Amen Clinics
Adult Intake Questionnaires

In order for us to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your medical chart it is okay to refrain from including it here. Thank you!

PATIENT IDENTIFICATION

Patient's Name: _____SS#: _____ - _____ - _____ Sex: ☐ M ☐ F
Date of Birth: _____ Age: _____ Marital Status: _____
Race: _____ Religion: _____ Number of Children: _____
Home Address: _____
Home Phone: (_____)_____ Work/School Phone: (_____)_____
Cell Phone: (_____)_____ Fax Phone: (_____)_____
E-mail Address: _____ Occupation: _____ ☐ Student
Employer (School, if student): _____
Employer/School Address: _____

REFERRAL SOURCE

How did you first learn about the Amen Clinics? _____
Please complete the following if a professional referred you to our clinic.
Name: _____ Phone number: _____ Fax number: _____
Specialty/Credentials: _____
Address: _____

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems.)

_____
_____
_____
_____
_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? (What are your goals in being here?)

_____
_____
_____
_____
_____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY

Please indicate if you have attempted the following treatments and how many providers you have seen:

- Psychiatrist: _____
- Neurologist: _____
- Alternative/Holistic/Naturopathic (include type): _____
- Therapy (include type and duration): _____
- Psychiatric Inpatient Hospitalization (if multiple attempts include overall duration): _____
- Outpatient Treatment Program (if multiple attempts indicate overall duration): _____
- Other: _____

Please list any prior diagnoses: _____

_____

BIOLOGICAL INFORMATION – This section is about the physical processes that make you who you are.

PRESENT and PAST MEDICATIONS

We included a detailed list of most psychiatric medications on pages 5-6 to be used as a reference. The information the doctor needs to know in order to do a thorough evaluation is:

1. The name of the medication
2. The mg dose (e.g., 20 mg)
3. The number of tablets or mg you took each day
4. The approximate dates taken – preferably in sequential order
5. Whether the medicine worked well, worked partially, or did not work at all
6. If you took any medications in combination with other medications
7. Any side effects or adverse effects from the medication

If you need more room, please attach another sheet.

Dates Taken	**Medication** *Individual or Combinations* *Dosage(s) and time(s) taken per day*	**Effectiveness**	**Side-Effects/Problems**
Ex: 3/2000-12/2005	**Example** *Ritalin 5 mg twice a day* *Prozac 10 mg in the a.m.*	**Example** *Somewhat effective*	**Example** *Very unfocused, hyperactive in evenings; dry mouth*
Dates Taken	**Medication**	**Effectiveness**	**Side-Effects/Problems**

MEDICATION REFERENCE LIST

ADD Medications

Adderall/Adderall XR *4 amphetamine salts*	Concerta *methylphenidate*	Cylert *pemoline*	Daytrana *methylphenidate transdermal*
Desoxyn *methamphetamine HCL*	Dexedrine *dextroamphetamine*	Dexedrine Spansules *dextroamphetamine*	Dextrostat *dextroamphetamine*
Focalin *dexmethylphenidate*	Focalin XR *dexmethylphenidate hydrochloride*	Intuniv *guanfacine*	Metadate *methylphenidate*
Metadate CR *methylphenidate hydrochloride*	Methylin *methylphenidate*	Provigil *modafinil*	Ritalin *methylphenidate*
Ritalin LA *methylphenidate*	Ritalin SR *methylphenidate*	Strattera *atomoxetine*	Vyvanse *lisdexamfetamine*

Antidepressants

Anafranil *clomipramine hcl*	Asendin *amoxapine*	Celexa *citalopram*	Cymbalta *duloxetine HCl*
Desyrel *trazodone*	Effexor/Effexor XR *venlafaxine*	Elavil *amitriptyline*	Eldepryl *selegiline HCl*
EMSAM *selegiline transdermal system*	Lexapro *escitalopram*	Ludiomil *maprotiline*	Luvox *fluvoxamine*
Marplan *isocarboxazid*	Nardil *phenelzine*	Norpramin *desipramine*	Pamelor *nortriptyline*
Parnate *tranylcypromine*	Paxil/Paxil CR *paroxetine*	Pristiq *desvenlafaxine extended release*	Prozac *fluoxetine*
Remeron *mirtazapine*	Serzone *nefazodone*	Sinequan *doxepin*	Surmontil *trimipramine*
Tofranil *imipramine*	Vivactil *protripfyline*	Wellbutrin/Wellbutrin SR or XL *bupropion*	Zoloft *sertaline*

