

PsychNP Wellness Center, LLC. 658 Kenilworth Drive Suite 206 Towson, MD 21204

Phone: (443) 841-7550 Fax: (443) 841-7572

New Patient Intake Form

Presenting Problems and Concerns (History of Present Illness) Please check all of the behaviors and symptoms that you consider problematic: of distractibility of londiness of londiness of problems of pr	Patient Name:		Appointment Date:							
Please check all of the behaviors and symptoms that you consider problematic: o distractibility oracing thoughts oracing tho	Describe the Problems that concern	n you:								
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If yes please describe:	if yes please describe:	41 4	11 1 0		NT					
	nave you ever been physically hurt o	or threaten	ea by someone else?	Y es	NO					
PMHNP Notes:	If yes please describe:									
	DMHND Notes									

							Page 2 of 5
Past N	<u>Medical History</u>						
Date of	last physical exam:						
Have y	ou experienced any of the follow	ving	during your lifetime?				
0	allergies	0	vision problems	0	kidney disease	0	heart surgery
0	surgery	0	high blood	0	HIV/AIDS	0	thyroid disease
0	seizures		pressure	0	congestive heart	0	chronic pain
0	chest pain/angina	0	kidney stones		failure	0	meningitis
0	pacemaker	0	heart palpitations	0	stomach aches	0	hearing problems
0	stroke/CVI/TIA	0	depression	0	dizziness/fainting	0	high cholesterol
0	liver disease	0	headaches	0	diabetes	0	osteoporosis
0	tuberculosis	0	head injury	0	heart attack	0	stomach ulcer
0	asthma	0	high fever	0	cancer	0	blood clots
0	serious accident	0	heart disease	0	hepatitis	0	glaucoma

 serious accid 			 heart diseas 	se	0	hepatitis		0 8	glaucoma
Review of Symptom	ıs								
ROS	(-)	Please o	check all current pos	sitive find	lings				
Constitutional		0	weight loss	0	fevers	0	chills	0	poor appetite
		0	fatigue	0	insomnia	0	weight gain	0	night sweats
Eyes		0	blurry vision	0	eye pain	0	eye discharge	0	eye redness
		0	decrease in	0	dry eyes	0	double vision	0	cataracts
			vision						
ENT/Mouth		0	sore throat	0	hoarseness	0	ear pain	0	hearing loss
		0	ear discharge	0	nose bleeds	0	sinus problems	0	oral surgery
Cardiovascular		0	chest pain	0	palpitations	0	rapid heart rate	0	
		0	poor circulation	0	swelling in	0	heart murmur		
			1		legs or feet				
Respiratory		0	shortness of	0	excess	0	coughing up	0	history of
1 3			breath chronic		sputum		blood		tuberculosis
			cough		production				
Gastrointestinal		0	nausea	0	vomiting	0	diarrhea	0	constipation
		0	blood in stool	0	frequent	0	trouble	0	IBS
					heartburn		swallowing		
Genitourinary		0	frequent	0	blood in	0	incontinence	0	painful
			urination		urine			_	urination
		0	urinary retention	0	abortion				
Skin		0	rash	0	hives	0	hair loss	0	skin sores
		0	itching	0	skin	0	nail changes	0	mole changes
			8		thickening		8	_	
Musculoskeletal		0	joint pain	0	muscle aches	0	frequent leg	0	muscle
		0	joint swelling	0	back pain		cramps	_	weakness
			Jg		F	0	fibromyalgia	0	motor vehicle
							, 8		accident
Psychiatric		0	Anxiety	0	Depression	0	insomnia	0	alcohol/drug
•		0	ADHD	0	Bipolar	0	panic attacks		dependence
					Disorder		1		1
Endocrine		0	goiter	0	heat	0	cold	0	change in
		0	increased thirst		intolerance		intolerance		skin pigment
				0	excess	0	hypothyroidism		1 0
					sweating				
Neurological		0	seizures	0	tremors	0	migraines	0	numbness
		0	dizziness/vertigo	0	loss of	0	stroke		
		1	5		balance				
Hemo/Lymph		0	low blood count	0	easy bruising	0	swollen lymph	0	
• •		0	prolonged	0	blood clots		nodes		
		1	bleeding				transfusions		
Allergy/Immune		0	allergic	0	hay fever	0	frequent	0	positive skin
		1	reactions	0	STD		infections		test
		0	HIV positive			0	hepatitis		
PHMNP Notes			•				•		

