New patient intake form

Patient's Name:

DOB:

Adress:

Zip:

City:

SSN:

Phone:

Email:

Emergency Contact:

Date:

Why are you seeking treatment with Dr.Hayes?

____

____

What is your primary insurance?____

Do you have ANY other insurance?____

Please list current diagnosis and recent provider that made the diagnosis.

____

____

____

Please circle any of the medications below you have taken:

Celexa

Lexapro

Zoloft

Paxil

Prozac

Wellbutrin

Effexor

Cymbalta

Pristiq

Trintillex

Viibryd

Risperdal

Seroquel

Abilify

Latuda

Rexulti

Lithium

Lamictal

Depakote

Tegretol

Trileptal

Buspar

Vistaril

Trazodone

Remeron

Doxepin

Other:

Depression:

How long have you suffered from depression?______________________________

Please circle if you currently experience the following?:

poor sleep

increased sleep

low energy

low appetite

anhedonia

agitation

feelings of worthlessness

guilt

poor concentration

Past thoughts of suicide or homicide

Current thoughts of suicide or homicide

Have you ever had a manic episode? Y or N

Anxiety:

How long have you suffered from anxiety?___________________________

Please circle if you experience the following?:

Excessive worry

Difficult to control worry

Restlessness

easily fatigued

on edge

difficulty concentrating

mind going blank

muscle tension

poor falling asleep

restless sleep

Have you ever experienced a panic attack? If so circle the following symptoms:

palpitations (heart fluttering or

skipping)

pounding heart

accelerated heart rate

sweating

shaking

shortness of breath

smothering

chest pain

nausea

abdominal distress

dizzy

lightheaded

faint

detachment

losing control

going crazy

fear of dying

numbness

tingling

chills

flushing

Do you worry about this occurring

again? Y or N