Williamsville Psychiatry PLLC

5904 Sheridan Drive, Williamsville, NY 14221 ● P (716) 886-5493 ● F (716) 886-5835

Patient Name: _____ Date of Birth: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Social Security Number: _____ Gender: ____Male ____Female _____Other

Marital Status: ____Single ____Married ____Divorced ____Widowed ____Other_____

Email address: _____

Employer / School: _____

Name of Parent/Guardian (if applicable): _____

Emergency Contact Name:_____ Phone#: _____

Relationship to Patient: _____

Primary Physician: _____ Phone#: _____

Address: _____

City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone#: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance: _____ ID#: _____

Subscriber: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____

Secondary Insurance: _____ ID#: _____

Subscriber: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____

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Please circle any of the following medications that you have previously tried. If possible, please add at what doses you tried the medication(s) and any side effects or adverse effects.

SSRIs

Zoloft / Sertraline

Prozac / Fluoxetine

Paxil / Paroxetine

Lexapro / Escitalopram

Celexa / Citalopram

Desyrel / Trazodone

Luvox / Fluvoxamine

Remeron / Mirtazapine

Viibryd

Brintellix

SNRIs

Effexor (XR) / Venlafaxine (ER)

Cymbalta / Duloxetine

Pristiq

Fetzima

Strattera

OTHER ANTIDEPRESSANTS

Wellbutrin(XL/SR/IR)/Buroprion

EMSAM / Selegiline

Elavil / Amitriptyline

Anafranil / Clomipramine

Tofranil / Imipramine

Pamelor / Nortriptyline

Norpramin / Desipramine

Sinequan / Doxepine

MOOD STABILIZERS

Lamictal / Lamotrigine

Depakote (ER) / Valproic Acid

Trileptal / Oxcarbazapine

Tegretol / Carbamazepine

Topamax / Topiramate

Zonegran / Zonisamide

Lithium

Abilify / Abilify Maintena

Geodon / Ziprasidone

Risperdal / Risperidone

Seroquel (XR) / Quetiapine

Zyprexa / Olanzapine

Zyprexa Relprevv

Invega

Saphris

Fanapt

Latuda

Rexulti

Clozaril / Clozapine

Thorazine / Chlorpromazine

Haldol / Haloperidol

Prolixin / Fluphenazine

Trilafon / Perphenazine

Mellaril / Thioridazine

Navane / Thiothixene

STIMULANTS

Adderall (XR) / Amphetamine

Dextroamphetamine

Ritalin / Methylphenidate

Concerta

Vyvanse

Focalin (XR)

Evekeo

OTHER

Ambien / Zolpidem

Sonata

Lunesta

Provigil / Modafinil

Nuvigil / Armodafinil

Xanax (XR) / Alprazolam

Ativan / Lorazapam

Valium / Diazepam

Klonopin / Clonazepam

Buspar / Buspirone

Vistaril / Hydroxyzine

Neurontin / Gabepentin

Lyrica

Horizant

Inderal / Propranolol

I acknowledge that the above information is correct and co-relates with my psychiatric history.

_____ _____

Print Name Signature

Patient Name _____

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Main reason for seeking help at this time: _____

_____

_____

CURRENT SYMPTOMS

Describe your current symptoms in your own words:

Please check all that apply:

