UF Health Psychiatry and Addiction

4037 NW 86th Terrace
Gainesville, FL 32606

We look forward to seeing you on _____ at _____with Dr._____.

You are scheduled with our **UF Health Psychiatry and Addiction Clinic, located at 4037 NW 86th Terrace, Gainesville, FL 32606 on the 3rd Floor**. Please plan to **arrive 15** minutes before your scheduled appointment to allow for traffic, finding our building, parking, and our intake process. If you arrive late, we may need to reschedule you for a later date in order to be fair to our other patients.

Please bring with you the following items: 1) a completed assessment form (enclosed), all of your medication bottles with all of your medication in them, and your insurance card. If you fail to bring in any of these items, your appointment may need to be rescheduled.

For your convenience, we have enclosed directions to our office. If you have any questions, please call us at **(352) 265-4357**. If you find that you cannot keep this appointment, you must cancel at least **24** hours prior to your scheduled appointment. If you fail to do this, you may not be permitted to reschedule your appointment. We look forward to meeting you and participating in your care.

Addiction Medicine

UF Health Physicians
Department of Psychiatry
4037 NW 86th Terrace
Gainesville, FL 32606
PH: 352-265-4357

AGREEMENT FOR BEHAVIOR STANDARDS REQUIREMENTS DURING CLINIC VISIT

I understand that I am personally responsible for my behavior while being treated by UF Health Physicians. Speaking in a loud voice, shouting, rude behavior, and/or use of profanity are disrespectful, disrupt the physician-patient relationship, interfere with efficient clinic operations and, therefore will not be tolerated in the clinic or by any type of communication (i.e. phone, email, mychart). If I fail to adhere to this policy, I understand I may be discharged from this clinic and/or from all UF Health Clinics.

_____	_____
Patient's Name	Patient's MRN
_____	_____
Patient's Signature	Date
_____	_____
Provider's Signature	Date

MR#_____ Date__/__/____

(For office use only)

New Patient Self-Report Questionnaire

Demographics

Name (last, first, mi):_____

Age:_____ Date of Birth:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Date of appointment:_____Who referred you?_____

Have you been treated here before?_____

What problem/s brings you to Florida Recovery Center Clinic?

_____

_____

Please describe the major stressor(s) in your life now:

_____

_____

Are you currently having any of the following problems?

☐ Irritability, anger ☐ Depressed mood ☐ Euphoric or elevated mood ☐ Mood swings ☐ Decreased need for sleep ☐ Overspending money ☐ Loss of interest in things ☐ Anxiety ☐ Panic attacks ☐ Phobias or fears ☐ Memory problems ☐ Feelings of hopelessness ☐ Difficulty in making decisions ☐ Fear of losing control ☐ Low self-esteem	☐ Trembling or shaking ☐ Excessive worrying ☐ Grunts, tics, jerks ☐ Compulsive or repetitive behaviors ☐ Weight gain ☐ Weight loss ☐ Hearing or seeing things that others cannot ☐ Fear for your safety ☐ Violence toward you/self ☐ Eating disorder ☐ Poor concentration ☐ Thoughts of death ☐ Poor concentration ☐Thoughts of harming yourself	☐ Intrusive memories ☐ Fear in social/public situations ☐ Obsessive or intrusive thoughts ☐ Recurring memories or dreams of past trauma ☐ Concerns about your health ☐ Death of someone close ☐ High level of stress ☐ Poor school work or performance ☐ Physical abuse ☐ Excessive guilt ☐ Feelings of worthlessness ☐ Pressure to keep talking

Psychiatric History

Have you received any *inpatient or outpatient* psychiatric care, counseling, therapy, or psychiatric medication management? *Please describe below.*

Date	For what problem?	What type of treatment?

