Emergency Contact Telephone #