Women's & Children's Center for Mental Wellness--New Patient Request Form
(Return to: by fax (318)550-3481 or by email contactus@wccmw.com or turn in "in person")

Name _____

City of Residence _____ Age _____ Gender _____

Ethnicity:_____ Language spoken:_____

Marital Status: _____ Any previous marriages: _____

Children: ☐ yes ☐ no *If yes, specify sex & ages* _____

Who lives in your household with you?

Name	Sex	Age	Relationship

Military Service? ☐ Yes ☐ No *If yes*, Branch?_____
Highest Rank_____ Date of service_____
Type of Discharge_____

Education, Employment and Legal History:

Highest Education Received *(please specify highest grade completed and degree)*:
_____

Are you currently employed: ☐ yes ☐ no ☐ Student

Current Occupation: _____ How Long _____

Job Difficulties?_____

If student, current grade:_____ Special Ed?_____

Are you currently on disability or seeking disability? _____ if yes, please specify
_____

Legal Difficulties? (arrested/incarcerated/ charges/ lawsuits/ custody) ☐ Yes ☐ No
Please explain

_____

_____

Habits:

Have you ever smoked?(cigarettes/tobacco/pipes/cigar/vape/etc) ☐ Yes ☐ No
If yes, please provide details

_____

Caffeine intake per day: Caffeinated Sodas:_____ Coffee:_____ Tea:_____

Alcohol use: How Much? _____ Type _____

Withdrawals/ Problems Associated_____ DWI/DUI ☐ Yes ☐ No

Drug use: (Street and/or over use of prescription drugs: example marijuana, spice, K2, xanax, sleeping pills, pain pills, crack, cocaine, stimulants, bath salts, etc)

Type_____ Problems_____

Medical Marijuana use? (explain) _____

Family Medical History:
Any sudden deaths or significant family medical illnesses?

_____

_____

Medical History:
Primary Care Physician _____

Allergies: _____

Last lab work? Where? Abnormal Results? _____

_____

List All Current Diagnosis or Significant Illnesses in past and present:

_____

_____

Illness	No	Yes	Age	Still Present?	Details
Allergies/Asthma	☐	☐			
Birth Complications	☐	☐			
Seizures/ Epilepsy	☐	☐			
Head Injury/ Concussions	☐	☐			
Hepatitis/Cirrhosis Other liver problems	☐	☐			
HIV/AIDS	☐	☐			
Hypertension	☐	☐			
Loss of Consciousness/Vertigo	☐	☐			
Migraines/ Headaches	☐	☐			
Mitral Valve Prolapse/ Other heart problems	☐	☐			
Sexually transmittable Disease	☐	☐			
Vision Problems/Glaucoma	☐	☐			
Stomach Issues/ IBS/ etc	☐	☐			
Thyroid Problems	☐	☐			
Arthritis/Fibromyalgia	☐	☐			
Neurological problems	☐	☐			
Diabetes	☐	☐			
Vitamin Deficiency	☐	☐			
Other	☐	☐			

Have you ever had a surgical procedure: ☐ No ☐ Yes *If yes, please describe*

Type	Date	Details

Are you currently taking any medications? ☐ No ☐ Yes *If yes, please list*

Name	Dose	Date Started	Reason

Do you take any Vitamin/ Herbal/ CBD or Over the Counter (non-prescribed) meds?

☐ No ☐ Yes *If yes, please list*

Name	Dose	Date Started	Reason

Symptoms list: Check symptoms that have been most bothersome or occurred frequently during last 4 weeks.

General Symptoms

- ☐ **Fever**
- ☐ **Repetitive, senseless thoughts**
- ☐ **Repetitive, senseless behaviors**
- ☐ **Fainting or feeling faint**
- ☐ **Tremors, trembling, or shakiness**
- ☐ **Seizures**
- ☐ **Easy bruising**
- ☐ **Skin rash**
- ☐ **Violent behavior**
- ☐ **Constant worry**
- ☐ **Irritability**
- ☐ **Tension**
- ☐ **Headache**
- ☐ **Feeling in a dreamlike state**
- ☐ **Fearful feelings**
- ☐ **Fear of losing control**
- ☐ **Jumpiness**
- ☐ **Restlessness**
- ☐ **Sweating**
- ☐ **Dizziness/lightheadedness**
- ☐ **Keyed up/on edge**
- ☐ **Agitation**
- ☐ **Nervousness**
- ☐ **Trouble concentrating**
- ☐ **Insomnia/trouble sleeping**
- ☐ **Decrease in sex drive**
- ☐ **Trouble making decisions**
- ☐ **Sad/depressed/down in the dumps**
- ☐ **Lack of/loss of interest in things**
- ☐ **Helpless feelings**
- ☐ **Fatigue/lack of energy**
- ☐ **Weakness**
- ☐ **Increase or decrease in appetite**
- ☐ **Increase or decrease in weight**
- ☐ **Frequent crying or weeping**
- ☐ **Worthless feelings**
- ☐ **Excessive feelings of guilt**
- ☐ **Hopeless feelings**
- ☐ **Feeling life is not worth living**
- ☐ **Sleeping too much**
- ☐ **Frequent negative feelings**
- ☐ **Memory problems**
- ☐ **Free of doing something uncontrollable**
- ☐ **Fear of dying**
- ☐ **Chills**
- ☐ **Seeing or hearing things**
- ☐ **Fear of going crazy**

