Welcome to GBCC's Mental Health Medication Management Program

Dear New Client,

We are looking forward to meeting you! Every effort will be made to be sensitive to your needs and assist you in the concerns that bring you to our office.

In order to help you, it is important for you to return this completed packet to our office prior to your first initial appointment. If you cannot return this prior to being seen, you must present 30 minutes prior to your first appointment and have all paperwork completed before you scheduled appointment time or you will lose your scheduled appointment time.

Here's a short list of things to gather:

- ❏ Current medication list including the name of the medication and dosage; of any somatic medications, such as blood pressure medication, diabetes, asthma, etc., and over the counter medications, herbs, and supplements. Be sure to list any medication allergies.
- ❏ Psychiatric medication history including responses to prior medications and approximate dates they were taken.
- ❏ Past psychiatric providers list including therapists, psychiatrist, psychiatric nurse practitioners, or other mental health providers
- ❏ Psychiatric hospitalization history including inpatient, partial hospital or IOP, along with locations, dates, and reasons for hospitalization. For recent hospitalizations, bring your discharge summary for review.
- ❏ Family mental health history including responses to medications, if known.
- ❏ Medical history including list of illnesses and surgeries.
- ❏ Most recent physical and any recent laboratory results.

We have provided you with easy to fill out forms to get you started. Thank you for your cooperation and we look forward to working together with you!

Sincerely,

GBCC's Psychiatric Mental Health Nurse Practitioners

Client Initials: _____ DOB:_____

*All clients under the age of 18 years must be accompanied by a parent/legal guardian.
Please bring necessary verification documents.

Client Name:_____DOB:____/____/____ Today's Date:____/____/____
Nickname/Preferred Name:_____ Gender Identity:_____
Name of Parent or Legal Guardian: (Mother) _____ (Father) _____
Who can we thank for your referral? Online I Insurance I Therapist I PCP I Other:
Name: _____ Credentials: _____ Location: _____
Ethnicity: White I African American I Native American I Hispanic I Asian I Middle Eastern I Other

Presenting problem:
_____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Acne Vulgaris
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis
- ❑ Asthma (type _____)
- ❑ Breast feeding, current
- ❑ Cancer (type_____)
- ❑ Cataracts
- ❑ Constipation, Chronic
- ❑ Crohn's disease
- ❑ Diabetes I or II
- ❑ Dry mouth
- ❑ DVT
- ❑ Eczema
- ❑ Emphysema
- ❑ Eye condition (other _____)
- ❑ Fibromyalgia
- ❑ Gastric sleeve/Bypass
- ❑ GERD/Acid Reflux
- ❑ Glaucoma
- ❑ Goiter
- ❑ Headaches
- ❑ Head trauma/TBI (age_____)
- ❑ Heart murmur
- ❑ Heart problem (other_____)
- ❑ Hepatitis (type_____)
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ HIV/AIDS
- ❑ Insomnia
- ❑ Kidney Disease
- ❑ Leukemia
- ❑ Liver disease/Cirrhosis
- ❑ Lyme Disease
- ❑ Medical Cannabis Card
- ❑ Menopause
- ❑ Migraines, chronic
- ❑ Obesity
- ❑ Pain, chronic (type _____)
- ❑ Pneumonia
- ❑ PCOS
- ❑ POTS
- ❑ Pregnant, current
- ❑ Psoriasis
- ❑ Rheumatic fever
- ❑ Seasonal allergies (type _____)
- ❑ Seizures/Epilepsy (type_____)
- ❑ STD (type _____)
- ❑ Stroke
- ❑ Thyroid Hyper or Hypo
- ❑ Tuberculosis
- ❑ Vitamin deficiency (type _____

Client Initials: _____ DOB:_____

Other illnesses not listed: _____

Surgeries:
Type:_____Year and Age: _____
Type:_____Year and Age: _____
Type: _____ Year and Age:_____

Medication Allergies

Name	Response

Current Medication List

Prescription Medication	Dose	Form (pill, patch, liquid)	Time of day	Use (daily or as needed)	Reason for use
Over the counter medications	**Dose**	**Form (pill, patch, liquid)**	**Time of day**	**Use (daily or as needed)**	**Reason for use**

Client Initials: _____ DOB:_____

Pharmacy Name: _____
Address:_____ ZIP CODE:_____

Prior Psychiatric Medication Trials

Medication	Reason for use	Response (circle one)	Adverse Reactions	Approximate start and stop dates
		Effective Initially Effective No change Worsened		
		Effective Initially Effective No change Worsened		
		Effective Initially Effective No change Worsened		
		Effective Initially Effective No change Worsened		
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		Effective Initially Effective No change Worsened		
		Effective Initially Effective No change Worsened		

Client Initials: _____ DOB:_____

Psychiatric Mental Health Inpatient Hospitalizations

(If recent, please bring all discharge paperwork to appointment)

Hospital name	Location	Dates of Service	Reason for hospitalization

Outpatient Psychiatric Treatment Including Day Programs and IOP's And Psychiatrists, Therapists, NP's, et.al.

