Taras W. Didenko, MD, PC & Associates
1827 Walden Office Square, Suite 510
Schaumburg, Illinois 60173
(847) 496-4525 (v) | (837) 660-2958 (f)

PATIENT INFORMATION

Today's Date *(mm/dd/yyyy)*: _____

Title?
☐ Dr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Mr. ☐ Mx.

Patient's Legal Name *(Last, First MI)*: _____

Patient's Preferred Name: _____

What is your gender?
☐ Female ☐ LGBTQ ☐ Male ☐ Prefer not to say

☐ Prefer to self-describe: _____

Do you identify as transgender?
☐ Yes ☐ No ☐ Prefer not to say

Date of Birth *(mm/dd/yyyy)*: _____ SSN: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

What is your ethnicity?
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to say

What is your race *(check all that apply)*?
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
☐ Other Race ☐ Prefer not to say

☐ Prefer to self-describe: _____

Marital Status?
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Cohabiting

Preferred Language *(if not English)*: _____

Parent's/Guardian's Name *(if patient is a minor)*: _____

Employer: _____ Occupation: _____

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How many "Close" friends do you have? _____ How often do you see them? _____

What are the names & ages of your spouse and/or children?

Name	Age	Name	Age
(Spouse) _____	___	_____	___
_____	___	_____	___
_____	___	_____	___
_____	___	_____	___

Whom do you live with *(check all that apply)*?

☐ Alone ☐ Parents ☐ Spouse ☐ Children ☐ Significant Other ☐ Roommates

Employment:
☐ Employed Full-Time *(over 32 hours)*
☐ Employed Part-Time
☐ Self Employed
☐ Unemployed
☐ Other: _____

Line of Work: _____

What is your highest level of education? _____

What is your religion? _____

Describe your stressors (what upsets you): _____

_____

Describe what you do at your job: _____

_____

Leisure activities and hobbies: ☐ None, or please list: _____

_____

Referred to our clinic by whom?

☐ Dr. _____ ☐ Yellow Pages ☐ Friend

☐ Insurance Plan _____ ☐ Close to Home/Work

☐ Hospital _____ ☐ Other: _____

☐ Family: Other family member seen here? _____

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Billing Information

Person responsible for the bill, if different than the Patient Information, listed above:

Legal Name *(Last, First MI)*: _____

Date of Birth *(mm/dd/yyyy)*: _____ Home Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Employer: _____ Occupation: _____

Insurance Information

Primary Insurance:

Name of Insurance Subscriber: _____ Relationship: _____

Date of Birth *(mm/dd/yyyy)*: _____ SSN: _____

Name of Insurance: _____ or ☐ Medicaid ☐ Medicare ☐ Self-Pay

Group #: _____ Member ID #: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance *(if applicable)*:

Name of Insurance Subscriber: _____ Relationship: _____

Date of Birth *(mm/dd/yyyy)*: _____ SSN: _____

Name of Insurance: _____ or ☐ Medicaid ☐ Medicare ☐ Self-Pay

Group #: _____ Member ID #: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

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In Case of Emergency

Name of local friend or relative not living at same address: _____

Relationship to patient: _____ Phone: (_____) _____-_____

Medical History

Family/Primary Care Provider: _____ Phone: (_____) _____-_____

Reason for your appointment/chief complaint: _____

_____

Is the condition due to a work-related injury? ☐ Yes ☐ No

Is the condition due to an automobile accident? ☐ Yes ☐ No

*(*If you answered "**Yes**" to either of the above two questions, please note that we **DO NOT** accept Worker's Compensation or any automobile insurance, except payment made in full at the time of service.)*

Date of last physical examination *(mm/dd/yyyy)*: _____

Where performed: _____

Date of last EKG *(mm/dd/yyyy)*: _____

Where performed: _____

Operations: _____

_____

Hospitalizations: _____

_____

Previous Mental Health Diagnosis: _____

Have you experienced any losses in the last two years? ☐ Yes ☐ No

If "Yes," whom & when: _____

What is your current Support System? _____

_____

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Drug allergies *(please do not list seasonal or food allergies here)*:

☐ Check this box if you have no known drug allergies.

Current medications *(prescriptions & non-prescriptions, inhalers, birth control, vitamins, & supplements)*:

Medication Name	Dose	Frequency

Have you ever been diagnosed with *(please check Yes or No)*?

Condition	Yes	No	Condition	Yes	No
Allergies/Asthma	☐	☐	Osteoarthritis	☐	☐
Angina/Chest Pain	☐	☐	Osteoporosis	☐	☐
Bronchitis	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Rheumatoid Arthritis	☐	☐
Diabetes	☐	☐	Seizures	☐	☐
Heart Disease	☐	☐	Sexually Transmitted Disease	☐	☐
High Blood Pressure	☐	☐	Stroke	☐	☐
Hormone Problems	☐	☐	Thyroid Problems	☐	☐
Immune Deficiency	☐	☐	Tuberculosis	☐	☐
Kidney Disease	☐	☐	Ulcers	☐	☐
Migraines	☐	☐			

Other: _____

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Have you ever experienced any of the following symptoms *(please check **ALL** that apply)*?