Eyes & Ears

- ☐ **Double Vision**
- ☐ **Difficulty in focusing vision**
- ☐ **Eye pain**
- ☐ **Sinus pain**
- ☐ **Increase or decrease in tearing**

Cardiovascular

- ☐ **Chest pain**
- ☐ **Chest discomfort**
- ☐ **Heart pounding**

Gastrointestinal

- ☐ **Diarrhea**
- ☐ **Constipation**
- ☐ **Heartburn**
- ☐ **Rectal bleeding**
- ☐ **Black, tarry stool**
- ☐ **Stomach pain**
- ☐ **Food intolerance**
- ☐ **Abdominal bloating**

Respiratory/Nose/Throat/Mouth

- ☐ **Cold (influenza)**
- ☐ **Nasal congestion**
- ☐ **Nosebleeds**
- ☐ **Hay fever**
- ☐ **Cough**
- ☐ **Wheezing**
- ☐ **Shortness of breath**
- ☐ **Pain when breathing**

URINARY

- ☐ **Frequent urination**
- ☐ **Painful urination**
- ☐ **Difficulty passing urine**
- ☐ **Blood in urine**

Other Symptoms not Listed

_____
_____
_____
_____

Neuropsychiatric History:

Age of first psychiatric symptoms: _____ Age of First Treatment _____

What were the first symptoms? _____

_____

_____

Have you ever had motor or vocal tics? ☐No ☐Yes if yes, details _____

_____

Have you ever sought professional treatment for any psychiatric, substance abuse, or any problems listed above? ☐ No ☐ Yes *if yes, please describe below*

See scales below in describing the details					
Problem (Diagnosis)	Start Date	Stop Date	Type of Treatment	Setting and Provider name	Outcome

<u>Type of treatment</u>: 1= Medication Therapy 2= Talk Therapy 3= Other

<u>Setting:</u> Inpatient-Hospital / Outpatient / Day Program/ Rehab

Treatment with ECT/ Biofeedback/ Hypnosis? ☐ No ☐ Yes *if yes please describe*

_____

Family Psychiatric History:
Are you Adopted? ☐ Yes ☐ No
Do you have siblings? _____ If yes, how many _____

Do you have *any blood relatives* who have a serious emotional, behavioral, neurological, or substance abuse problem or history of suicides? ☐ Yes ☐ No

If yes, please complete

Name	Age	Relationship	Problem/ Medication

Developmental History:
How would you describe your childhood family life? ☐ Stable ☐ Unstable
Did you experience any of the following during your childhood or adolescence?

Check and complete all that apply

Yes	Situation	Your Age	Duration	Comments
☐	Death of parent		n/a	
☐	Death of loved one		n/a	
☐	Separation from parent or family			
☐	Parents' divorce/ separation		n/a	
☐	Loss of home			
☐	Family financial problems			
☐	Physical abuse			
☐	Sexual abuse			
☐	Rape			
☐	Parent with substance abuse problem			
☐	Conflicts with parents			
☐	Foster care			
☐	Unwanted child			
☐	School problems			
☐	Illness in self			
☐	Illness in family			
☐	Problems with walking/talking/learning on time as a child			
☐	Other			

Medication History:

Have you ever been treated for emotional or psychiatric problems with medication?