Anti-Anxiety Medications

Ativan *lorazepam*	BuSpar *buspirone*	Klonopin *clonazepam*	Librium *chlordiazepoxide*
Serax *oxazepam*	Tranxene *clorazepate*	Valium *diazepam*	Visatril *hydroxyzine*
Xanax *alprazolam*			

Mood Stabilizers

Depakene *valproic acid*	Depakote *divalproex*	Dilantin *phenytoin*	Donnatal *phenobarbital*
Gabitril *tigabine*	Keppra *levetiracetam*	Lamictal *lamotrigine*	Lithium/Eskalith *lithium carbonate*
Lyrica *pregablin*	Neurontin *gabapentin*	Tegretol/Carbatrol/Tegretol XR *carbamazepeine*	Trileptal *oxcarbazepine*
Topamax *topiramate*	Zonegran *zonisamide*		

Anti-Tic Hypertensive Medications

Catapres *clonidine*	Inderal *propranolol*	Tenex *guanfacine*	

Anti-Psychotic Medications

Abilify *aripiprazole*	Clozaril *clozapine*	Geodon *ziprasidone HCl*	Haldol *haloperidol*
Invega *paliperidone*	Latuda *lurasidone*	Moban *molindone*	Navane *thiothixene*
Orap *pimozide*	Prolixin *fluphenazine*	Risperdal *risperidone*	Saphris *asenapine*
Serentil *mesoridazine*	Seroquel *quetiapine*	Stelazine *trifluoperazine*	Symbyax *olanzapine/fluoxetine HCl*
Trilafon *perphenazine*	Zydis *olanzapine*	Zyprexa *olanzapine*	

Movement Disorders

Artane *trihexyphenidyl*	Benadryl *diphenhydramine*	Cogentin *benztropine*	Symmetrel *amantadine*

Memory/Alzheimer's Medications

Aricept *donepezil HCl*	Exelon *revastigmine tartrate*	Namenda *memantine*	Reminyl - now Razadyne ER *galantamine HBR*

Sleep Aids

Ambien/Ambien CR *zolpidem tartrate*	Dalmane *flurazepam*	Desyrel *trazodone*	Doral *quazepam tablets*
Halcion *triazolam*	Lunesta *zopiclone*	ProSom *estazolam*	Restoril *temazepam*
Rohypnol *flunitrazepam*	Rozerem *ramelteon*	Sonata *zaleplon*	

Weight Loss

Fenfluramine *fenfluramine hydrochloride*	Meridia *sibutramine hydrochloride monohydrate*	Phentermine *phenethylamine*	

Sexual Dysfunction

Cialis *tadalafil*	Levitra *Cardenafil HCl*	Viagra *sildenafil citrate*	

Pain Medications

Avinza *morphine sulfate extended release*	Darvocet *propoxyphene*	Darvon *propoxyphene*	Fentanyl *fentanyl citrate*
Kadian *morphine sulfate extended release*	Oxycontin *oxycodone*	Percocet *oxycodone HCl/APAP CII*	Percodan *aspirin / hydrocodone*
Roxanol *morphine sulfate*	Vicodin *hydrocodone*		

PRESENT and PAST SUPPLEMENTS

Dates Taken	**Supplement** *Individual or Combinations*	**Effectiveness**	**Side-Effects/Problems**
Ex: 3/2000-12/2005	**Example** *SAMe 200 mg twice a day*	**Example** *Effective*	**Example** *Dry mouth*

MEDICAL HISTORY

Name of primary care physician: _____
Prior hospitalizations: _____
Allergies/drug intolerances (describe): _____
Date of last physical exam: _____ Height: _____ Weight: _____ Waist size: _____
For females, date started last menstrual period, if menstruating: _____
History of seizures or seizure-like activity? _____
_____
Exposure to environmental toxins (mold, fumes, etc.)? _____

