SELECT PSYCHIATRY ADULT INITIAL EVALUATION FORM

Please complete these forms and bring them with you to your initial appointment. If you have any questions, please call us at (813) 974-8900.

Name _____ Date _____

Date of Birth _____ Age ____ Gender ☐ Male ☐ Female ☐ Other:_____

Primary Phone _____ Secondary Phone _____

Email _____ Handedness ☐ Right-handed ☐ Left-handed

Address _____

Contact Person _____ ☐ Contact in emergency only

Relationship _____

Primary Phone _____ Secondary Phone _____

Ethnicity ☐ White ☐ Asian ☐ Native American/Alaskan Native
☐ Black/African American ☐ Hispanic ☐ Native Hawaiian/Pacific Islander
☐ Other:_____

Referring Physician Information

Were you referred to the USF Department of Psychiatry by a physician? ☐ Yes ☐ No

If yes, please complete the following:

Name of referring physician _____ Specialty _____

Address _____

Phone _____ Fax _____

Primary Care Physician Information

Do you have a Primary Care Physician (one who is responsible for your overall healthcare and/or the one who has to authorize your treatment at the USF Department of Psychiatry because you belong to an HMO/PPO insurance program)? ☐ Yes ☐ No

Name of primary care physician _____ Specialty _____

Address _____

Phone _____ Fax _____

Clinical Information

Reason for evaluation _____

Allergies to medication/foods and type of reaction _____

_____

Has there been any change in your general health within the last year? ☐ Yes ☐ No

If yes, please describe _____

_____

Have you had any of the following diseases?				**Are you under a doctor's care for this problem?**	
	Yes	No	Describe	Yes	No
Emphysema	___	___	_____	___	___
Asthma	___	___	_____	___	___
TB	___	___	_____	___	___
Hypertension	___	___	_____	___	___
Heart Disease	___	___	_____	___	___
Head Injury with Loss of Consciousness	___	___	_____	___	___
Diabetes	___	___	_____	___	___
Thyroid Disease	___	___	_____	___	___
Kidney Disease	___	___	_____	___	___
Sexually Transmitted Disease	___	___	_____	___	___
Glaucoma	___	___	_____	___	___

Nutritional Assessment

Do any of the following apply to you?	Yes	No
I eat less than two meals a day	___	___
My diet has changed over the last 3 months	___	___
I have lost or gained weight in the last 6 months without trying	___	___

If yes, how much? _____

If yes to any of the above, please describe _____

_____

Do you have specific religious or cultural practices that may affect your treatment? Please describe:

_____

Current Medications & Herbal Treatments

Name	Dose	Date Started	Reason Taking

For Women Only

Date of last menstrual cycle _____

Chance of being pregnant ☐ None ☐ Possible ☐ Definite

Number of pregnancies _____

Worsening psychiatric symptoms during or after pregnancy? ☐ Yes ☐ No ☐ N/A

Medical Conditions

Diagnosis	Date Identified	Treatment

Past Surgeries

Procedure	Date	Hospital	Outcome

Past Medical Hospitalizations

Hospital	Dates Inpatient	Reason for Admission	Outcome

Past Psychiatric Hospitalizations

Hospital	Dates Inpatient	Reason for Admission	Outcome

Past Suicide Attempts Number _____

Date	Method	Hospitalized (Y/N)	Outcome

Current Psychiatric Diagnosis (include month/year diagnosed):

Past Psychiatric Diagnosis (include month/year diagnosed):

