MICHIGAN INTEGRATIVE PSYCHIATRY, PC
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PATIENT INFORMATION FORM

~Please Print Clearly~

DATE: ________________________

PATIENT NAME: ____

BILLING ADDRESS: _________________________________CITY,STATE,ZIP _____________________

PERMANENT ADDRESS: _____________________________ CITY,STATE,ZIP ____________________

TELEPHONE: HOME: ________________WORK: _________________CELL: ____________________
EMAIL ADDRESS: ____

GENDER: MALE FEMALE
BIRTH DATE: ______________________ AGE: __________________

PATIENT SOC.SEC.# (FOR INSURANCE): ______________________________________

HOW DID YOU HEAR ABOUT US?: ____

ARE YOU: Single Married Divorced Widow/er

ARE YOU: Employed Full-time Student Part-time Student Unemployed Other

EMPLOYER/SCHOOL: ____

EMERGENCY CONTACT NAME/ADDRESS/PHONE: ____
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INSURANCE INFORMATION: Please also provide your insurance card for copying.

Primary Insurance:
Insurance Co.Name:_____________________
Ins.Co.Address:_________________________
Policy Holder Name:_____________________
Relationship to Patient:__________________
Employer: ______________________________
Policy No.:______________________________
Group Claim No.: _______________________
Policy Holder Sex: Female or Male
Policy Holder DOB: ______________________
Copay$ __________ Deductible$ __________

Secondary Insurance:
Insurance Co. Name: ________________________
Ins.Co.Address: _____________________________
Policy Holder Name: _________________________
Relationship to Patient: ______________________
Employer: ___________________________________
Policy No.: _________________________________
Group Claim No.: _____________________________
Policy Holder Sex: Female or Male
Policy Holder DOB: ___________________________
Copay$____________ Deductible$ _____________
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With whom do you currently live? ___

Primary Care Medical Provider: ___
Office Location & Phone #: ___

The main reason you are seeking evaluation and treatment:

___
___
___

How long have you had these symptoms or problems? ___

What is your goal for coming here? ___
___

Please describe any significant current life stress (e.g., relationship problems, health problems, job or school issues, career changes, recent move or other changes):

___
___
___

Psychiatric Treatment History:
Please list previous health care providers from whom you have sought treatment for psychiatric conditions. Types of therapies may include psychotherapy, counseling, medical treatment, or complementary/alternative therapies. Please also list any history of psychiatric hospitalizations or intensive treatments. Use back of page if necessary for more room:

Year + Length of Time	Name of Provider	Location	Type of Treatment	Helpful/ Not Helpful

Please list any current or past PSYCHIATRIC medications or herb/supplement treatments (use back of page if necessary for more room):

Medication/ Supplement	Dates Taken	Reason	Dosage	Effectiveness	Side Effects/ Problems

Medication/ Supplement	Dates Taken	Reason	Dosage	Effectiveness	Side Effects/ Problems

Medical History:

Please list any current or past medical issues, including surgeries: ______________________________

____

____

____

____

Please list any history of neurological problems if not noted above (e.g., head trauma, seizures, strokes, multiple sclerosis):

____

____

Are you currently having any physical symptoms of any kind? If so, please describe:

____

____

Please list any current NON-PSYCHIATRIC medications, herbs or supplements you are taking (use back of page if necessary for more room):

Medication/ Supplement	Dates Taken	Reason	Dosage	Effectiveness	Side Effects/ Problems

Medication/ Supplement	Dates Taken	Reason	Dosage	Effectiveness	Side Effects/ Problems

Any significant allergies or sensitivities to medications, foods, or environments? Please describe:

____

____

____

Family History:

Please list any family history of psychiatric conditions, including drug/alcohol abuse or suicide attempts, and which family member had this:

____

____

____

If a family member had a psychiatric condition that was treated, what was the treatment (e.g., medication type, therapy type) and was the treatment helpful? ______________________________

____

Please list any family history of major medical conditions, and which family member had this:

____

____

____

Substance History:

Do you use caffeine (in the form of coffee, tea, pills, chocolate)? If yes, how much and how often?

