**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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!**