

\*We are not accepting any New Patients who are currently taking any controlled pain medications  
\*Note: completion of the following paperwork and Initial Screening Exam does not guarantee acceptance

*Richard Heidenfelder M.D.*

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**Request for Treatment Form**

In order to schedule a **Medi-Cal New Patient Evaluation** please complete this **Request for Treatment Form** and submit it in person at your New Patient Screening Appointment. After submission your information will be reviewed by Dr. Heidenfelder and your **New Patient Evaluation** appointment will be formally scheduled.

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone # \_\_\_\_\_ Cell phone # \_\_\_\_\_

Email \_\_\_\_\_ Parent/Guardian's Name \_\_\_\_\_

Social Security # \_\_\_\_\_

Medi-Cal ID # \_\_\_\_\_ Other Insurance \_\_\_\_\_

Do you give permission for ongoing regular updates to be provided to your primary care physician? \_\_\_\_\_

Current Therapist/Counselor \_\_\_\_\_

Therapist's Phone \_\_\_\_\_

What are the problem(s) for which you are seeking help?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

What are your treatment goals?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Depressed mood              | <input type="checkbox"/> Racing thoughts         | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Unable to enjoy activities  | <input type="checkbox"/> Impulsivity             | <input type="checkbox"/> Anxiety attacks |
| <input type="checkbox"/> Sleep pattern disturbance   | <input type="checkbox"/> Increase risky behavior | <input type="checkbox"/> Avoidance       |
| <input type="checkbox"/> Loss of interest            | <input type="checkbox"/> Increased libido        | <input type="checkbox"/> Hallucinations  |
| <input type="checkbox"/> Concentration/forgetfulness | <input type="checkbox"/> Decrease need for sleep | <input type="checkbox"/> Suspiciousness  |
| <input type="checkbox"/> Change in appetite          | <input type="checkbox"/> Excessive energy        |  |
| <input type="checkbox"/> Excessive guilt             | <input type="checkbox"/> Increased irritability  |  |
| <input type="checkbox"/> Fatigue                     | <input type="checkbox"/> Crying spells           |  |
| <input type="checkbox"/> Decreased libido            |  |  |

**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

How often do you have these thoughts? \_\_\_\_\_

When was the last time you had thoughts of dying? \_\_\_\_\_

Has anything happened recently to make you feel this way? \_\_\_\_\_

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?  
\_\_\_\_\_

Would anything make it better? \_\_\_\_\_

Have you ever thought about how you would kill yourself? \_\_\_\_\_

Is the method you would use readily available? \_\_\_\_\_

Have you planned a time for this? \_\_\_\_\_

Is there anything that would stop you from killing yourself? \_\_\_\_\_

Do you feel hopeless and/or worthless? \_\_\_\_\_

Have you ever tried to kill or harm yourself before? \_\_\_\_\_

Do you have access to guns? If yes please explain \_\_\_\_\_

**Past Medical History:**

Allergies \_\_\_\_\_ Current Weight \_\_\_\_\_ Height \_\_\_\_\_



Liver problems ----- ( ) ( )  
 Other ----- ( ) ( )

**Past Psychiatric History:**

**Outpatient treatment** ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

**Psychiatric Hospitalization** ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason	Date Hospitalized	Where

**Past Psychiatric Medications:** If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

	Dates	Dosage	Response/Side-Effects
<b>Antidepressants</b>			
Prozac (fluoxetine)	_____	_____	_____
Zoloft (sertraline)	_____	_____	_____
Luvox (fluvoxamine)	_____	_____	_____
Paxil (paroxetine)	_____	_____	_____
Celexa (citalopram)	_____	_____	_____
Lexapro (escitalopram)	_____	_____	_____
Effexor (venlafaxine)	_____	_____	_____
Cymbalta (duloxetine)	_____	_____	_____
Wellbutrin (bupropion)	_____	_____	_____
Remeron (mirtazapine)	_____	_____	_____
Serzone (nefazodone)	_____	_____	_____
Anafranil (clomipramine)	_____	_____	_____
Pamelor (nortrptyline)	_____	_____	_____
Tofranil (imipramine)	_____	_____	_____
Elavil (amitriptyline)	_____	_____	_____
Other	_____	_____	_____

**Mood Stabilizers**

Tegretol (carbamazepine) \_\_\_\_\_

Lithium \_\_\_\_\_  
Depakote (valproate) \_\_\_\_\_  
Lamictal (lamotrigine) \_\_\_\_\_  
Topamax (topiramate) \_\_\_\_\_  
Other \_\_\_\_\_

**Past Psychiatric medications (continued)**

<b>Antipsychotics/Mood Stabilizers</b>	<b>Dates</b>	<b>Dosage</b>	<b>Response/Side-Effects</b>
Seroquel (quetiapine)	_____	_____	_____
Zyprexa (olanzepine)	_____	_____	_____
Geodon (ziprasidone)	_____	_____	_____
Abilify (aripiprazole)	_____	_____	_____
Clozaril (clozapine)	_____	_____	_____
Haldol (haloperidol)	_____	_____	_____
Prolixin (fluphenazine)	_____	_____	_____
Risperdal (risperidone)	_____	_____	_____
Other	_____	_____	_____

**Sedative/Hypnotics**

Ambien (zolpidem) \_\_\_\_\_  
Sonata (zaleplon) \_\_\_\_\_  
Rozerem (ramelteon) \_\_\_\_\_  
Restoril (temazepam) \_\_\_\_\_  
Desyrel (trazodone) \_\_\_\_\_  
Other \_\_\_\_\_

**ADHD medications**

Adderall (amphetamine) \_\_\_\_\_  
Concerta (methylphenidate) \_\_\_\_\_  
Ritalin (methylphenidate) \_\_\_\_\_  
Strattera (atomoxetine) \_\_\_\_\_  
Other \_\_\_\_\_

**Antianxiety medications**

Xanax (alprazolam) \_\_\_\_\_  
Ativan (lorazepam) \_\_\_\_\_  
Klonopin (clonazepam) \_\_\_\_\_  
Valium (diazepam) \_\_\_\_\_  
Tranxene (clorazepate) \_\_\_\_\_  
Buspar (buspirone) \_\_\_\_\_  
Other \_\_\_\_\_

**Family Psychiatric History:**

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( )Yes ( )No	Schizophrenia	( )Yes ( )No
Depression	( )Yes ( )No	Post Traumatic Stress	( )Yes ( )No
Anxiety	( )Yes ( )No	Alcohol abuse	( )Yes ( )No
Anger	( )Yes ( )No	Other substance abuse	( )Yes ( )No
Suicide	( )Yes ( )No	Violence	( )Yes ( )No

**Check if you have ever tried the following:**

	<b>Yes</b>	<b>No</b>	<b>If yes, how long and when did you last use?</b>
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Other	( )	( )	_____

Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature (if under age 18) \_\_\_\_\_ Date \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone # \_\_\_\_\_

**\*Note: The New Patient Screening Appointment is for screening purposes ONLY and is not a formal Initial Evaluation.**

**Upon submission and review of your information you will be scheduled for a full Initial Evaluation at a subsequent date-typically within 2 weeks.**

**\*Submission of the Treatment Request Form does not guarantee acceptance as a patient with our practice.**