Psychiatric Associates, Inc.
6406 N Santa Fe Ave., Suite A Oklahoma City, OK 73116
Phone: 405-840-3793 Fax: 405-840-3794 Website: psychiatricinc.com

PERSONAL INFORMATION

NAME: _____ **DATE OF BIRTH:** _____
First Middle Last

PHONE NUMBER: _____ **EMAIL ADDRESS:** _____

GENDER: _____ **SOCIAL SECURITY #:** _____

ADDRESS: _____
Street Address **City, State** **Zip Code**

INSURANCE INFORMATION: (Must attach copies of front and back)

PRIMARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____ RELATIONSHIP: _____

BASIC INFORMATION

Please tell us about what you would like to address in your appointment and what your treatment goals are:

_____

_____

_____

What other medical illnesses do you currently have?

_____

_____

_____

EMPLOYMENT STATUS: **(Circle One)**

Unemployed Self-Employed Employed Student Retired Work Disabled Homemaker

EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____

COUNSELOR/THERAPIST/PSYCHIATRIST: _____

CURRENT RELATIONSHIP STATUS: **(Circle One)**

Married Single Divorced Widowed Same-Sex Relationship Committed Relationship Other

SUBSTANCE USE HISTORY (Circle One)

Are you currently seeking, or ever been through drug or alcohol treatment? **Y or N**

Have you ever felt the need to cut down your alcohol consumption? **Y or N**

MEDICAL HISTORY

Have you ever been hospitalized for mental health issues? (Circle One) YES NO

IF YOU ANSWERED YES: How many times have you been inpatient? _____

What facility? 1. _____ 2. _____

When were you there? 1. _____ 2. _____

Did you follow-up with a doctor when you left? **(Circle One) YES NO**

Are you currently having thoughts of suicide? (Circle One) YES NO

IF YES, please explain: _____

Have you had thoughts of hurting yourself or others in the past? YES NO

IF YES, please explain: _____

Is this appointment for disability, long term disablement, or FMLA paperwork? **YES NO** _____

SYSTEMS REVIEW

IN THE PAST MONTH, have you experienced any of the following?

Depressed Mood	Racing Thought	Excessive Worry	Unable to Enjoy Activities	Impulsivity
Increased risky behavior	Anxiety Attacks	Suicidal Thoughts	Loss of Interest	Increased Libido
Decreased Need for Sleep	Hallucinations	Forgetful	Suspiciousness	Change in Appetite
Fatigue	Excessive Energy	Thoughts of harming self or others	Increased Irritability	Crying Spells
Poor Concentration	Decreased libido	Sleep Difficulty	Excessive Daytime Drowsiness	Little Pleasure in Relationships

MEDICATION RECONCILIATION

Please list your CURRENT medications – Include prescriptions, over the counter, dietary and herbal supplements

Medication	Dose/Strength	Reason for Taking	Prescribing Doctor

IF YOU ARE NOT TAKING ANY MEDICATIONS, PLEASE INITIAL HERE: _____

Medication Review

IN THE PAST have you taken ANY of the following medications?
If so, how long did you take it and what was your experience with the medication?

ANTIDEPRESSANTS	**For how long?**	**How did you feel?**
Prozac (Fluoxetine)		
Paxil (Paroxetine)		
Zoloft (Sertraline)		
Celexa (Citalopram)		
Effexor (Venlafaxine)		
Wellbutrin (Bupropion)		
Lexapro (Escitalopram)		
Pristiq		
Cymbalta (Duloxetine)		
Viibryd		
Trintillex		
Remeron (Mirtazapine)		
MOOD STABILIZERS	**For how long?**	**How did you feel?**
Zypreza (Olanzapine)		
Geodone (Ziprazadone)		
Abilify (Aripiprazole)		
Seroquel (Quetiepine)		
Invega (Paliperidone)		
Saphris		
Risperdal (Risperidone)		
SLEEP	**For how long?**	**How did you feel?**
Lunesta (Eszopiclone)		
Ambien (Zolpidem)		
Restoril (Temazepam)		
Desyrel (Trazodone)		
ANXIETY	**For how long?**	**How did you feel?**
Ativan (Lorazepam)		
Xanax (Alprazolam)		
Klonopin (Clonazepam)		
Valium (Diazepam)		
Buspar (Buspirone)		
ADD/ADHD	**For how long?**	**How did you feel?**
Adderall (Dextro-Amphet)		
Ritalin (Methylphenidate)		
Vyvanse (Lisdeyamfetamine)		
Concerta (Methylpenadate)		
BIPOLAR	**For how long?**	**How did you feel?**
Depakote (Valproic Acid)		
Tegretol (Carbamazepine)		
Lamictal (Lamotrigine)		
Trileptal (Oxycarbazapine)		
Lithium		

IF YOU HAVE NOT TAKEN ANY MEDICATIONS IN THE PAST, PLEASE INITIAL HERE: _____

PHQ-9 Depression

IN THE LAST TWO WEEKS: how often have you been bothered by the following?	No Days	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead or off hurting your in some way?	0	1	2	3
Column Totals:	+	+	+	

Total Score: _____

INSTRUCTIONS

- Once we receive your information, it USUALLY takes the providers 1-5 days to review.
- After the providers have reviewed the information, we will call you to let you know if we will be able to schedule an initial, in-person consultation and with which provider.
- Once you have your appointment date and time, we will require additional paperwork which can be emailed to you and brought in at your consultation, or you can come in the office 15 minutes early on the appointment date to complete it.
- Please attach a copy of your ID and health insurance card to this paperwork or bring them into the office with you when you drop off this paperwork.

No-show and Late Cancellation Policy

We understand that you may need to cancel an appointment occasionally. In such circumstances, please contact us no later than 24 hours before your scheduled appointment time. You may do so by calling 405-840-3793.

If you do not show up for your appointment, or cancel or reschedule within 24 hours of your appointment time, we will consider that a no-show. ***No-show appointments may be subject to a $75 fee***. No-show fees are the patient's sole responsibility and must be paid in full before your next appointment. Three no-shows in a year will constitute a discharge from the practice. If the no-show fee might prevent you from receiving necessary care, please contact us.

We know that unexpected situations sometimes arise. In the case of emergencies or extenuating circumstances, we may waive the no-show fee. Waivers are determined on a case-by-case basis at the practice management's sole discretion.

Service Billing

Copayments, deductibles, or coinsurance are due at the time of service. If you are experiencing financial hardship, please reach out to the billing department at (405) 833-1880 for payment options.

Printed: _____ Date of birth: _____

Signature: _____ Date: _____