Have you been treated with any of the following medications? *Check all that apply.*

	Abilify		Eskalith		Naltrexone		Serzone
	Adderall		Gabitril		Namenda		Sonata
	Ambien		Geodon		Nardil		Stelazine
	Antabuse		Haldol		Navane		Strattera
	Aricept		Imipramine		Neurontin		Suboxone
	Ativan		Inderal		Parnate		Tegretol
	Buspar		Keppra		Pamelor		Topamax
	Campral		Klonopin		Paxil		Thorazine
	Celexa		Lamictal		Pristiq		Trazodone
	Chloral Hydrate		Lexapro		Prolixin		Trileptal
	Clozaril		Librium		Prozac		Tranxene
	Cogentin		Lithium/Lithobid		Remeron		Valium
	Concerta		Loxitane		Reminyl		Vistaril
	Cymbalta		Lunesta		Restoril		Vyvanse
	Dalmane		Luvox		Risperdal		Wellbutrin
	Depakote		Mellaril		Ritalin		Xanax
	Effexor		Methadone		Serax		Zoloft
	Elavil		Miltown		Seroquel		Zyprexa

Which of these medications were particularly helpful, or problematic?

_____

_____

Have you ever attempted suicide, or intentionally injured yourself? *Please describe.*

_____

_____

Substance Use History

Substance	Type	Age started	Last Use	Amount	Frequency
Nicotine					
Alcohol					
Marijuana					
Cocaine					
LSD					
Mushrooms					
Inhalants					
Ecstasy					
Heroin					
Opiates/ Painkillers					
Benzodiazepines/ (Xanax,Ativan,etc.)					
Barbiturates					
Sleeping Pills					
Soma/muscle relaxers					
Amphetamines					
Stimulants-other					
PCP/Ketamine					
Designer Drugs					
Cold/Allergy Meds					

Have you ever had treatment for substance abuse/dependence?
Outpatient treatment ☐ Yes ☐ No
Inpatient treatment ☐ Yes ☐ No
*If yes, please describe (type, when,where)*_____
_____
_____
_____

Regarding substance(s) listed above, have you ever experienced:

	Yes	No
Recurrent failure to fulfill duties at work/school/home?		
Using in situations that could be dangerous (e.g. driving a car)?		
Legal problems (arrest, DUI, etc.)?		
Recurrent social or relationship problems (e.g. arguments with spouse)?		
Needing more and more to get the same effect? Less effect on same dose?		
Withdrawal symptoms when you stopped or reduced your dose?		
Taking more, or for a longer time, than you planned?		
Wanting, or trying unsuccessfully, to cut back or quit?		
Spending a great deal of time in activities surrounding the substance?		
Reducing important social/occupational/recreational activities because of the substance?		
Knowing that it was harming your physical or mental health and taking it anyway?		
Doing things that violate your own personal code of ethics (e.g. lying, stealing, etc.)?		

Medical History

Do you currently have a primary care doctor? Name_____
Are you presently being treated for medical problems? If yes, for what problem and who is treating you?_____
_____
_____
When was your last physical examination?_____
Where and by whom?_____
What major illnesses have you had I the past?
_____
_____
What surgeries have you had?
_____
_____
Have you had any serious injuries, including head injuries? Please explain.
_____
_____
List all medications you are currently taking, including over the counter and herbal/natural preparations:

Medication	Dosage and times per day	Why do you take it?	Who prescribes?

Describe any allergic reactions to medications:
_____
_____

Are you currently having any of these physical symptoms?

	Blurred vision		Hot flashes		Poor memory
	Change in appetite		Inability to control your bowel or bladder		Ringing in your ears
	Loss weight by 5 pounds or more in past month.		Inability to obtain orgasm		Shortness of breath
	Weight gain by 5 pounds or more in past month.		Irregular or rapid heartbeat		Sleep disturbance

	Chronic cough		Joint aches and pains		Slowed Thinking
	Chronic sore throat		Lack of energy		Swollen glands
	Delayed ejaculation		Lack of sex drive		Vaginal dryness
	Dizziness		Muscle aches and pains		Black-out spells
	Fatigue		Nausea/vomiting		Fatigue
	Feeling of fullness or bloating		Tremors		Low energy or fatigue
	Shortness or breath		Accelerated heart rate		Increased need for sleep
	Muscle tension		Feeling of choking		Premenstrual symptoms
	Poor appetite		Insomnia		Overeating or binging
	Headaches		Pain in your legs when you walk		Chest Pain

Reproductive History (Women only)

When was your last menstrual period?_____
Do you currently use birth control? If yes, what kind? Any problems?

_____

Are you currently pregnant? ☐ Yes ☐ No
If not pregnant, are you trying to become pregnant? ☐ Yes ☐ No
Have you experienced any of the following:

Pregnancies ☐ Yes ☐ No
Miscarriages ☐ Yes ☐ No
Elective Abortion ☐ Yes ☐ No
Infertility ☐ Yes ☐ No

Weight and Eating Habits

Current Weight _____Highest_____Lowest_____ Height_____

	Yes	No
Are you unhappy with your current weight?		
Do you have intense fear of becoming fat?		
Have you ever missed 3 menstrual cycles in a row?		
Have you ever restricted your eating below 1000 calories/day?		
Do you ever binge or lose control of how much you eat?		
Do you ever intentionally vomit after eating?		
Do you ever use laxatives, diuretics, or other drugs to lose weight?		
Have you had a significant weight gain in the past 6 months?		
Have you had a significant weight loss in the past 6 months?		

Family Medical and Psychiatric History

Please list the blood relatives who have suffered from the following illnesses or problems:

Alcoholism: _____
Abuse of illegal drugs:_____
Depression:_____
Manic depression/bipolar:_____
Postpartum depression:_____
Schizophrenia:_____
Suicide:_____
Cancer:_____
Heart disease:_____
Diabetes: _____
Osteoporosis:_____
Strokes:_____
Thyroid disease:_____

Social Supports

Indicate who currently provides social and emotional support to you:
☐Family ☐Friends ☐Co-workers ☐Others_____
☐Church ☐Neighbors ☐No support
Who lives with you?_____
Are you currently having any problems with the persons that you live with?
☐ Yes ☐ No *If yes, please explain*:_____

Developmental History

Please indicate which of the following you experienced while you were growing up:

Experience	Age	Comments
Death of a parent		
Death of other loved one		
Separation from parent or family		
Parent's separation/divorce		
Loss of home		
Financial problems		
Physical abuse		
Sexual abuse/in childhood		
Sexual assault or rape		
Parents with substance abuse		
Conflicts with parents/family		
Foster care		
Adoption		

Unwanted pregnancy		
School problems		
Medical illness in self		
Medical illness in family member		

Social History

What is the highest level of education you have achieved?_____
_____
What jobs/occupations have you had?_____
_____
_____
Are you currently employed? ☐ Yes ☐ No
Where do you work, and what is your occupation? _____
_____
How long have you been at current employment?_____
Are you experiencing any problems at your job?_____
_____
If not employed, how do you support yourself?_____
_____
Are finances are a cause of stress for you? How?_____
_____
How many times have you been: Married?_____ Divorced?_____ Widowed?_____
What is your present marital status?_____
Do you have any problems or concerns about your current intimate relationship?
_____
How many children do you have?_____
Do any of children live with you? ☐ Yes ☐ No

Spiritual/Religious Background

Please summarize your spiritual or religious beliefs:_____
_____
Do you belong to a congregation or formal religion? Which?_____
How important are your spiritual/religious beliefs/affiliation?_____
_____

Safety

Do you feel unsafe in your current environment? ☐ Yes ☐ No
If no, please describe your concerns_____
_____

Do you have access to any firearms in your home? ☐ Yes ☐ No
Do you currently have thoughts/plans of hurting anyone else? ☐ Yes ☐ No
Do you currently have thoughts/plans of hurting yourself? ☐ Yes ☐ No

Grief and Loss

Have you experienced any significant losses or changes (such as deaths, divorce, relocations, unemployment) that may be contributing to your current problems? Please explain. _____
_____
_____

History of Emotional Trauma

Have you ever been the victim of a violent crime? _____
_____
Have you ever witnessed a severe act of violence?_____
_____
Have you been the victim of physical abuse?_____
_____
Have you ever been a victim of rape or sexual assault?_____
_____
Have you ever been a victim of childhood sexual abuse?_____
_____

Recreation and Relaxation

Please list your favorite activities/hobbies:_____
_____
_____

Current Stress Level

Please rate the current level of stress in your life by placing an "x" on the lines below.

