**Progressive Psychiatry**

**Sara Markey, MD**

**3955 E. Exposition Ave, Suite 100**

**Denver, Colorado 80209**

**Phone 720-551-6830/Fax #769-235-0741**

Welcome to our practice.  The following is a demographic and history form that will help us use our session time as well as possible.  All answers are confidential.

Date: \_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of Dr. Markey? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Name you prefer to be called, if different from above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:   married    partnered    separated    divorced    widowed     single

Emergency contact (name & phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred pharmacy (name & phone or cross-streets) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of internist or primary care provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of therapist and/or psychiatrist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am an out-of-network provider for insurance, but I will provide codes to you that you can send to your insurance company for reimbursement.

Insurance name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle all that apply:

Employment:   full-time work    part-time

work    homemaker   unemployed    student    retired    veteran    disability

Name of current/most recent employer or school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names and ages of children:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives with you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who do you feel is supportive of you (including family, friends, co-workers, etc.)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STRESSORS:  Please circle if these occurred in the past 3 years:

moved        divorce/separation       death or loss of family/close friend          marriage         pregnancy        serious fights

serious illness/injury caring for elderly        economic strain/job loss       legal problems           other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description/Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:  Have you had allergies or a bad reaction to medications, vitamins, herbals, foods, latex or anything else?   Yes          No

If yes, please name what caused the reaction and describe your response\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Please put an “X” to indicate if any blood relatives have had any of the following mental health problems, even if it hasn’t been officially diagnosed.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mom | Dad | Sister | Brother | Child | Grand-  parent | Cousin | Aunt/  Uncle |
| Depression |  |  |  |  |  |  |  |  |
| Bipolar Disorder or Mania |  |  |  |  |  |  |  |  |
| Schizophrenia or Psychosis |  |  |  |  |  |  |  |  |
| Alcohol Problems |  |  |  |  |  |  |  |  |
| Drug Problems |  |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |  |
| ADHD |  |  |  |  |  |  |  |  |
| Other psychiatric problems not listed above |  |  |  |  |  |  |  |  |
| Seizures / convulsions |  |  |  |  |  |  |  |  |
| Neurologic diseases/stroke |  |  |  |  |  |  |  |  |
| Heart problems (heart attack, abnormal rhythm, sudden death, etc.) |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |  |
| Thyroid problems |  |  |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |  |  |
| Other serious medical problems not listed above |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

**Your Medical History:**

Please check column for yes or no regarding whether you have had the medical problems below and provide year(s) and description:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | No | Yes | Years Occurred | Description |
| Birth defect |  |  |  |  |
| Eye problems/glaucoma |  |  |  |  |
| Seizures/convulsions |  |  |  |  |
| Tremor |  |  |  |  |
| Fainting/dizzy |  |  |  |  |
| Headache/migraine |  |  |  |  |
| Hearing loss |  |  |  |  |
| Serious head trauma/concussion |  |  |  |  |
| Tics (non-purposeful movements) |  |  |  |  |
| Other neurologic problems |  |  |  |  |
| Abnormal heart rhythm |  |  |  |  |
| High blood pressure (above 130/85) |  |  |  |  |
| High cholesterol |  |  |  |  |
| Other heart problem (heart attack, etc.) |  |  |  |  |
| Diabetes |  |  |  |  |
| Blood disorders/anemia |  |  |  |  |
| Hormone problems/thyroid issue |  |  |  |  |
| Serious joint/bone problems (exclude simple fractures) |  |  |  |  |
| Asthma/sleep apnea/lung problems |  |  |  |  |
| Fibromyalgia |  |  |  |  |
| Chronic pain (name location) |  |  |  |  |
| Hepatitis/liver problems |  |  |  |  |
| HIV/AIDS |  |  |  |  |
| Urinary / kidney problems |  |  |  |  |
| Sexual /erectile problems |  |  |  |  |
| Tobacco Smoker |  |  |  |  |
| Marijuana smoker |  |  |  |  |
| Currently pregnant or possibly pregnant? |  |  |  |  |
| Breastfeeding |  |  |  |  |
| Cancer |  |  |  |  |
| Other significant medical issues: |  |  |  |  |
|  |  |  |  |  |

Please list all prescription and over-the-counter medications / herbals / vitamins that you have used in the past 12 months for any reason, medical or psychiatric:

|  |  |  |  |
| --- | --- | --- | --- |
| Medicine/herbal/vitamin | Dose | Frequency of use | Reason for use |
|  |  |  |  |
|  |  |  |  |
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**Please circle reasons you are seeking my help:**

Aggression/Drug Dependence/Paranoia

Alcohol Dependence Elevated/high mood/Parenting concerns

Anger Management/Fatigue/Phobias-fears

Anxiety-Worry/Gambling Recurring/Upsetting thoughts

Avoiding people/Hallucinations/Sexual addiction

Developing more coping skills/Hopelessness/Sexual difficulties

Cyber addiction/Hyperactivity/Feeling sick often

Depression/Impulsivity/Sleep problems

Poor focus-concentration/Loneliness/Suicidal thoughts

Panic attacks/Memory problems/Traumatic experience(s)

Self-abuse-mutilation/Gender identity issues/Homicidal thoughts

Other Reasons:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Substance Use History:**

Please list prescription and over-the-counter medication use below, if you ever used the medications other than as prescribed or indicated on the bottle.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Amount Used  (drinks, grams, bags, # of pills, etc.) | How often used  (daily/weekly/monthly) | Year first used | Date of  last use |
| Alcohol |  |  |  |  |
| Barbiturates |  |  |  |  |
| Benzodiazepines |  |  |  |  |
| Cocaine/Crack |  |  |  |  |
| Opiates/Heroin/Pain Pills |  |  |  |  |
| Marijuana/THC |  |  |  |  |
| PCP/LSD/Mescaline |  |  |  |  |
| Inhalants |  |  |  |  |
| Methamphetamine/Sudafed |  |  |  |  |
| Sleep medications |  |  |  |  |
| Other substances:  Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |

**Thank you very much for taking the time to complete this form!**