Abigail Enelow Myers

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Please email completed registration form before our first appointment

R E G I S T R A T I O N

Date _____ Date of birth _____

Name _____

Address _____

City, State, Zip _____

Phone _____ OK to leave message? ☐ Yes ☐ No

Email _____

Referred by _____

Emergency contact name and phone _____

Preferred pharmacy (name and location) _____

Any allergies to medications? ☐ Yes ☐ No If yes, please list: _____

RELATIONSHIPS AND FAMILY

Are you currently ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed

For how long? _____ How satisfied? _____

Have you been married in the past? ☐ Yes ☐ No If yes, how many times? _____

Partner/Spouse _____ Date of Birth _____ Phone _____

Partner/Spouse/Ex-spouse occupation _____

Do you have children? ☐ Biological ☐ Step ☐ Adopted ☐ Foster ☐ No children

List ages and genders of any children _____

_____

Who do you currently live with? _____

_____

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INSURANCE

Primary subscriber _____ Subscriber's date of birth _____

Insurance company _____

(For other insurance, payment is due upon service and statement will be provided)

Subscriber ID (include letters) _____

Group number _____

Insurance company phone number _____

Please scan the front and back of your insurance card and send in with this form

CURRENT SYMPTOMS

What are your reasons for seeking help today?

_____

_____

_____

_____

Please put a check mark next to any of these that you have experienced over the past 2 weeks

- ☐ Depressed mood
- ☐ Feelings of hopelessness
- ☐ Loss of motivation
- ☐ Difficulty concentrating
- ☐ Suicidal thoughts
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Self-harm
- ☐ Insomnia
- ☐ Weight gain or loss
- ☐ Difficulty socializing (virtually or otherwise)
- ☐ Little interest or pleasure in doing things
- ☐ Feeling easily irritated/irritable
- ☐ Other _____

PSYCHIATRIC HISTORY

Are you currently in therapy? ☐ Yes ☐ No

If yes, therapist's name and phone _____ OK to contact? ☐ Yes ☐ No

If you have been in past therapy, how many times and when?

_____

_____

_____

Have you been in inpatient treatment? ☐ Yes ☐ No

If yes, please explain the experience, and what approximate age(s) were you?

_____

_____

_____

Psychiatric medications:

If you remember doses, please include

Antidepressant:

☐ Prozac (fluoxetine) ☐ Zoloft (sertraline) ☐ Luvox (fluvoxamine) ☐ Paxil (paroxetine)

☐ Celexa (citalopram) ☐ Lexapro (escitalopram) ☐ Effexor (venlafaxine) ☐ Cymbalta (duloxetine)

☐ Wellbutrin (bupropion) ☐ Remeron (mirtazapine) ☐ Other _____

Sleeping medication:

☐ Ambien ☐ Sonata ☐ Lunesta ☐ Trazodone

☐ Over-the-counter (e.g. Benadryl) _____

☐ Other _____

ADHD medication:

☐ Adderall ☐ Ritalin ☐ Strattera ☐ Vyvanse ☐ Other _____

Antianxiety medication:

☐ Xanax (alprazolam) ☐ Ativan (lorazepam) ☐ Klonopin (clonazepam) ☐ Propranolol

☐ Valium (diazepam) ☐ Buspar (buspirone) ☐ Other _____

Mood stabilizer:

☐ Lithium ☐ Depakote ☐ Lamictal ☐ Other _____

Antipsychotic medication:

☐ Abilify ☐ Latuda ☐ Risperdal ☐ Other_____

Supplements: (e.g. Kava, Valerian, etc.)

_____ _____

_____ _____

FAMILY PSYCHIATRIC HISTORY (please check all that apply for immediate family)

☐ Bipolar disorder ☐ Obsessive compulsive disorder ☐ Alcohol abuse

☐ Depression ☐ Suicide ☐ Other substance abuse

☐ Anxiety/Panic attacks ☐ Schizophrenia ☐ Violence

☐ Postpartum depression ☐ PTSD ☐ Other _____

☐ Personality disorder (narcisstic pd, borderline pd) diagnosed or suspected

Which family members had any of these diagnoses? _____

_____

_____

HEALTH HISTORY

Current medical diagnoses and treatments _____

_____

_____

Date of most recent labs _____

SUBSTANCE USE

Have you thought you might have a problem with substance use (e.g. alcohol or other)? ☐ Yes ☐ No

Any treatment for substance use? ☐ Yes ☐ No

If yes, please describe _____

_____

_____

Current alcohol use _____ Binge drinking? ☐ Yes ☐ No

Current marijuana use _____

TOBACCO USE

Do you smoke? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

FAMILY BACKGROUND AND CHILDHOOD HISTORY

Where did you grow up?_____

_____

Are your parents ☐ Married ☐ Divorced ☐ Deceased

If divorced or deceased, please list your age for each event_____

List siblings, full and half, and their ages _____

_____

TRAUMA HISTORY

Have you experienced trauma in your childhood and/or adulthood? ☐ Yes ☐ No

If yes, please describe _____

_____

_____

EDUCATIONAL HISTORY

What is your highest level of education? _____

OCCUPATIONAL HISTORY

Are you currently ☐ Working ☐ Unemployed ☐ Stay-at-home parent ☐ Retired

What is or was your occupation? _____

——POSTPARTUM PATIENTS, PLEASE GO TO NEXT PAGE ——

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Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- □ Yes, all the time
- ☒ Yes, most of the time
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have coped quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .