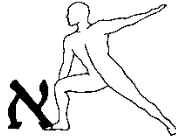
THE *ALEPH* CENTER, P.L.L.C.



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Tucson, AZ 85715-3809
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Welcome, please complete as much of this form as you can. The answers you provide will help us to plan your care. You will only have to fill this form out one time. If you would like a copy let us know and we will be happy to provide one. We will be happy to assist you as needed, Thank you.

Today's date	Patient's name:	Name you prefer to be called:

Date of birth:	Age:

Emergency contact:	Relationship:	Best contact number:

Primary care physician:	Outpatient psychiatric provider:	Other providers involved in your care:

Reason for today's visit?

Do you and your family understand your medications and current treatment? ☐ clearly ☐ need more information

What pharmacy do you use? (name and phone number)

Allergies

(medication/food, indicate reaction)

Medications

Please list ALL medications you take, Include Aspirin, Water Pills, Vitamins, Herbal Supplements, Laxatives, Heart Medicine, Birth Control Pills, ETC.

name of medication	dose(s)	how often

Past medications

Please check any of the medications below that you have taken in the past that you can remember.

	Antidepressants				Drug & Alcohol		
☐	Prozac/fluoxetine	☐	Paxil/paroxetine	☐	Naltrexone	☐	Campral/acamprosate
☐	Effexor/venlafaxine &/or Pristiq/desvenlafaxine	☐	Celexa/citalopram &/or Lexapro/escitalopram	☐	Antabuse/disulfuram	☐	Buprenorphine
☐	Cymbalta/duloxetine	☐	Zoloft/sertraline		**Medications for Dementia**		
☐	Luvox/fluvoxamine	☐	Fetzima/milnacipran	☐	Tacrine	☐	Aricept/donepezil
☐	Wellbutrin/bupropion	☐	Remeron/mirtazapine	☐	Exelon/rivastigmine	☐	Razadyne/galantamine
☐	Serzone/nefazodone	☐	Trintellix/vortioxetine	☐	Namenda/memantine		
☐	Viibryd/vilazodone	☐	Ketamine/esketamine				
	Tricyclic Antidepressants (TCA's)				**Sleep Aids**		
☐	Anafranil/Clomipramine	☐	Pamelor/Nortiptyline	☐	Desyrel/Trazodone	☐	Benadryl/Diphenhydramine
☐	Elavil/Amitriptyline	☐	Norpramin/Desipramine	☐	L-TRP/Tryptophan	☐	Ambien
☐	Tofranil/Imipramine	☐	Sinequan/Doxepin	☐	Sonata	☐	Chloral Hydrate
☐	Vivactil/Protriptyline	☐	Ludiomil/Maprotiline	☐	Lunesta	☐	Rozerem
	MAOI's			☐	Melatonin	☐	Belsomra
☐	Parnate/Tranylcypromine	☐	Nardil/Phenelzine		**Treatment for ADHD**		
☐	Marplan/isocarboxazid	☐	Eldepryl/Selegeline	☐	Ritalin/Concerta	☐	Dexedrine
☐	Emsam Patch/selegiline			☐	Adderall	☐	Strattera
	Alternative/Agents				**Mood Stabilizers/Anticonvulsants**		
☐	St. John's Wort	☐	SAM-e	☐	Lithium	☐	Tegretol/Carbamazepine
☐	Omega 3 Fatty Acid	☐	Valerian	☐	Trileptal/oxcarbazapine	☐	Depakote/Valproate
☐	Kava Kava	☐	Gingko	☐	Lamictal/Lamotrigine	☐	Gabitril/Tiagabine
☐	Gingseng			☐	Topamax/Topiramate		
	Non-Medications Treatment				**Medications for Sleep Disorders**		
☐	Transcranial Magnetic Stimulation(rTMS)	☐	Vagal Nerve Stimulation (VNS)	☐	Provigil/Nuvigil (modafinil/armodafinil)	☐	Xyrem/Sodium Oxybate
☐	ECT						
	Antipsychotics				**Anti Anxiety Agents**		
☐	Risperdal/Risperidone	☐	Zyprexa/Olanzapine	☐	Xanax/Alprazolam	☐	Ativan/Lorazepam
☐	Seroquel/Quetiapine	☐	Clozaril/Clozapine	☐	Klonopin/Clonazepam	☐	Serax/Oxazepam
☐	Geodon/Ziprasidone	☐	Abilify/Aripipazole	☐	Tranxene/Clorazepate	☐	Librium/Chlordiazepoxide
☐	Invega/paliperidone	☐	Fanapt/iloperidone	☐	Valium/Diazepam	☐	Prosom/Estazolam
☐	Latuda/lurasidone	☐	Saphris/asenapine	☐	Dalmane/Flurazepam	☐	Restril/Temazepam
☐	Vraylar/cariprazine	☐	Rexulti/brexpiprazole	☐	Buspar/buspirone	☐	Vistaril/Hydroxyzine
☐	Haldol/Haloperidol	☐	Thorazine	☐	Medical MJ,THC,CBD	☐	Neurontin/Gabapentin
☐	Loxitane/Loxapine	☐	OTHER(S):				

Psychiatric History

Have you ever participated in individual or group therapy and/or seen a psychiatrist? ☐Yes ☐ No

Have you ever been treated for any of the following?☐ yes ☐ no (If Yes, Check all that apply)

☐depression ☐ anxiety/panic ☐adjustment problem(s) ☐ eating disorder ☐chemical dependency ☐other

If you answered "Yes" to either of the above questions please give the date(s) and indicate treatment effectiveness:

Medical History

Please check all that apply

Cardiovascular	Current	Past	Never	Endocrine/Other	Current	Past	Never	Gastrointestinal	Current	Past	Never
High Blood Pressure	☐	☐	☐	Diabetes Type 1	☐	☐	☐	Nausea and Vomiting	☐	☐	☐
Heart Attack	☐	☐	☐	Diabetes Type 2	☐	☐	☐	Heartburn/indigestion	☐	☐	☐
Chest Pain/Angina	☐	☐	☐	Thyroid Disease	☐	☐	☐	Ulcers	☐	☐	☐
Pacemaker	☐	☐	☐	Adrenal disease	☐	☐	☐	Loss of Appetite	☐	☐	☐
Internal Defibrillator	☐	☐	☐	Immune disorder	☐	☐	☐	Colostomy	☐	☐	☐
Irregular Heart Rhythm/Murmur	☐	☐	☐	Blood Disorders-Bleeding	☐	☐	☐	Diarrhea	☐	☐	☐
Swelling of Ankles	☐	☐	☐	Anemia	☐	☐	☐	Constipation	☐	☐	☐
Cardiac Catherization/Angioplasty	☐	☐	☐	Cancer	☐	☐	☐	Change in Stool	☐	☐	☐
Circulation Problems	☐	☐	☐	**HEENT**				Liver Disease	☐	☐	☐
Congestive Heart Failure	☐	☐	☐	Hearing loss	☐	☐	☐	Hiatal Hernia	☐	☐	☐
Genitourinary				Glaucoma	☐	☐	☐	Hepatitis	☐	☐	☐
Difficult or painful urination	☐	☐	☐	Cataracts	☐	☐	☐	**Musculoskeletal**			
Kidney stones	☐	☐	☐	Hay Fever/ Allergies	☐	☐	☐	Rashes/Bruises/Sores	☐	☐	☐
Frequent urination	☐	☐	☐	Vision Loss	☐	☐	☐	Arthritis	☐	☐	☐
Prostate Problems	☐	☐	☐	Nosebleeds	☐	☐	☐	Limited Mobility	☐	☐	☐
Kidney Disease	☐	☐	☐	**Respiratory**				Have you fallen recently	☐	☐	☐
Urinary Infections	☐	☐	☐	Shortness of Breath	☐	☐	☐	**Prosthesis/Assistive**			
Venereal disease	☐	☐	☐	Chronic Cough	☐	☐	☐				
Last menstrual period				Cold/Sore Throat	☐	☐	☐	Valves	☐	☐	☐
				Asthma/ Bronchitis	☐	☐	☐	Joints	☐	☐	☐
Pregnant	☐	☐	☐	Oxygen at home	☐	☐	☐	Eyes	☐	☐	☐
Neurological				Tuberculosis				Hearing Aids	☐	☐	☐
Headaches	☐	☐	☐	Phlegm	☐	☐	☐	Dentures/Teeth	☐	☐	☐
Seizures	☐	☐	☐	Chronic Lung Disease	☐	☐	☐	Contact lens	☐	☐	☐
Faintness/dizziness	☐	☐	☐	Sinus infection	☐	☐	☐	Glasses	☐	☐	☐
Weakness/Tingling Numbness	☐	☐	☐								
Stroke	☐	☐	☐								

To your knowledge, was your mother's pregnancy with you normal? ☐ yes ☐ no If no please explain:

Childhood: Major Illnesses/Injuries/handicaps/surgeries:

Pain History

Do you have Pain? ☐ yes ☐ no ☐ new ☐ chronic

How do you manage your pain at home? ☐ well ☐ marginally ☐ not at all

Continuum of Care

Do you live alone? ☐ yes ☐ no Are others dependent on you for their care? ☐ yes ☐ no

Do you live in a nursing home, adult care home, or use home health services? ☐ yes ☐ no

Facility Name: ______________________________ Facility phone: ____________________

Do you have assistance available for your daily care?(example meals, bathing, transportation) ☐ yes ☐ no

Do you feel safe at home? ☐ yes ☐ no

Psychosocial History

Do you have an advance directive/living will? ☐ yes ☐ no Where is it located?

