

New patient intake form

Patient's Name _____ Date _____

Phone _____ Email _____

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

Rexulti

Lexapro

Lithium

Zoloft

Lamictal

Paxil

Depakote

Prozac

Tegretol

Wellbutrin

Trileptal

Effexor

Buspar

Cymbalta

Vistaril

Pristiq

Trazodone

Trintillex

Remeron

Viibryd

Doxepin

Risperdal

Seroquel

Abilify

Other:

Latuda

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