Allergic/Immune	☐ Excessive Sweating	☐ Dry Eyes/Irritation
☐ Frequent Infections	☐ Excessive Thirst	☐ Ear Pain
☐ Hay Fever	☐ Excessive/Painful Urination	☐ Headaches
☐ Hepatitis	☐ Goiter	☐ Hoarseness
☐ HIV Positive	☐ Heat Intolerance	☐ Sinus Pain
☐ Positive TB/PPD Skin Test	☐ Increased Thirst	☐ Sore Throat
Cardiovascular	☐ Libido Changes	☐ Trouble Swallowing
☐ Chest Pain	**Gastrointestinal**	☐ Vision Loss/Eye Pain
☐ Elevated Blood Pressure	☐ Abdominal Pain	**Hematology/Lymphatic**
☐ Heart Disease	☐ Bloody Stool	☐ Anemia
☐ Irregular Heartbeat	☐ Constipation	☐ Bleeding Issues
☐ Shortness of Breath	☐ Diarrhea	☐ Easy Bruising
☐ Swelling of Limbs	☐ Frequent Heartburn	☐ Low Blood Count
Constitutional	☐ Jaundice	☐ Swollen Lymph Nodes
☐ Binging	☐ Kidney Stones	☐ Transfusions
☐ Fatigue/No Energy	☐ Nausea	**Respiratory**
☐ Fever	☐ Vomiting	☐ Chronic Cough
☐ Insomnia	**Genitourinary**	☐ Coughing Up Blood
☐ Memory Loss	☐ Blood in Urine	☐ Excess Sputum Production
☐ Night Sweats/Chills	☐ Frequent Urination	☐ Shortness of Breath
☐ Poor Appetite	☐ Frequent UTIs	☐ Wheezing
☐ Weight Gain	☐ Incontinence	**Skin**
☐ Weight Loss	☐ Menstrual Irregularities	☐ Eczema
Endocrine	☐ Pain Urinating	☐ Hives
☐ Change in Skin Pigment	☐ Urinary Retention	☐ Rash
☐ Cold Intolerance	**HEENT**	☐ Skin Sores/Ulcers
☐ Diabetes	☐ Decreased Hearing	

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Neuro/Psychiatric *(Have you experienced any of these in the last six months?)*		
Appetite	☐ Tired Mornings	☐ Perfectionist
☐ Normal	☐ Tremors/Tics	☐ Procrastinates
☐ Binging	☐ Truancy	☐ Self-Centered
☐ Craving Sweets	☐ Unable to Fall Asleep	☐ Unstable/Intense Relationships
☐ Decreased Appetite	☐ Violent Behavior	**Mood**
☐ Increased Appetite	☐ Wake up to Soon	☐ Normal
☐ Vomiting	**Concentration**	☐ Anxiety, Occasional
☐ Weight Change	☐ Normal	☐ Anxiety, Constant
Behavior/Motor	☐ Bizarre Thoughts	☐ Crying Spells
☐ Normal	☐ Delusions	☐ Decrease in Energy/Fatigue
☐ Alcohol Dependence	☐ Easily Distracted	☐ Decrease in Sexual Activity
☐ Illicit Drug Dependence	☐ Hallucinations	☐ Decrease in Social Activity
☐ Opioid Drug Dependence	☐ Indecisiveness	☐ Depressed Mood
☐ Agitated Behavior	☐ Obsessive Thoughts	☐ Euphoric Mood
☐ Aggression/Rage	☐ Paranoid	☐ Fear of Being Alone
☐ Argumentative	☐ Poor Attention Span	☐ Fear of Crowds
☐ Blackouts	☐ Poor Concentration	☐ Fear of Public Speaking
☐ Compulsive Behavior	☐ Poor Decision Making	☐ Fear of Travel
☐ Criminal Activity	☐ Poor Memory	☐ Fearfulness
☐ Cruelty to Animals/People	☐ Suicidal Thoughts	☐ Feeling Guilty
☐ Destructive to Others/Property	☐ Thoughts too Fast	☐ Increase in Occupational Activity
☐ Dizziness	☐ Thoughts too Slow	☐ Increase in Sexual Activity
☐ Impulsive Behavior/Speech	**Interpersonal/Social**	☐ Increase in Social Activity
☐ Neglect Hobbies	☐ Normal	☐ Irritable
☐ Not Attending School/Work	☐ Avoids Significant Interpersonal Contact	☐ Loneliness
☐ Repetitious Behavior	☐ Chooses Relationships that Lead to Disappointment	☐ Loss of Interest in Activities
☐ Running Away	☐ Constantly Seeking Praise/Admiration	☐ Mood Shifts/Swings
☐ Seizures	☐ Excessive Devotion to Work	☐ Panic Attacks
☐ Self-Destructive Behavior	☐ Expects to be Exploited/Harmed by Others	☐ Persistent Emptiness/Boredom
☐ Sleep too Little	☐ Exploiting Others	☐ Restless/Overactive
☐ Sleep too Much	☐ Inability to Sustain Consistent Work	☐ Short-Tempered
☐ Socially Withdrawn	☐ Indifferent to Others' Feelings	
☐ Speech Disturbances	☐ No Close Friends/Confidants	