____

Do you smoke or chew tobacco? If yes, how much and how often? If you have quit, then how long ago? ______________________________

Do you currently use alcohol? If so, how much and how often? ______________________________

____

Have you ever had a problem with alcohol use? If yes, please describe: ______________________________

____

Please list any other drugs you have used, and the nature of your use:

____

____

____

Prenatal / Childhood / Education / Employment/ Trauma History:

Please list any known complications for you during the prenatal/pregnancy period (e.g., maternal drug use, infections, maternal diabetes, low oxygen, premature):

____

Please describe your school years and list any problems you may have had (e.g., emotional, behavioral, grades, peers, bullies, learning disabilities):

____

____

____

Highest grade (and degree, if applicable) completed:

____

What is your current occupation, and for how long have you been there? If retired, disabled, or unemployed, what was your last job? ____________________

____

Are you having any work related issues? If so, please describe: ____________________

____

____

History of military service: ____________________

History of legal problems or unlawful behaviors:

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____

Please describe any history of physical, emotional, or sexual abuse, or any life-threatening experience (such as a major auto accident, life-threatening illness, military trauma, or natural disaster). How do these events still affect you now?:

____

____

____

____

Relationship History:

Do you currently have a "significant other"? If yes, how would you describe your current relationship with that person?

____

____

Do you have any children? If so, please list son(s), daughter(s), and their ages:

____

Spirituality:

Do you have a spiritual practice or religious faith? If so, please describe: ____________________

____

General:

What are your strengths and gifts?

Is there anything else that is important for me to know about you?

Thank You for taking the time and care to fill out this form! This will help me get to know you better and will help us develop a clear plan for treatment towards deeper health and wellness.

Please continue to pages 7 through 10, to fill out a checklist of information related to specific symptoms and experiences you may have. It contains 79 items - lengthy, but will allow us to spend more time moving into your treatment plan during our first session.

Please rate yourself on each of the items below as to how much they apply to you, per the following scale:

U	0	1	2	3	4	N/A
Unknown	Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable

If possible, to give us a more complete picture, please have another person who knows you well (such as a parent, spouse, partner, close friend, or family member) rate you also. Please list the other person and their relationship to you: ____

Self	Other	
_____	_____	1. Depressed or sad mood most of the time.
_____	_____	2. Frequent negative thoughts.
_____	_____	3. Decreased interest in things that are usually fun or joyful.
_____	_____	4. Low energy.
_____	_____	5. Low appetite.
_____	_____	6. High appetite.
_____	_____	7. Cannot sleep well.
_____	_____	8. Sleeps too much.
_____	_____	9. Feel irritable or agitated.
_____	_____	10. Have feelings of worthlessness.
_____	_____	11. Feel hopeless.
_____	_____	12. Decreased concentration ability.
_____	_____	13. Crying spells.
_____	_____	14. Withdrawn or disinterested in being with others.
_____	_____	15. Excessive feelings of guilt.
_____	_____	16. Thoughts of suicide.
		*************
_____	_____	17. Periods of elevated or high mood without the use of substances or drugs.
_____	_____	18. Periods of very high self-esteem or grandiose thinking.

_____ _____ 19. Periods of excessive energy and/or racing thoughts.

_____ _____ 20. Periods of decreased need for sleep without feeling tired.

_____ _____ 21. Periods of being excessively talkative or a sense of pressure to talk excessively.

_____ _____ 22. Periods of impulsive behaviors or excessive pleasure seeking which may seem to most to be poor judgment (eg, Excessive spending, foolish business ventures, excessive gambling, sexual indiscretions).

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_____ _____ 23. Panic attacks, which are episodes of intense, uncontrollable fear accompanied by physical symptoms such as: difficulty breathing, heart pounding, sweats, shaking, tremors, choking sensation, nausea, numbness in hands or feet, chest pain.