Job/Employment None ⟷ Overwhelming

Family None ⟷ Overwhelming

Life in General None ⟷ Overwhelming

CHECKLIST: Review of Systems

Patient Name: _____ Date of visit: _____

CONSTITUTIONAL:
Yes No
☐ ☐Weight Loss
☐ ☐ Fatigue
☐ ☐ Fever

EYES:
Yes No
☐ ☐ Glasses/Contacts
☐ ☐ Eye Pain
☐ ☐ Double Vision
☐ ☐ Cataracts

EAR,NOSE,THROAT:
Yes No
☐ ☐ Difficulty Hearing
☐ ☐ Ringing in Ears
☐ ☐ Vertigo
☐ ☐ Sinus Trouble
☐ ☐ Nasal Stuffiness
☐ ☐ Frequent Sore Throat

CARDIOVASCULAR:
Yes No
☐ ☐ Murmur
☐ ☐ Chest Pain
☐ ☐ Palpitations
☐ ☐ Dizziness
☐ ☐ Fainting Spells
☐ ☐ Shortness of Breath
☐ ☐ Difficulty lying Flat
☐ ☐ Swelling Ankles

ENDOCRINE:
Yes No
☐ ☐ Loss of Hair
☐ ☐ Heat/Cold Intolerance

RESPIRATORY:
Yes No
☐ ☐ Cough Easy
☐ ☐ Coughing Blood
☐ ☐ Wheezing
☐ ☐ Chills

GASTROINTESTINAL:
Yes No
☐ ☐ Heartburn/Reflux
☐ ☐ Nausea/Vomiting
☐ ☐ Constipation
☐ ☐ Change in BMs
☐ ☐ Diarrhea
☐ ☐ Jaundice
☐ ☐ Abdominal Pain
☐ ☐ Black or Bloody BM

GENITOURINARY:
Yes No
☐ ☐ Burning/Frequency
☐ ☐ Nighttime
☐ ☐ Blood in Urine
☐ ☐ Erectile Dysfunction
☐ ☐ Abnormal Discharge
☐ ☐ Bladder Leakage

ALLERGIC/IMMUNOLOGIC:
Yes No
☐ ☐ Hives/Eczema
☐ ☐ Hay Fever

PSYCHIATRIC:
Yes No
☐ ☐ Anxiety/Depression
☐ ☐ Mood Swings
☐ ☐ Difficult Sleeping

HEMATOLOGY/LYMPH:
Yes No
☐ ☐ Easy Bruising
☐ ☐ Gums Bleed Easily
☐ ☐ Enlarged Glands

MUSCULOSKELETAL:
Yes No
☐ ☐ Joint Pain/Swelling
☐ ☐ Stiffness
☐ ☐ Muscle Pain
☐ ☐ Back Pain

SKIN:
Yes No
☐ ☐ Rash/Sores
☐ ☐ Lesions
☐ ☐ Itching/Burning

NEUROLOGICAL:
Yes No
☐ ☐ Loss of Strength
☐ ☐ Numbness
☐ ☐ Headaches
☐ ☐ Tremors
☐ ☐ Memory Loss

FEMALES ONLY:
Date Last Mammogram_____
Normal_____Abnormal_____
Date last PAP_____
Normal_____Abnormal_____
Age Onset Periods_____
Age Onset Menopause_____
Periods Regular?
Yes_____No____
Number
Pregnancies_____

http://compliance.med.ufl.edu/compliance-tips/review-of-systems-ros-in-em-services/