Name	Location	Dates of Service
Current Therapist:		

Have you ever had a suicide attempt? Yes No

Year: _____ Age: _____ Method:
_____
Year: _____ Age: _____ Method:
_____
Year: _____ Age: _____ Method:
_____

Have you ever committed purposeful self harm? (ex. cutting, burning, banging your head, punching yourself) Yes No

Client Initials: _____ DOB:_____

If yes, age to age:_____--_____ Frequency: _____Most recent date: _____
To what part of the body?
_____
If yes, age to age:_____--_____ Frequency: _____Most recent date: _____
To what part of the body?
_____

TRAUMA History

Any history of trauma, abuse, neglect or exploitation? □ No □ Yes

If yes: When, Age:
_____

Type: (circle)
Emotional Verbal Sexual Combat Natural Disaster Witness of Violence/abuse

FAMILY HISTORY						
If living					**If deceased:**	
	Age (s)	Health Issues	Psychiatric	Substance Abuse	Age at death	Cause of death
Father						
Mother						
Siblings	**1.** **2.** **3.** **4.**					
Children	**1.** **2.** **3.** **4.**					
Other:						

Client Initials: _____ DOB:_____

Social History

Relationship status: Married l Domestic partner l Single l Divorced l Separated l Widowed l Polyamorous l
Other:_____

Sexual preference: Heterosexual l Homosexual l Bisexual l Other: _____

Employment status: l Employed full-time l Employed part-time l Unemployed l Disabled l Retired Homemaker l Other:_____ Disability:_____

High school graduate: Yes l No GED: Yes l No
Highest level of education completed: _____School Attending:_____
Educational support? IEP 504 Plan Special education
Describe school problems:
_____
_____
_

Are you employed? Yes l No Full time l Part time l Own business
Job title: _____ TIme in current position: _____
Prior: _____ Time in position: _____
Describe any job problems/concerns: _____
_____
_

Any legal or arrest history: l Yes l No Probation/Parole: l Yes l No
If yes, what type: Alcohol/Drug l Property/Financial l Assault/Violence/Weapons l

Armed services history: l Yes l No If yes, branch: _____ Length of time:_____
Discharge: l Honorable l Other: _____

Active religious/spiritual practice: l Yes l No Type: _____

Who lives with you now in your household?_____

Hobbies and leisure activities _____

Who is supportive when you need help? _____

Are there guns or weapons in the home? Yes l No
If yes, where are they kept? _____ Does client have access? Yes l No

Client Initials: _____ DOB:_____

Substance Use:

Drug type	Method of use	Age first used	Age of regular, daily use	Date last used	Last 48 hours	Last 30 days	Last year
A. Depressants: Alcohol (beer, wine, liquor)							
Anti-Anxiety Agents (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)							
Barbiturates (Phenobarbital, Tuinal, Seconal, etc.)							
Others (Methaqualone, Paraldehyde, Equanil, Miltown, muscle relaxants, etc.)							
B. NARCOTICS (Heroin, Opium, Morphine, Codeine (Tylenol #3/#4, Cough Syrup), Methadone, Dilaudid, Percodan, Darvon, Talwin, etc.)							
Amphetamines (Benzedrine, Dexedrine, Ritalin, etc.)							
Cocaine/Crack							
Caffeine							
Nicotine							

Client Initials: _____ DOB:_____

Substance Use Continued:

Drug type	Method of use	Age first used	Age of regular, daily use	Date last used	Last 48 hours	Last 30 days	Last year
D. HALLUCINOGENS (LSD, Ketamine, PCP, etc.)							
E. INHALANTS (glue, poppers, gasoline, etc.)							
F. CANNABIS (Marijuana, Hashish)							

Are you currently in substance abuse treatment? Yes I No Attending Meetings? Yes I No
If yes, where: _____ Type: _____

Do you have a history of being in treatment? Yes I No If yes:
Name of facility/Support:_____ Dates: _____ For?_____
Name of facility/Support:_____ Dates: _____ For?_____
Name of facility/Support:_____ Dates: _____ For?_____

Have you ever had any legal problems related to your use of alcohol/drugs? Yes No
If yes explain: _____

Have you ever had any relationship problems related to your use of alcohol/drugs? Yes No
If yes explain: _____

Medical Cannabis

Medical Cannabis Card Holder: Yes I No Card holder since: Month _____ Year _____
For? (circle) Cachexia I anorexia I wasting syndrome I severe or chronic pain I severe nausea seizures I severe or persistent muscle spasms I glaucoma I post-traumatic stress disorder
Other: _____
Name of Prescriber: _____
Obtained Date:
_____

Client Initials: _____ DOB:_____

Type: _____Dose: _____ TImes a day:_____