_____ _____ 24. Avoidance of everyday places, unfamiliar places or situations.

_____ _____ 25. Avoidance or anxiety of social situations from a fear of being embarrassed or judged.

_____ _____ 26. Tendency to “freeze” in anxiety-provoking situations.

_____ _____ 27. Shy or timid.

_____ _____ 28. Very sensitive to criticism.

_____ _____ 29. Tics (motor or vocal).

_____ _____ 30. Frequent feelings of nervousness or anxiety.

_____ _____ 31. Persistent and excessive phobias (eg, Heights, closed-in spaces, specific animals, etc.). Please list: ____

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_____ _____ 32. Recurrent bothersome thoughts, ideas, or images.

_____ _____ 33. Gets “stuck” in the same thought (obsessively ruminates).

_____ _____ 34. Excessive or senseless worrying.

_____ _____ 35. Repetitive negative thoughts.

_____ _____ 36. Tendency to always pick out something that is wrong with a situation, place or person.

_____ _____ 37. Difficulty with flexibility or getting upset or anxious when things do not go your way.

_____ _____ 38. Tendency toward compulsive behaviors, such as repetitive checking, counting, or washing.

_____ _____ 39. Tendency to be oppositional or argumentative.

_____ _____ 40. Excessive resistance or dislike of change.

_____ _____ 41. Tendency to hold grudges.

_____ _____ 42. Need to have things done in just a certain way or becomes upset or anxious.

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_____ _____ 43. Recurrent or upsetting thoughts or re-experiencing of a past traumatic event.
Please list: ____

_____ _____ 44. Sense of fear or panic when experiencing events or places that resemble a past traumatic event.

_____ _____ 45. Recurrent upsetting dreams or nightmares.

_____ _____ 46. Inability to recall the events of a past traumatic event.

_____ _____ 47. Sense of numbness or restriction of emotions or feelings.

_____ _____ 48. Easily startled.

_____ _____ 49. A sense that you are almost always on guard for the next bad or traumatic event to happen.

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_____ _____ 50. Trouble sustaining attention or concentration in everyday activities such as work, school, classes, meetings, conversation, reading, etc.

_____ _____ 51. Easily distracted.

_____ _____ 52. Difficulty completing tasks or projects.

_____ _____ 53. Feeling overwhelmed by tasks of everyday living.

_____ _____ 54. Difficulty with keeping organized.

_____ _____ 55. Poor attention to details, such as leaving out letters or words when writing or speaking, careless mistakes.

_____ _____ 56. Procrastinates and avoids activities and tasks that take sustained mental effort or are not exciting such as homework, projects, paperwork, paying bills, reading, etc.

_____ _____ 57. Impatient, has difficulty waiting or is easily frustrated.

_____ _____ 58. Tendency to change subjects or ideas quickly.

_____ _____ 59. Acts impulsively without considering consequences for actions.

_____ _____ 60. Makes comments before considering their impact.

_____ _____ 61. Tends to be restless or fidgety.

_____ _____ 62. Easily bored.

_____ _____ 63. Tendency towards being hyperactive and/or talking excessively.

_____ _____ 64. Feels spacey or “in a fog”.

_____ _____ 65. Feels apathetic or unmotivated.

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_____ _____ 66. Prone to frequent rages with little provocation.

_____ _____ 67. Often misinterprets comments as negative when they are not intended to be.

_____ _____ 68. Periods of spaciness or confusion.

_____ _____ 69. Periods of panic or fear for no specific reason.

_____ _____ 70. Brief visual or auditory hallucinations, such as seeing shadows or hearing muffled sounds.

_____ _____ 71. Frequent headaches.

_____ _____ 72. Dark thoughts, may involve suicidal or homicidal ideas.

_____ _____ 73. Periods of forgetfulness.

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_____ _____ 74. Delusional or bizarre thoughts (thoughts you know others would think are false).

_____ _____ 75. Perceptions not as others perceive, such as seeing objects or hearing sounds.

_____ _____ 76. Peculiar or odd beliefs and/or behaviors.

_____ _____ 77. Lack of personal grooming and/or hygiene.

_____ _____ 78. Frequent feelings that someone is out to hurt or discredit you.

_____ _____ 79. Repetitive speech or behavior.

Thank You for filling out this checklist. It will help in developing your treatment plan.