Do you have a durable power of attorney? ☐ yes ☐ no

If you have either please bring a copy with you next time.

Are you an organ donor? ☐ yes ☐ no

Are there any situations that are causing you stress? ☐ yes ☐ no

Explain: ____

Past Surgical History (indicate date if known)

☐ Adenoidectomy	☐ C-Section	☐ Tonsillectomy
☐ Appendectomy	☐ Heart Valve	☐ Tubal Ligation
☐ Bowel/Stomach Resection	☐ Hernia	☐ Prostate Surgery/Resection
☐ Cardiac Stents	☐ Hysterectomy	☐ Bladder Surgery
☐ Cataracts	☐ LASIK	☐ Spinal Surgery
☐ Colonoscopy	☐ Pacemaker	☐ Bariatric Surgery
☐ Coronary Bypass	☐ Thyroidectomy	☐ Orthopedic/Joints
☐ Other		

Social/Dietary Habits

How many meals do you eat a day?	When is your largest meal?
Do you eat a special diet (specify)	
How much coffee/tea /caffeine do you drink each day?	How much alcohol do you drink?
Any change in appetite? ☐ Yes ☐ No	Have you ever smoked? ☐ Yes ☐ No
How much do you smoke?	How long have you smoked?
Smoking start date:	Smoking stop date:
Usual Weight:	Current Weight:

Family Medical & Psychiatric History

Is there any family history of emotional problems? ☐ no ☐ yes (please explain)

Is there any family history of any mental health diagnosis? ☐ yes ☐ no

Has anyone in your family completed a suicide? ☐ yes ☐ no

Has anyone in your family been institutionalized? ☐ yes ☐ no

Has anyone in your family has problems with substance abuse? ☐ yes ☐ no

Social History

Family of Origin

As a child who did you live with? ☐natural, ☐ adoptive, ☐step-parents, ☐grandparents, ☐ in a foster home?
List all that apply and explain:

How many brothers and sisters did you have? Number of brothers Number of sisters
Which child were you?

Brothers/Sisters

name	alive/deceased	amount of contact

Mother: age: age at death: year of death:

Cause of death:

Quality of relationship (past or present:):

Father: age: age at death: year of death:

Quality of relationship (past or present):

Parent's relationship:

Marital/Relationship History

Sexual Orientation: ☐ bisexual ☐ gay/lesbian ☐ heterosexual ☐ other

Gender Identity: ☐ male ☐ female ☐ transgender ☐ other

☐single ☐married ☐widowed ☐divorced ☐other

Number of Marriages:

	age	length	termination	children	spouse's name
1st marriage					
2nd marriage					
3rd marriage					
4th marriage					

Describe the relationship of current and/or past marriages:

Children

Name	Age	Alive/deceased	Amount of contact	Quality of relationship past/present

miscarriages, abortions, stillbirths:

Environment

Do you live in a ☐house ☐apartment ☐ nursing home ☐ other

Do you : ☐rent ☐own ☐live with relatives

Who are the members of your household?

Financial summary: (Include resources, stability of resources and ability to live on current income)

Vocational/Avocational History

Education: grade completed: Trade school/college attended:

Current employment status: ☐ employed full time ☐ employed part time ☐ simi retired date:
☐ retired date: ☐ disabled date:

Are you satisfied with your current employment status?

Work history:

Hobbies and Interests (past and present):

Military History ☐ **Not Applicable**

Branch of service: rank: date: from To

assignments:

Wounded in action?

Type of discharge:

Peer Relationships/Social Life

Describe peer relationships:

Has anyone important to you died or moved away recently? ☐ Yes ☐ No

Who?

Describe your social life, past and present:

Club and/or organization affiliation, past and present

Cultural Influences/Spiritual History

Are there any particular cultural influences you feel need to be taken into consideration while you are in treatment?

Religious affiliations:

Present/past participation in church:

Drug and Alcohol History

Have you ever used Illegal drugs? ☐ yes ☐ no (If yes, check all that apply)

☐ marijuana ☐ LSD ☐ mushrooms ☐ peyote ☐ other hallucinogens ☐ cocaine ☐ speed ☐ huffing gas
☐ Paint
☐ stimulants (meth, cocaine) ☐ opiates (heroin, RX) ☐ I.V. drugs ☐ other drugs
Explain:

Have you ever sought treatment for drug abuse? ☐ Yes ☐ No

Has or anyone in your family attended/ing any other support groups? ☐ Yes ☐ No

If yes, Specify who and what group:

Are you concerned about drinking/drug abuse? ☐ Yes ☐ No If yes, why?

What changes about your personality when you drink or use?

When did you first become concerned and why?

____
Patient/Family Signature

_ ____________________ __ _____________
Date Time

THANK YOU FOR CHOOSING US TO HELP YOU.
THE *ALEPH* CENTER, P.L.L.C.