Head Injury/Trauma: Please indicate if you have a history of the following:

- ❑ Falls
- ❑ Motor vehicle accidents
- ❑ Assaults
- ❑ Sports-related concussions
- ❑ Loss of consciousness
- ❑ Altered consciousness, such as seeing stars, forgetfulness, etc.
- ❑ Describe anything checked above, list date or approximate age: _____
  _____
  _____

Abnormal Test & Labs: Please indicate if you have a history of the following tests or examinations:

N=No, Y= Yes			Date	Abnormality
N	Y			
☐	☐	Blood Work	_____	_____
☐	☐	EKG	_____	_____
☐	☐	EEG	_____	_____
☐	☐	CT Scan	_____	_____
☐	☐	PET Scan	_____	_____
☐	☐	MRI/fMRI Scan	_____	_____
☐	☐	SPECT Scan	_____	_____
☐	☐	Quantitative EEG	_____	_____
☐	☐	Echocardiogram	_____	_____
☐	☐	Holter Monitor	_____	_____
☐	☐	Carotid Ultrasound	_____	_____
☐	☐	Other: _____		

Prenatal and Birth Events:

Your parents' attitudes toward their pregnancy with you: _____
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc.): _____
Any birth problems, trauma, forceps, or complications? _____
_____

Medical Review

Please place a check mark in the box/boxes that apply. (C = Current, P = Past)

General

C P
- ☐ ☐ Being overweight
- ☐ ☐ Weight loss
- ☐ ☐ Sensitive to hot or cold
- ☐ ☐ Cold or hot spells
- ☐ ☐ Fatigue
- ☐ ☐ Lowered resistance to infection
- ☐ ☐ Flu-like or vague sick feeling
- ☐ ☐ Night sweats
- ☐ ☐ Daytime sweating
- ☐ ☐ Excessive thirst
- ☐ ☐ Other: _____

Neurological

C P
- ☐ ☐ Seizures
- ☐ ☐ Dizziness
- ☐ ☐ Vertigo
- ☐ ☐ Muscle spasms or tremors
- ☐ ☐ Slurred speech
- ☐ ☐ Speech problems
- ☐ ☐ Muscle weakness
- ☐ ☐ Other: _____

Respiratory

C P
- ☐ ☐ Asthma, wheezing
- ☐ ☐ Cough
- ☐ ☐ Coughing up blood or sputum
- ☐ ☐ Shortness of breath
- ☐ ☐ Rapid breathing
- ☐ ☐ Repeated nose or chest colds
- ☐ ☐ Other: _____

Chest and Cardiovascular

C P
- ☐ ☐ Ankle swelling
- ☐ ☐ Rapid/irregular pulse
- ☐ ☐ High cholesterol
- ☐ ☐ Low cholesterol
- ☐ ☐ Breast tenderness
- ☐ ☐ Chest pain
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Stroke
- ☐ ☐ Other: _____

Head, Eye, Ear, Nose, & Throat

C P
- ☐ ☐ Facial pain
- ☐ ☐ Headaches
- ☐ ☐ Neck pain or stiffness
- ☐ ☐ Frequent sore throat
- ☐ ☐ Blurred or double vision
- ☐ ☐ See spots or shadows
- ☐ ☐ Hearing loss
- ☐ ☐ Ear ringing
- ☐ ☐ Chronic ear infections
- ☐ ☐ Disturbances in smell
- ☐ ☐ Dry mouth
- ☐ ☐ Sore tongue
- ☐ ☐ Other: _____

Gastrointestinal and Hepatic

C P
- ☐ ☐ Nausea or vomiting
- ☐ ☐ Abdominal (stomach/belly) pain
- ☐ ☐ Anal itching
- ☐ ☐ Painful bowel movements
- ☐ ☐ Infrequent bowel movements
- ☐ ☐ Liquid bowel movements
- ☐ ☐ Loss of bowel control
- ☐ ☐ Frequent belching or gas
- ☐ ☐ Vomiting blood
- ☐ ☐ Rectal bleeding (red or black blood)
- ☐ ☐ Jaundice (yellowing of skin)
- ☐ ☐ Other: _____

