***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**

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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)

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

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 _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name **Total Daily Dosage** **Estimated Start Date**

_____
_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements:

_____
_____

Current medical problems:

_____
_____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____
_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ .
Was the EKG ( ) normal ( ) abnormal or ( ) unknown**?**

Personal and Family Medical History:

	You	**Family**
Thyroid Disease ----------	( )	( )
Anemia----------	( )	( )
Liver Disease ----------	( )	( )
Chronic Fatigue ----------	( )	( )
Kidney Disease ----------	( )	( )
Diabetes ----------	( )	( )
Asthma/respiratory problems ------	( )	( )
Stomach or intestinal problems ---	( )	( )
Cancer (type) ----------	( )	( )
Fibromyalgia ----------	( )	( )
Heart Disease ----------	( )	( )
Epilepsy or seizures ----------	( )	( )
Chronic Pain ----------	( )	( )
High Cholesterol ----------	( )	( )
High blood pressure----------	( )	( )
Head trauma ----------	( )	( )

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
Antidepressants			
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)

Antipsychotics/Mood Stabilizers	**Dates**	**Dosage**	**Response/Side-Effects**

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:

	Yes	**No**	**If yes, how long and when did you last use?**
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.**