Sadness	☐ YES ☐ NO	Lack of Sleep	☐ YES ☐ NO	Anger	☐ YES ☐ NO	Panic	☐ YES ☐ NO
Fatigue	☐ YES ☐ NO	Low Energy	☐ YES ☐ NO	High Energy	☐ YES ☐ NO	Worry	☐ YES ☐ NO
Tearfulness	☐ YES ☐ NO	Slowed Thinking	☐ YES ☐ NO	Fast Thinking	☐ YES ☐ NO	Social Withdrawal	☐ YES ☐ NO
Lack of Interest	☐ YES ☐ NO	Impulsivity	☐ YES ☐ NO	Paranoia	☐ YES ☐ NO	More than Usual Sleep	☐ YES ☐ NO
High Motivation	☐ YES ☐ NO	Forgetfulness	☐ YES ☐ NO	Low Motivation	☐ YES ☐ NO	Helpless	☐ YES ☐ NO
Poor Organization	☐ YES ☐ NO	Short-Temper	☐ YES ☐ NO	Hopeless	☐ YES ☐ NO	Lack of Focus	☐ YES ☐ NO
High Appetite	☐ YES ☐ NO	Low Appetite	☐ YES ☐ NO	Weight Gain	☐ YES ☐ NO	Joint Pains	☐ YES ☐ NO
Increased Urgency	☐ YES ☐ NO	Homicidal Ideations/Plan	☐ YES ☐ NO	Weight Loss	☐ YES ☐ NO	Muscle Aches	☐ YES ☐ NO
Seasonal Mood Changes	☐ YES ☐ NO	Seasonal Energy Change	☐ YES ☐ NO	Obsessions /Compulsions	☐ YES ☐ NO	Hallucinations	☐ YES ☐ NO
Poor Concentration	☐ YES ☐ NO	Fears of having illness	☐ YES ☐ NO	Suicidal Ideations/Plan	☐ YES ☐ NO	Headaches	☐ YES ☐ NO
Urinary Symptoms	☐ YES ☐ NO	Stomach Symptoms	☐ YES ☐ NO	Other Physical Symptoms	☐ YES ☐ NO	Explain Other:	

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PAST HISTORY OF PSYCHIATRIC TREATMENTS			
Have you ever had mental health counseling / psychotherapy?			☐ YES ☐ NO
If Yes, list:			
Name of Therapist	Type of Therapy	Time Period / # of Sessions	Any Comments / Describe Experience

ELECTROCONVULSIVE TREATMENTS (ECT)				
Have you ever had Electroconvulsive Treatment (ECT)?				☐ YES ☐ NO
If Yes, When, Where, inpatient/outpatient and time period				
What was your response to the treatment?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Describe your experience with ECT:				

TRANSCRANIAL MAGNETIC STIMULATION THERAPY (TMS)				
Have you ever had Transcranial Magnetic Stimulation (TMS)?				☐ YES ☐ NO
If Yes, When, Where, and time period				
What was your response to the treatment?	Excellent	Good	Fair	Poor
Describe your experience:				

CURRENT MENTAL HEALTH RELATED QUESTIONS		
Are you currently seeing a mental health counselor or therapist?		☐ YES ☐ NO
Name:	Phone:	Fax:
Address:		
Do you wish to continue counseling with your current counselor / therapist?		☐ YES ☐ NO
If Yes, let the Doctor know. If No, would you like to receive both medication and counseling?		☐ YES ☐ NO

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FAMILY MENTAL HEALTH HISTORY		
	AGE	SIGNIFICANT HEALTH PROBLEMS, CHEMICAL ABUSE, OR MENTAL HEALTH HISTORY
Father		
Mother		
Siblings	M F	
	M F	
	M F	
	M F	
Children	M F	
	M F	
	M F	
	M F	
Grandmother (Maternal)		
Grandfather (Maternal)		
Grandmother (Paternal)		
Grandfather (Paternal)		

List all Physical Health Illnesses since Birth	List all Mental Health Illnesses since Birth

Hospitalizations since birth (Surgical / Medical)		
Year	Reason	Hospital

Hospitalizations since birth (Mental)		
Year	Reason	Hospital

Patient Name _____

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SPECIAL HEALTH QUESTIONS		
Check if you have any of the following:		
☐ Seizure	☐ Brain Surgery	☐ Aneurism Surgery
☐ Epilepsy	☐ Heart Surgery	☐ Dental
☐ Head Trauma	☐ Pace Maker Placement	☐ Gun shot/Metal in the body
Describe:		