Have you ever had suicidal thoughts? ☐ No ☐ Yes
If "Yes," how often? ☐ Occasionally ☐ Frequently
If "Yes," do you have a plan? ☐ No ☐ Yes
If "Yes," do you have the means? ☐ No ☐ Yes

Have you ever attempted suicide? ☐ Yes ☐ No Number of times: _____

If "Yes," when & how was the last attempt made? _____

_____

Have you ever had thoughts of harming others? ☐ Never ☐ Occasionally ☐ Frequently

Have you ever been arrested? ☐ Yes ☐ No Number of times: _____

Have you ever smoked tobacco? ☐ Never ☐ Past ☐ Current

If past/current, what type of tobacco? _____

If past/current, how much per day? _____ Date of last use *(mm/yyyy)*: _____

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Alcohol consumption:
Do you typically have? ☐ None
☐ 1 to 2 drinks ☐ 3 to 4 drinks ☐ 5 to 6 drinks ☐ 7 to 8 drinks ☐ 9 or more drinks

How often do you consume alcohol?
☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Have you ever experienced DTs after you had stopped drinking? ☐ Yes ☐ No

Have you ever misused your prescription medications or used illegal drugs? ☐ Yes ☐ No

If "Yes," what, when, & how? _____

If "Yes," date of last use *(mm/yyyy)*: _____

If "Yes," frequency of use? _____

Is there a family history of mental illness? ☐ Yes ☐ No

If "Yes," who was it? ☐ Step-Mother ☐ Brother(s) ☐ Aunt/Uncle
☐ Mother ☐ Step-Father ☐ Sister(s) ☐ Grandmother
☐ Father ☐ Children ☐ Cousins ☐ Grandfather

If "Yes," what did they suffer from? _____

Is there a family history of Substance Abuse/Alcoholism? ☐ Yes ☐ No

If "Yes," who was it? ☐ Step-Mother ☐ Brother(s) ☐ Aunt/Uncle
☐ Mother ☐ Step-Father ☐ Sister(s) ☐ Grandmother
☐ Father ☐ Children ☐ Cousins ☐ Grandfather

If "Yes," what did they suffer from? _____

Have you ever been abused? ☐ No ☐ Physical ☐ Emotional ☐ Sexual

For females only:

Are you currently pregnant? ☐ Yes ☐ No

Date of last menstrual cycle *(mm/dd/yyyy)*: _____

Are you currently on birth control? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No

If "Yes," what was the outcome of the pregnancy(ies)? _____

_____

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CHILDREN ONLY

For children only – Developmental Milestones:

At **one** month, did your child cry to communicate and/or have eye contact?	☐ Yes	☐ No
At **four** months, could your child turn from their back to their abdomen, lift their head, and laugh?	☐ Yes	☐ No
At **seven** months, was your child able to crawl and bear weight on feet when supported?	☐ Yes	☐ No
At **nine** months, was your child able to walk alongside furniture, crawl well, bang objects together, drink from a cup, and attempt to feed themselves?	☐ Yes	☐ No
At **eleven** months, was your child able to understand the meaning of words, shook their head to say "No," follow simple directions, cooperate with dressing activities, and use a spoon?	☐ Yes	☐ No

TEENS

For adolescents only:

Did you ever runaway? ☐ Yes ☐ No Number of times? _____

What grade are you at in school? _____ What are your grades in school? _____

SUBSTANCE ABUSE ONLY

For substance abuse only:

During the last year, have you had a feeling of guilt or remorse after drinking?	☐ Yes	☐ No
During the last year, have you failed to do what someone would typically expect from you because of drinking?	☐ Yes	☐ No
During the last year, has a friend or a family member ever told you about things you said or did while you were drinking, that you could not remember?	☐ Yes	☐ No
Do you sometimes take a drink when you first get up in the morning?	☐ Yes	☐ No
Can you get through the week without using drugs?	☐ Yes	☐ No
Are you always able to stop using drugs when you want to?	☐ Yes	☐ No
Do you ever feel bad or guilty about your drug use?	☐ Yes	☐ No
Does your spouse (or parents) ever complain about your involvement with drugs?	☐ Yes	☐ No

I certify that the above is truthful, accurate, and complete to the best of my knowledge; and that there may be an influence on my treatment plan by what I have written or omitted. I agree to inform my clinicians of any future changes or updates to my condition(s).

Printed Name: _____

Signature: _____ Date *(mm/dd/yyyy)*: _____