Psychotherapy

Clinician	Type of Therapy	Started	Stopped	Outcome

Previous Psychiatric Medications

Medication	Ever Taken?		Dose	Duration	Helpful?		
Citalopram or CELEXA	Yes	No	_____	_____	Yes	No	Some
Escitalopram or LEXAPRO	Yes	No	_____	_____	Yes	No	Some
Fluoxetine or PROZAC, SARAFEM	Yes	No	_____	_____	Yes	No	Some
Fluvoxamine or LUVOX	Yes	No	_____	_____	Yes	No	Some
Paroxetine or PAXIL	Yes	No	_____	_____	Yes	No	Some
Paroxetine CR or PAXIL CR	Yes	No	_____	_____	Yes	No	Some
Sertaline or ZOLOFT	Yes	No	_____	_____	Yes	No	Some
Desvenlafaxine or PRISTIQ	Yes	No	_____	_____	Yes	No	Some
Duloxetine or CYMBALTA	Yes	No	_____	_____	Yes	No	Some
Milnacipran or SAVELLA, IXEL	Yes	No	_____	_____	Yes	No	Some
Venlafaxine XR or EFFEXOR XR	Yes	No	_____	_____	Yes	No	Some
Bupropion or WELLBUTRIN, ZYBAN	Yes	No	_____	_____	Yes	No	Some
Mirtazapine or REMERON	Yes	No	_____	_____	Yes	No	Some
Nefazodone or SERZONE	Yes	No	_____	_____	Yes	No	Some
Nomifensine or MERITAL	Yes	No	_____	_____	Yes	No	Some
Trazodone or DESYREL	Yes	No	_____	_____	Yes	No	Some
Vilazodone or VIIBRYD	Yes	No	_____	_____	Yes	No	Some
Amitriptyline or ELAVIL	Yes	No	_____	_____	Yes	No	Some
Amoxapine or MOXADIL	Yes	No	_____	_____	Yes	No	Some
Clomipramine or ANAFRAMIL	Yes	No	_____	_____	Yes	No	Some
Desipramine or NORPRAMINE	Yes	No	_____	_____	Yes	No	Some
Doxepin or SINEQUAN, SILENOR	Yes	No	_____	_____	Yes	No	Some
Imipramine or TOFRANIL	Yes	No	_____	_____	Yes	No	Some
Maprotiline or LUDIOMIL	Yes	No	_____	_____	Yes	No	Some
Nortriptyline or PAMELOR	Yes	No	_____	_____	Yes	No	Some
Protriptyline or VIVACTIL	Yes	No	_____	_____	Yes	No	Some
Trimipramine or SURMONTIL	Yes	No	_____	_____	Yes	No	Some
Isocarboxazid or MARPLAN	Yes	No	_____	_____	Yes	No	Some
Tranylcypromine or PARNATE	Yes	No	_____	_____	Yes	No	Some
Phenelzine or NARDIL	Yes	No	_____	_____	Yes	No	Some
Selegiline or Emsam	Yes	No	_____	_____	Yes	No	Some
Carbamezapine or TEGRETOL	Yes	No	_____	_____	Yes	No	Some
Lamotrigine or LAMICTAL	Yes	No	_____	_____	Yes	No	Some
Lithium or LITHOBID	Yes	No	_____	_____	Yes	No	Some
Topiramate or TOPAMAX	Yes	No	_____	_____	Yes	No	Some
Valproic Acid or DEPAKOTE	Yes	No	_____	_____	Yes	No	Some
Aripiprazole or ABILIFY	Yes	No	_____	_____	Yes	No	Some
Asenapine or SAPHRIS	Yes	No			Yes	No	Some
Clozapine or CLOZARIL	Yes	No	_____	_____	Yes	No	Some
Iloperidone or FANAPT	Yes	No	_____	_____	Yes	No	Some
Quetiapine or SEROQUEL	Yes	No	_____	_____	Yes	No	Some
Olanzapine or ZYPREXA	Yes	No	_____	_____	Yes	No	Some
SYMBYAX	Yes	No	_____	_____	Yes	No	Some
Paliperidone or INVEGA	Yes	No	_____	_____	Yes	No	Some
Risperidone or RISPERDAL	Yes	No	_____	_____	Yes	No	Some
Ziprasidone or GEODON	Yes	No	_____	_____	Yes	No	Some
Alprazolam or XANAX	Yes	No	_____	_____	Yes	No	Some
Chlordiazepoxide or LIBRIUM	Yes	No	_____	_____	Yes	No	Some