Musculoskeletal

C P
- ☐ ☐ Arthritis
- ☐ ☐ Back pain or stiffness
- ☐ ☐ Bone pain
- ☐ ☐ Joint pain or stiffness
- ☐ ☐ Leg pain
- ☐ ☐ Muscle cramps or pain
- ☐ ☐ Other: _____

Skin and Hair

C P
- ☐ ☐ Dry hair or skin
- ☐ ☐ Itchy skin or scalp
- ☐ ☐ Easy bruising
- ☐ ☐ Hair loss
- ☐ ☐ Increased perspiration
- ☐ ☐ Sun sensitivity
- ☐ ☐ Other: _____

Genitourinary

C P
- ☐ ☐ Itchy privates or genitals
- ☐ ☐ Painful urination
- ☐ ☐ Excessive urination
- ☐ ☐ Decreased sexual desire
- ☐ ☐ Other: _____

Females

C P
- ☐ ☐ No menses
- ☐ ☐ Menstrual irregularity
- ☐ ☐ Painful or heavy periods
- ☐ ☐ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, and headache
- ☐ ☐ Painful intercourse or sex
- ☐ ☐ Sterility/infertility
- ☐ ☐ Abnormal vaginal discharge
- ☐ ☐ Other: _____

Males

C P
- ☐ ☐ Impotence (weak male erection)
- ☐ ☐ Inability to ejaculate or orgasm
- ☐ ☐ Scrotal pain
- ☐ ☐ Abnormal penis discharge
- ☐ ☐ Other: _____

Illnesses

C P
- ☐ ☐ Pneumonia
- ☐ ☐ Hypothyroidism
- ☐ ☐ Hyperthyroidism
- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Fibromyalgia
- ☐ ☐ Encephalitis
- ☐ ☐ Meningitis
- ☐ ☐ Lyme Disease
- ☐ ☐ Lupus
- ☐ ☐ Epstein - Barr virus (Mononucleosis)
- ☐ ☐ Fevers over 105°
- ☐ ☐ Autoimmune Disorder
- ☐ ☐ Other: _____

Surgical Procedures

- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Myringotomy (ear tubes)
- ☐ Appendectomy
- ☐ Hernia repair
- ☐ Other: _____

Diet and Exercise History:

Would you consider your diet mostly healthy or unhealthy? _____

Food allergies/sensitivities: ☐ Yes ☐ No – If yes, please list: _____

Are you currently on a restricted diet (vegetarian, high protein only, etc)? ☐ Yes ☐ No

If yes, please list restrictions: _____

Any experience with a gluten-free diet? ☐ Yes ☐ No – If yes, please list results: _____

Any experience with a casein-free diet? ☐ Yes ☐ No – If yes, please list results: _____

Caffeine consumption per day (coffee, soda, tea, chocolate, etc.): _____

How many days a week do you eat fruits: _____ vegetables: _____ breakfast: _____

Describe your current bowel function: _____

Describe your current exercise regimen: _____

Alcohol and Drug History:

Do you or have you ever experienced withdrawal symptoms from alcohol or drugs? _____

Has anyone told you they thought you had a problem with drugs or alcohol? _____

Have you ever felt guilty about your drug or alcohol use? _____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____

Have you ever used drugs or alcohol first thing in the morning? _____

If you have used or experimented with any of the following, please list the age you started, the extent of your use, and how the substance made you feel (benefits, side effects, or changes to mood).

C= Current, P= Past

C	P	
☐	☐	Alcohol (hard liquor, beer, wine): _____
☐	☐	Nicotine (cigarettes, cigars, tobacco chew): _____
☐	☐	Marijuana or hash: _____
☐	☐	Inhalants (glue, gasoline, cleaning fluids, etc): _____
☐	☐	Cocaine or crack: _____
☐	☐	Amphetamines: _____
☐	☐	Crank or ice: _____
☐	☐	Steroids: _____
☐	☐	Opiates (heroin, oxycodone, morphine, other pain killers): _____
☐	☐	Barbiturates: _____
☐	☐	Hallucinogens (LSD, mescaline, mushrooms, ecstasy): _____
☐	☐	Prescription tranquilizers or sleeping pills: _____
☐	☐	Other: _____

