Mindspring Health Inc.
1074 Ponce De Leon Ave NE Atlanta, GA 30306
49B Lenox Pointe NE Atlanta, GA 30324
404-333-8829 (P)
980-495-8849 (F)
info@mindspringhealth.com

NEW PATIENT INTAKE FORM

Please fill out the following form to the best of your ability. Some sections may not apply to you. We will discuss your responses in greater detail during your first appointment.

First Name: _____ Middle Name: _____ Last Name: _____	Date of Birth: ____ /____ / _____	
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed	Age: _____	Sex: ☐ Male ☐ Female ☐ Non-binary ☐ Other _____
Race/Ethnicity: _____		

Address and Contact Info

Billing Street Address:_____
City:_____ State:_____ Postal Code:_____
Country:_____ Email _____
Address:_____
Direct Telephone: (_____)_____-_____

Preferred Pharmacy Information

Address:_____
City:_____ State:_____ Postal Code:_____
Country:_____
Direct Telephone: (_____)_____-_____

Do you have a current psychiatrist? Name/Address/Phone
_____
_____
_____

Do you have a current therapist? Name/Address/Phone
_____
_____
_____

Reason(s) for seeking treatment at this time:
_____
_____
_____

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Current Symptoms include (check all that apply):

□ No problems or concerns
□ Depressed mood
□ Unable to enjoy activities
□ Sleep pattern disturbance
□ Loss of interest
□ Change in appetite
□ Excessive guilt
□ Concentration/forgetfulness
□ Decreased libido
□ Suicidal thoughts
□ Fatigue/Low energy
□ Low self esteem
□ Violent thoughts
□ Racing thoughts
□ Impulsivity
□ Increased risky behavior
□ Increased libido
□ Decreased need for sleep
□ Excessive energy
□ Increased irritability
□ Crying spells
□ Pain
□ Memory problems
□ Stress
□ Flashbacks
□ Nightmares
□ Nervousness, tension
□ Anxiety or panic attacks
□ Fears, phobias
□ Obsessions/compulsions
□ Hallucinations
□ Suspiciousness
□ Disorganized/ illogical thoughts
□ Anger/temper problems
□ Attention problems
□ Avoidance
□ Other symptoms/concerns:

_____

_____

_____

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How long have these symptoms been present?

_____

What are your treatment goals?

_____
_____
_____

Recent Stressful Life Events:
Check any of the following events that have occurred during the last 2 years.
□ Married
□ Divorced
□ Child left home
□ Adoption
□ Miscarriage
□ Problems or changes at work/school
□ Legal problems
□ Engaged
□ Arguments /conflicts
□ Death of spouse, significant other
□ Infertility
□ Injury or significant illness
□ Lost or changed job, retired
□ Financial difficulties
□ Separated
□ Breakup of important relationship
□ Loss of a child
□ Pregnancy
□ Sexual difficulties
□ Changed residence
□ Other:

_____
_____
_____

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Past Medical History:

Medication Allergies _____ Other Allergies _____ Current Weight _____
Height _____ Date & Location of last physical exam _____
Have you had a recent EKG? □ Yes □ No If Yes, was the EKG □ Normal □ Abnormal When?_____

Please list all current medical problems:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you had any non-psychiatric hospitalizations or surgeries? Please describe:

_____
_____
_____

Please check all medical problems that you or a family member has had in the past?			
	You	**Family**	**Which Family Member?**
Thyroid Disease	□	□	
Anemia	□	□	
Liver Disease	□	□	
Chronic Fatigue	□	□	
Kidney Disease	□	□	
Diabetes	□	□	
Asthma/respiratory problems	□	□	
Stomach or intestinal problems (inflammatory bowel, GERD, Celiac)	□	□	
Cancer (type)	□	□	
Fibromyalgia	□	□	
Heart Disease	□	□	
Autoimmune Disorders (lupus, multiple sclerosis)	□	□	
Seizures	□	□	
Chronic Pain	□	□	
High Cholesterol	□	□	
High Blood Pressure	□	□	
Head Trauma	□	□	
Genetic disorder (e.g. sickle cell, cystic fibrosis)	□	□	

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Migraines	□	□	
Skin problems (eczema, psoriasis)	□	□	
Other (please list):	□	□	

Review of Systems:

Gastrointestinal: Have you had problems with a sensitive stomach, reflux, diarrhea, constipation, or ulcers? □ Yes □ No
Any history of ulcers? □ Yes □ No
Problems with high or low blood sugar? □ Yes □ No

Hormonal: Have you had any problems with weight gain, dry skin, or sluggishness? □ Yes □ No
Did you develop normally into adolescence? □ Yes □ No
For women: do you have normal menstrual cycles? □ Yes □ No

Immune: Do you get sick and catch colds easily or frequently? □ Yes □ No
Have you taken a lot of antibiotics in your life? □ Yes □ No
Do you have problems with seasonal or food allergies? □ Yes □ No