Check if you have had metal work done in any of the following areas:				
☐ Mouth	☐ Face	☐ Chest	☐ Head	☐ Neck
Please list and give details of any non-removable metallic objects in or around your head and/or neck:				

HEALTH HABITS AND PERSONAL SAFETY				
CAFFINE	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			

ALCOHOL	Do you drink alcohol?	☐ Yes	☐ No
	Have you ever felt you should cut down on your drinking?	☐ Yes	☐ No
	Have people annoyed you by criticizing your drinking?	☐ Yes	☐ No
	Have you felt bad or guilty about your drinking?	☐ Yes	☐ No
	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes	☐ No
	Do you drive after drinking?	☐ Yes	☐ No

TOBACCO	Do you use tobacco		☐ Yes	☐ No
	☐ Cigarettes- pks/day	☐ Chew- #/day	☐ Pipe- #/day	☐ Cigars- #/day
	☐ # of years		☐ Or year quit	

DRUGS	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever used recreational or street drugs?	☐ Yes	☐ No

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	Have you ever given yourself recreational or street drugs with a needle?	☐ Yes	☐ No
	Have you ever felt you should cut down on your drug use?	☐ Yes	☐ No
	Have people annoyed you by criticizing your drug use?	☐ Yes	☐ No
	Have you ever felt bad or guilty about using drugs?	☐ Yes	☐ No
	Have you ever used drugs first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes	☐ No
	Do you drive after using drugs?	☐ Yes	☐ No

CHEMICAL USE	Do you have a problem with chemical use?	☐ Yes	☐ No
	If yes, are you in treatment?	☐ Yes	☐ No
	If not in treatment, do you wish to pursue treatment?	☐ Yes	☐ No

SEX	Are you trying for a pregnancy?	☐ Yes	☐ No
	Are you taking any female hormones irrespective of reasons?	☐ Yes	☐ No
	Are you using any birth control measures?	☐ Yes	☐ No
	Do you have sex related issues / concerns or medical side effects?	☐ Yes	☐ No

EDUCATION / WORK HISTORY		
WORK HISTORY	Current Employer:	Date of employment From _____ To _____
EDUCATION HISTORY		

DISABILIY HISTORY			
Are you currently disabled to work?	☐ Yes	☐ No	☐ Maybe
If you are disabled?	☐ Officially	☐ Unofficially	
If YES, then answer the following question on the type of disability			

Social Security ☐ Yes ☐ No Comment:	Social Service ☐ Yes ☐ No Comment:	No Fault ☐ Yes ☐ No Comment:
Workers Compensation: ☐ Yes ☐ No	Comments:	
Have you been disabled in the past	☐ Yes ☐ No	

Patient Name _____

Any specific issues you would like to discuss with the doctor?

_____

_____

_____

Patient Name _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✔" to indicate your answer)	Not at all	Several days	More than half the	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
	TOTAL			

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very Difficult	_____
	Extremely difficult	_____

Williamsville Psychiatry PLLC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____
Home Phone: _____ Work or Cell Phone: _____
Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone: _____
Facility Address: _____ Facility Fax:_____
City/State/Zip: _____
Dates and Type of information to disclose:

☐ 2 years prior from last date seen ☐ Dates Other: _____ ☐ Specific Information Requested

_____

The purpose of this disclosure is:

☐ Change of Insurance or Physician ☐ Continuation of Care ☐ Referral ☐ Other:_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The information may be disclosed and used by the following individual or organization:

Williamsville Psychiatry, Pllc (including any and all of its providers)
5904 Sheridan Drive
Williamsville, NY 14221
P 716-886-5493 F 716-886-5835
PLEASE FAX RECORDS

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, or condition: _____.**
If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ Date: _____
Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status)

_____ _____
Printed name of Authorized Representative Relationship/Capacity to patient

_____
Address and phone number of Authorized Representative