Sleep Behavior:

Problems falling asleep? _____

Problems staying asleep? _____

Problems waking up? _____

On average, how many hours do you sleep per night? _____

History of sleepwalking, recurrent dreams, sleep apnea, heavy snoring, or sleep bruxism (grinding your teeth)? _____

_____
_____
_____
_____

Biological Mother's History: ☐ Living; Age: ____ ☐ Deceased; Age: ____ Cause of death: _____
Marriages: _____ Highest level of education: _____ Occupation: _____
Medical problems (include heart problems, sudden death, congenital disorders): _____
_____
Behavioral/emotional problems: _____
Has mother ever had learning or psychiatric problems? ☐ Yes ☐ No
If yes, please explain and indicate if treatment was sought: _____
_____
Alcohol/drug use history: _____
_____
Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations? (Specify): _____
_____

Biological Father's History: ☐ Living; Age: ____ ☐ Deceased; Age: ____ Cause of death: _____
Marriages: _____ Highest level of education: _____ Occupation: _____
Medical problems (include heart problems, sudden death, congenital disorders): _____
_____
Behavior/emotional problems: _____
Has father ever had learning or psychiatric problems? ☐ Yes ☐ No
If yes, please explain and indicate if treatment was sought: _____
_____
Alcohol/drug use history: _____
_____
Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations? (Specify): _____
_____

Patient's Siblings (Include names, ages, relationship to you and indicate if any of your siblings ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations): _____
_____
_____
_____

Patient's Children (Include names, ages and if any of your children have ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts,

or psychiatric hospitalizations): _____

_____

_____

_____

PSYCHOLOGICAL INFORMATION – This section includes how you think, body image, significant developmental events, and any past psychological traumas.

Describe your predominant (or most frequent) thought patterns (positive, negative, trusting, suspicious) and feeling patterns (anxious, sad, depressed, etc.): _____

_____

_____

Significant developmental events: (Please include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.) _____

_____

_____

Significant perceived successes: _____

_____

Significant perceived failures: _____

_____

What was your relationship like with your mother as a child and teen, and now? _____

_____

_____

_____

What was your relationship like with your father as a child and teen, and now? _____

_____

_____

_____

Sexual History: (Please answer only as much as you feel comfortable.)
Age at the time of first sexual experience: _____ Number of sexual partners: _____
History of sexually transmitted disease: _____ History of abortion: _____
History of sexual abuse, molestation, or rape: _____
Current sexual problems: _____

Do you have a history of being physically or emotionally abused? _____

_____

_____

Describe your body image or perception of how you look: _____

_____

Describe your strengths: _____

_____

Describe your hope for the future: _____

_____

SOCIAL INFORMATION

Current Life Stressors: (Include anything that is currently stressful for you, examples include relationships, job, school, finances, children.) _____

_____

_____

School History: Highest level of education: _____ Last school attended: _____
Average grades received: _____ Learning strengths: _____
Specific learning disabilities: _____
Behavioral problems in school: _____
What have teachers said about you? _____

Employment History: (Summarize jobs you've had, list most favorite and least favorite.)

_____

_____

Work-related problems: _____
What would your employers or supervisors say about you? _____

Military History: _____

Legal Problems: (Include traffic violations.) _____

_____

Family Structure: (Who lives in your current household? Please describe how you get along with each person.) _____

_____

Current Marital or Relationship Satisfaction: _____

_____

History of Past Marriages: _____

Cultural/Ethnic Background: _____

Describe your relationships with your family, friends, and the people with whom you spend the most time: _____

Describe the health of your family, friends, and the people with whom you spend the most time:

Community Connection: (Are you connected to your community? Do you have experience and/or interest in volunteering?) _____

SPIRITUAL INFORMATION – This section is about meaning and purpose.

What is your spiritual background? _____

What motivates you to be healthy? _____

What is your purpose in life? _____

Do you consistently act in a way that is consistent with your goals in life? _____

What spiritual practices have you tried, such as meditation/prayer, etc.? _____

Have you had any unusual spiritual experiences, including out of body or near death experiences?