Past Mental Health Treatment

Yes	No	Type of Treatment	Date or Age	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (Mental Health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			

Substance Abuse History

Substance type	Curre	ent Us	e	Past U	Past Use			
	Yes	No	Frequency/Amount	Yes	No	Frequency/Amount		
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/Crack								
Ecstasy								
Heroine/Methadone								
Amphetamines								
Pain Killers								
PCP/LSD/Mushrooms								
Steroids								
Tranquilizers								

Have you had withdrawal symptoms when trying to stop using any substances? Yes No If yes, please describe:

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? Yes No If yes please describe:

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Please	list	known	medical	nroh	ems
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Father:	Mother:
Siblings:	
Your Children:	

Family Mental Health Problems

Type of Problem	Who?	Type of Problem	Who?
Hyperactivity		Panic Attacks	
Sexually abused		Obsessive compulsive	
Depression		Anger/abusive	
Manic Depression		Schizophrenia	
Suicide		Eating Disorder	
Anxiety		Alcohol/Drug abuse	

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Family Relatio	<u>onships</u>					
Relationship	Name		Age	Quality of	f Relationship	
•						
Family, Marita	al, and Developme	ntal History		•		
	legally married or l					
	temporarily separat					
	divorced or perman					
Mother:	remarried (number	of times)			
	emarried (number o)			
Interpersonal/S	Social/Cultural In	<u>formation</u>				
Please describe	your social support	t network				
Family						
 Neighbor 	ors					
Friends						
 Students 	S					
Co-worl	kers					
	/self-help group					
Commu	nity group					
 Religiou 	us/Spiritual center (which one)				
To which cultur	ral/ethnic group do	you belong:				
If you are exper	riencing any difficu	lties due to cult	tural or ethnic is	sues?		
		_				
-	are spiritual matter	•	Not at all	Little	Somewhat	Very Much
	your strengths skill	_				
PMHNP Notes:	:					
3.4° 11	T 6 /*					
Miscellaneous	Information					
Employment From 1			D = =:4:			
Current Employ	yer e in this position:		Positio	on: - 11 - 641-	is position: Low	N (- 1' TT' - 1.
Length of Time	in this position:		Stres			
Previous Emplo	oyer e in this position:		POSIT	ion:	is position: Low	M - 1: II: -1.
Length of Time	in this position:		Stres	s ievei oi in	is position: Low	Medium High
Previous Empio	oyere in this position:		POSIT	ion:	is position: Low	N (- 1' TT' - 1.
Length of Time	in this position:		Stres	s level of th	is position: Low	Medium High
Previous Emplo	oyer e in this position:		Posit	ion:	· · · · · · · · · · · · ·	N # 1' TT' 1
Length of Time	in this position:		Stres	s level of th	is position: Low	Medium High
Education	.1 1 . 1 . 1	0.37 3.7				
	tly attending school		X 7			
	chool Graduate			<u> </u>		
o Associat		Y ear	Major/area of	t study:		
	raduate degree	Y ear	Major/area of	t study:		
 Graduat 	e degree	Y ear	Major/area of	r study:		

Military Service			
Yes No (If no,		Type of disaborace	Donk
Dranch 1 40	Date of Discharge	Type of discharge:	Kank
Were you in combat?	Yes No		
Legal			
TO 1 1 1 1		J (Yes No
If yes please explain:		d custody proceedings?	
Are you currently inv	olved in any divorce or child	d custody proceedings?	Yes No
If yes please explain:			
PMHNP Notes:			
	y medications Yes No		
Medication	Dosage	Date First Prescribed	Prescribed by
Current over the coun	ter medications (including v	vitamins, herbal remedies, etc.)	None
Allergies and/or adve	rse reactions to medications	None	
Women			
	ation:		
Birth Control Method	:		