☐ Yes ☐ No

Medications (trade name)	No	Yes	Start Date	Stop Date	Dose (max)	Symptom Treated	Response Good, fair, poor	Side Effects?
Antidepressants								
Paroxetine (paxil)	☐	☐						
Sertaline (zoloft)	☐	☐						
Fluoxetine (Prozac)	☐	☐						
Citalopram (celexa)	☐	☐						
Escitalopram (lexapro)	☐	☐						
Venlafaxine (effexor, XR)	☐	☐						
Desvenlafaxine (pristiq)	☐	☐						
Duloxetine (cymbalta)	☐	☐						
Vilazodone (vibryd)	☐	☐						
Levomilnacipran (fetzima)	☐	☐						
Vortioxetine (trintellix)	☐	☐						
Buproprion (wellbutrin, SR, XL)	☐	☐						
Mitrazapine (remeron)	☐	☐						
Deplin	☐	☐						
Trazadone (desyrel)	☐	☐						
Fluvoxamine (luvox, CR)	☐	☐						
Amitriptyline (elavil)	☐	☐						
Auvelity (dex/bup)	☐	☐						
Other (Zulresso, MAOI, ensam, etc)	☐	☐						

Medication History, cont.:

Medications (trade name)	No	Yes	Start Date	Stop Date	Dose (max)	Symptom Treated	Response Good, fair, poor	Side Effects?
Antipsychotics/Mood Stabilizers								
Ziprasidone (geodon)	☐	☐						
Aripripazole (abilify)	☐	☐						
Risperidone (risperdal)	☐	☐						
Palperidone (invega)	☐	☐						
Quetiapine (seroquel, xr)	☐	☐						
Olanzapine (zyprexa)	☐	☐						
Asenapine (saphris)	☐	☐						
Lurasidone (latuda)	☐	☐						
Olanzapine/ fluoxetine (symbyax)	☐	☐						
Cariprazine (vraylar)	☐	☐						
Brexpiprazole (rexulti)	☐	☐						
Lumateperone (caplyta)	☐	☐						
Other(fanapt, navane, clozaril, Haldol, long acting injections,lybalvi, etc)	☐	☐						
Lithium (eskalith, lithobid)	☐	☐						
Valproic Acid (depakote, ER)	☐	☐						
Carbamazepine (tegretol)	☐	☐						
Oxcarbazepine (trileptal)	☐	☐						
Lamotrigine (lamictal)	☐	☐						
Topiramate (topamax)	☐	☐						
Other	☐	☐						

Medication History, cont:

Medications (trade name)	No	Yes	Start Date	Stop Date	Dose (max)	Symptom Treated	Response Good, fair, poor	Side Effects?
Anti-Anxiety/ Sleep Aids								
Clonazepam (klonopin)	☐	☐						
Diazepam (valium)	☐	☐						
Lorazepam (ativan)	☐	☐						
Alprazolam (xanax, XR)	☐	☐						
Buspirone (buspar)	☐	☐						
Hydroxyzine (vistaril, atarax)	☐	☐						
Other(librium, tranxene, etc)	☐	☐						
Esketamine	☐	☐						
Ingrezza/Austedo	☐	☐						
Amitriptyline (elavil)	☐	☐						
Doxepin (silenor)	☐	☐						
Zaleplon (sonata)	☐	☐						
Zolpidem (ambien, CR)	☐	☐						
Trazodone (desyrel)	☐	☐						
Eszopiclone (lunesta)	☐	☐						
Ramelteon (rozerem)	☐	☐						
Other ,(belsomra	☐	☐						

Medication History, cont. :

Medications	No	Yes	Start Date	Stop Date	Dose (max)	Symptom Treated	Response Good, fair, poor	Side Effects?
Stimulants (ADHD)/ Narcolepsy/ Appetite Suppressants								
Ritalin, LA, SR	☐	☐						
Metadate ER/CD	☐	☐						
Concerta	☐	☐						
Daytrana (patch)	☐	☐						
Adderall, XR	☐	☐						
Mydayis	☐	☐						
Vyvanse	☐	☐						
Focalin, XR	☐	☐						
Quillivant/ Quillichew	☐	☐						
Strattera	☐	☐						
Nudexta	☐	☐						
Intuniv	☐	☐						
Provigil/ Nuvigil	☐	☐						
Contrave	☐	☐						
Belviq	☐	☐						
Phentermine	☐	☐						
Dexedrine	☐	☐						
Other (orlistat,adipex, wegovy, mounjaro,etc)	☐	☐						

Medication History, cont. :

Medications	No	Yes	Start Date	Stop Date	Dose (max)	Symptom Treated	Response Good, fair, poor	Side Effects?

Alcohol/Drug/Smoking Cessation

Chantix	☐	☐						
Campral	☐	☐						
ReVia/vivitrol (naltrexone)	☐	☐						
Suboxone	☐	☐						
Methadone	☐	☐						
Antabuse	☐	☐						
Other	☐	☐						

Miscellaneous

Benadryl	☐	☐						
Benztropine (cogentin)	☐	☐						
Amantadine (symmetrel)	☐	☐						
Clonidine (catapres)	☐	☐						
Thyroid (cytomel, synthroid)	☐	☐						
Propanolol (inderal)	☐	☐						
Cyproheptadine (Periactin)	☐	☐						
Other	☐	☐						