Musculoskeletal: Do you have any problems with achy muscles or joints? □ Yes □ No
Weak bones? □ Yes □ No

Genitourinary: Do you experience problems with urination, water balance? □ Yes □ No
Any problems with libido and/or sexual function? □ Yes □ No
Any history of bladder or kidney infections? □ Yes □ No

For women only:
Date of last menstrual period _____
Are you currently pregnant or think you might be pregnant? □ Yes □ No
Are you planning to get pregnant in the near future? □ Yes □ No
Birth control method _____
How many times have you been pregnant? _____ Full term births _____ Preterm births _____
Abortions/miscarriages _____ Living children _____
Have you gone through menopause? _____ When? _____

Current Medications:

Please list your current medications **(include prescription, over the counter, supplements and herbs)**:

Medication	Dosage & Frequency	Reason for Medication	Is it helpful?

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Past Psychiatric History:

Have you had outpatient psychiatric treatment in the past?			
Reason	Dates Treated	By Whom	Nature of Treatment (Medications, therapy, etc.)

	YES	NO	If YES, please describe:
Have you ever been hospitalized for psychiatric reasons?	☐	☐	
Have you ever had thoughts about death or wanting to die? Have you ever threatened to hurt yourself?	☐	☐	

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History of suicide attempts or suicidal gestures?	☐	☐	
History of self-harm (e.g. cutting)?	☐	☐	

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and whether they were helpful (as best you are able to remember)	
ANTIDEPRESSANTS:	**ANTI-ANXIETY:**
Anafranil (clomipramine)	Ativan (lorazepam)
Celexa (citalopram)	Buspar (buspirone)
Cymbalta (duloxetine)	Klonopin (clonazepam)
Effexor (venlafaxine)	Inderal (propranolol)
Elavil (amitriptyline)	Librium (chlordiazepoxide)
Fetzima (levomilnacipran)	Valium (diazepam)
Lexapro (escitalopram)	Vistaril (hydroxyzine)
Luvox (fluvoxamine)	Xanax (alprazolam)
Pamelor (nortriptyline)	Other (Name_____)
Paxil (paroxetine)	**MOOD STABILIZERS / ANTI-EPILEPTICS:**
Pristiq (desvenlafaxine)	Depakote (valproate)
Prozac (fluoxetine)	Dilantin (phenytoin)
Remeron (mirtazapine)	Eskalith / Lithobid (lithium)
Serzone (nefazodone)	Keppra (levetiracetam)
Trintellix /Brintellix (vortioxetine)	Lamictal (lamotrigine)
Viibryd (vilazodone)	Neurontin (gabapentin)
Wellbutrin / Zyban (buproprion)	Tegretol (carbamazepine)
Zoloft (sertraline)	Topamax (topiramate)
Other (Name: _____)	Trileptal (oxcarbazepine)
ANTIPSYCHOTICS:	Other (Name_____)
Abilify (aripiprazole)	**STIMULANTS / ADHD Meds:**
Fanapt (iloperidone)	Adderall (amphetamine mixture)
Geodon (ziprasidone)	Dexedrine (dextroamphetamine)
Haldol (haloperidol)	Focalin (dexmethylphenidate)
Invega (paliperidone)	Intuniv / Tenex (guanfacine)
Latuda (lurasidone)	Nuvigil (armodafinil)
Risperdal (risperidone)	Provigil (modafinil)
Saphris (asenapine)	Ritalin / Concerta (methylphenidate)
Seroquel (quetiapine)	Strattera (atomoxetine)
Zyprexa (olanzapine)	Vyvanse (lisdexamfetamine)
Other (Name_____)	Other (Name_____)
SLEEP AIDS:	**NATURAL SUPPLEMENTS/MEDICAL FOODS:**
Ambien (zolpidem)	5-hydroxtryptophan
Belsomra (suvorexant)	Deplin (L-methylfolate)
Desyrel (trazodone)	Melatonin

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Lunesta (eszopiclone)	Omega-3 fatty acids
Restoril (temazepam)	S-adenosyl methionine (SAM-e)
Rozerem (ramelteon)	St. Johns Wort
Sinequan (doxepin)	Valerian
Sonata (zaleplon)	Vayarin
Other (Name_____)	Other (Name_____)

Treatment Resistant/Neuromodulation Treatments:

ECT:
Have you ever undergone Electroconvulsive Therapy (ECT)? □ Yes □ No
If Yes, How many treatments? _____
Location/Institution? _____
Response? _____

rTMS (repetitive Transcranial Magnetic Stimulation):
Have you ever undergone repetitive Transcranial Magnetic Stimulation (rTMS)? □ Yes □ No
If Yes, How many treatments? _____
Location/Institution? _____
Response? _____