Medication	Ever Taken?		Dose	Duration	Helpful?		
Clonazepam or KLONOPIN	Yes	No	_____	_____	Yes	No	Some
Diazepam or VALIUM	Yes	No			Yes	No	Some
Lorazepam or ATIVAN	Yes	No	_____	_____	Yes	No	Some
Temazepam or RESTORIL	Yes	No	_____	_____	Yes	No	Some
Buspirone or BUSPAR	Yes	No	_____	_____	Yes	No	Some
Liothyronine or CTOMEL, T3	Yes	No	_____	_____	Yes	No	Some
Modafinil or PROVIGIL	Yes	No	_____	_____	Yes	No	Some
Pemoline or CYLERT	Yes	No	_____	_____	Yes	No	Some
Pindolol or VISKEN	Yes	No	_____	_____	Yes	No	Some
Pramipexole or MIRAPEX	Yes	No	_____	_____	Yes	No	Some
Prazosin or MINIPRESS	Yes	No	_____	_____	Yes	No	Some
Dexmethylphenidate or FOCALIN	Yes	No			Yes	No	Some
Methylphenidate or RITALIN	Yes	No	_____	_____	Yes	No	Some
Methylphenidate XR or CONCERTA	Yes	No	_____	_____	Yes	No	Some
Amphetamine or ADDERALL	Yes	No	_____	_____	Yes	No	Some
Dextroamphetamine or DEXEDRINE	Yes	No	_____	_____	Yes	No	Some
Dextromethamphetamine or DESOXYN	Yes	No	_____	_____	Yes	No	Some
Lisdexamphetamine or VYVANSE	Yes	No	_____	_____	Yes	No	Some

Other Psychiatric Medications	**Reason for Taking**	**Dose**	**Duration**

Previous Brain Stimulation (ECT, rTMS, VNS, DBS, tDCS, EpCS):

Treatment	Facility	Date	No. of Treatments	Outcome (improvement/ side effects)

Social History

Marital Status
- ☐ Single
- ☐ Married _____ time(s) on date(s) _____
- ☐ Divorced _____ time(s) on date(s) _____
- ☐ Widowed _____ time(s) on date(s) _____

Children ☐ No ☐ Yes, number: _____ ages: _____

Siblings (brothers/sisters) ☐ No ☐ Yes, ages: _____

Education
Years of Schooling _____(e.g., graduate high school = 12 years)
Degrees Obtained _____

Current Occupation

Position	Date Started

Previous Occupations

Position	Date Started	Date Stopped	Reason Stopped

Current Living Situation _____

Weapons in the Home? ☐ No ☐ Yes (type) _____

Do you exercise? ☐ No ☐ Yes

What is the form of exercise, how many times a week, and for how many minutes?

Traumatic Events in Life

Event	Date	Degree of Impact

Do you use the following?

Tobacco	☐ No	☐ Yes	started _____	amount _____	stopped _____
Caffeine	☐ No	☐ Yes	started _____	amount _____	stopped _____
Alcohol	☐ No	☐ Yes	started _____	amount _____	stopped _____
	Withdrawal symptoms?	☐ No	☐ Yes	symptoms _____	
Marijuana	☐ No	☐ Yes	started _____	amount _____	stopped _____
Heroin	☐ No	☐ Yes	started _____	amount _____	stopped _____
Cocaine	☐ No	☐ Yes	started _____	amount _____	stopped _____
Hallucinogens	☐ No	☐ Yes	started _____	amount _____	stopped _____
Other	☐ No	☐ Yes	started _____	amount _____	stopped _____

Current Source(s) of Stress _____

Arrest or Legal Issues _____

Leisure Activities _____

Family History
Does a relative related to you by blood have any of the conditions below? If so, please list the relationship after the diagnosis (no names).

Depression _____
Bipolar Disorder _____
Schizophrenia _____
Anxiety Disorder _____
Social Phobia _____
Post Traumatic Stress Disorder _____
Panic Disorder _____
Eating Disorder (Anorexia or Bulimia) _____
Attention Deficit/Hyperactivity Disorder _____
Dementia/Alzheimer's Disease _____
Alcohol Dependence _____
Drug Dependence _____
Impulse Control Disorder _____
Personality Disorder (e.g., Paranoid, Borderline, Antisocial, Avoidant) _____
Committed Suicide _____
Seizure Disorder _____
Cerebrovascular Disease (e.g., Stroke) _____
Multiple Sclerosis _____
Brain Tumor _____
Other Neurologic Conditions (List) _____

_____
Endocrine Disorders _____
Sudden Cardiac Death _____

Please list any questions you would like to ask your provider at the USF Department of Psychiatry & Behavioral Neurosciences:

_____
_____
_____
_____
_____
_____
_____

Signature of person completing this form _____ Date _____

Print name of person completing this form _____