Ketamine:
Have you ever undergone ketamine? □ Yes □ No
If Yes, How many treatments? _____
Location/Institution? _____
Response? _____

Suicide Risk Assessment:
Have you ever had feelings or thoughts that you didn't want to live? □ Yes □ No

If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you don't want to live? □ Yes □ No

1) How often do you have these thoughts?
_____
2) When was the last time you had thoughts of dying?
_____
3) Has anything happened recently to make you feel this way? □ Yes □ No
_____
4) On a scale of 1 to 10, (10 being the strongest) how strong is your desire to kill yourself currently?
_____
5) Would anything make it better? □ Yes □ No
_____
6) Have you ever thought about how you would kill yourself? □ Yes □ No
_____
7) Is the method you would use readily available? □ Yes □ No
_____

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8) Have you planned a time for this? □ Yes □ No

9) Is there anything that would stop you from killing yourself? □ Yes □ No

10) Do you feel hopeless and/or worthless? □ Yes □ No

11) Have you ever tried to kill or harm yourself before? □ Yes □ No

12) Do you have access to guns? □ Yes □ No If YES, please explain.

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for the following:					
	Yes	No		Yes	No
Bipolar Disorder	□	□	Schizophrenia	□	□
Depression	□	□	Post-traumatic stress	□	□
Anxiety	□	□	Alcohol use	□	□
Anger	□	□	Other substance use	□	□
Suicide	□	□	Violence	□	□

If yes, who had each problem?

What type of treatment (e.g. medications) did they receive and was it effective?

Substance Use History:

Please describe your current use of drugs and alcohol			
	YES	NO	If yes, please describe:
Has using drugs or alcohol ever caused problems for you (legal, family, medical)?	□	□	
Have you ever been treated for drug or alcohol problems in the past?	□	□	
Have you ever abused prescription medication?	□	□	

Do you smoke tobacco? □ Yes □ No
How many cigarettes per day? _____
How many caffeinated beverages do you drink per day? _____

Family Background and Childhood History:
Were you adopted? □ Yes □ No
Where did you grow up?

List your siblings and their ages:

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_____

What was your father's occupation?

_____

What was your mother's occupation?

_____

Did your parents divorce? □ Yes □ No If Yes, how old were you when they divorced? _____
Who did you live with growing up?

_____

How is your relationship with your family?

_____

Have there been any deaths in your immediate family? If so, who?

_____

When your mother was pregnant with you, are you aware of any complications during the pregnancy or birth?

_____

Were you born premature? □ Yes □ No How were you delivered? _____
Were you breastfed or bottle fed as an infant? _____
Did you have any significant injuries or illnesses as a child?

_____

_____

Do you have a history of being abused emotionally, sexually, physically, or by neglect? □ YES □ NO If YES, please describe:

Education/Employment History:

Education		**Spouse's Education (if applicable)**	
Highest Degree Completed:		Highest Degree Completed:	
Area of Study:		Area of Study:	
History of learning disorder/difficulties? Please describe:			
Employment		**Spouse's Employment (if applicable)**	
Occupation:		Occupation:	
Place of Employment:		Place of Employment:	
Please describe any current difficulties you are experiencing at work:			

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Relationship History and Current Family:

Are you currently: □ Married □ Partnered □ Divorced □ Single □ Widowed How long? _____
If not married, are you currently in a relationship? □ Yes □ No If Yes, how long? _____
Are you sexually active? □ Yes □ No
How would you identify your sexual orientation?
□ straight/heterosexual
□ lesbian/gay/homosexual
□ bisexual
□ transsexual
□ unsure/questioning
□ asexual
□ other _____
□ prefer not to answer
Describe your relationship with your spouse or significant other:
_____
Have you had any prior marriages? □ Yes □ No. If Yes, how many? _____
How long? _____
Do you have children? □ Yes □ No No If yes, list ages and gender:
_____
_____
Describe your relationship with your children:
_____
List everyone who currently lives with you:
_____
_____

Legal History:

Have you ever been arrested? □ Yes □ No
Details: _____
Do you have any pending legal problems? □ Yes □ No
Details: _____

Exercise/Fitness History:

Please describe your type and level of activity of exercise:
_____

Nutritional History:

What do you like to eat? _____
What would a typical day look like with respect to breakfast, lunch, dinner, and snacks?
_____
_____
_____
_____
_____
Do you crave certain foods? _____
Do particular foods make you tired? _____
Do you have a dairy or wheat allergy/sensitivity? _____

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Spiritual History:

Please describe your spiritual and religious background and beliefs:
_____ _____ _____

Is there anything else I should know that doesn't appear on this form or other forms, but that is or might be important?

_____
_____
_____
_____
_____
_____

My signature below indicates that I have voluntarily and accurately completed the New Patient Intake Form.

_____	_____	_____
Patient Name	Signature	Date