Center for Adult & Geriatric Psychiatry

2002 Richard Jones Rd
Suite C 206
Nashville, TN 37215
Phone: 615-383-0055

111 Highway 70 East
East Pavilion, 2nd Floor MH2-227
Dickson, TN 37255
Phone: 615-383-0055

www.DrRajPsychiatry.com

Patient Information

Name: _____ Sex: _M/F

Address: _____

City: _____ St: _____ Zip: _____

Phone: (H) _____ (W):_____ (M) _____

Date of Birth: _____ SS #: _____

Spouse's Name: _____

Emergency Contact Name and Number: _____

Please note that Dr. Raj is NOT a participating provider for most insurance carriers. Please check with your insurance company for your benefits. We are happy to help you file claim with your insurance company but payment in full is expected at the time of service, unless specified otherwise. You are welcome to contact us if you have any question about our participation in specific panel.

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Patient Name_____Referred by_____

What is your main problem? _____

List difficulties/symptoms/issues which have prompted you to seek treatment:

_____

What, if anything, happened recently to make the problem worse?

_____

Please circle each symptom that relates to you:

Depression	Pain	Perfectionist
Decreased interest	Muscle Tension	Addicted to drugs/alcohol
Weight loss/gain	Excessive Worry	Feel ugly
Feeling guilty	Racing thoughts	Feel empty
Irritability	Talkative	Flashbacks
Feeling agitated	Excessive Energy	Extreme fatigue
Worthlessness	Paranoid	Loud snoring
Hopelessness	Hearing Voices	Sleeping too much
Diminished ability to think	Seeing images	Trouble going to sleep
Poor concentration	Obsessive thoughts	Trouble staying asleep
Easily distracted	Intrusive thoughts	Jerking legs while sleeping
Difficulty staying on task	Suicidal thoughts	Panic attacks

Yes **No**

____ ____ Have you ever been a patient of a psychiatrist?
If yes, what was your diagnosis and how long were you treated?
_____
_____

____ ____ Have you ever been in in talk therapy/psychotherapy?
If yes, when and for how long?
_____
_____

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Yes	**No**	
____	____	Have you ever attempted suicide?
____	____	Have you ever been hospitalized for any psychiatric reason? If yes, how many times, where and for what ailment? _____ _____
____	____	Have you ever taken any psychiatric medication? If yes, please list them, response, any side effects, and dates taken._____ _____

Some examples are:

Paxil	Lamictal	Risperdal	Ambien
Paxil CR	Lithium	Zyprexa	Lunesta
Lexapro	Depakote	Geodon	Temazepam
Prozac	Neurontin	Abilify	Trazodone
Celexa	Topamax	Saphris	Xanax
Zoloft	Provigil	Seroquel	Valium
Luvox/Luvox CR	Adderall	Fanapt/Clozaril	Lorazepam
Remeron	Ritalin	Nardil	Clonazepam
Wellbutrin	Vyvanse	Emsam	Rozeram
Effexor (Venlafaxin)	Concerta		
Cymbalta			
Pristiq			

Any other psychiatric medications taken:	Reason discontinued:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current treatment providers: (Please include therapists, primary care physicians, etc.)

Name	Role	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Medication allergies:_____

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Patient Name: _____

List all current medications and dosages:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List all medical illness you now have, or have had in the past: (include high blood pressure, diabetes, heart disease, etc.): _____
_____

Have any of your family members had psychiatric difficulties including depression, bipolar disorder (manic depression), alcohol abuse, anxiety, panic disorder or dementia?

Relationship of family member	Type of psychiatric problem
_____	_____
_____	_____
_____	_____

Where were you born? _____ Where did you grow up? _____

Yes	**No**	
____	____	Are your parents living?
____	____	Are they married?
____	____	Do you have any brothers/sisters? If so, how many?
____	____	Are you married?
____	____	Have you been divorced? If yes, how many times?
____	____	What do you like most about your spouse?
____	____	What do you like least about your spouse?
____	____	Do you have children? If yes, how many?

How far in the school did you go? _____

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Yes	No	
____	____	Are you employed? If yes, what is your job?
____	____	Have you ever been in military?
____	____	If yes, what branch and for how long?
____	____	Do you have any history of childhood abuse/trauma?

Whom do you currently live with?_____

What would you say is the most stressful thing in your life currently?_____

_____

____	____	Do you attend church or a religious service?
____	____	Do you drink alcohol?
		If yes, how much do you drink? _____Rarely _____ Occasionally _____ Frequently
____	____	Have you ever tried to cut back your drinking unsuccessfully?
____	____	Do you get annoyed at friends/family telling you that you need to drink less?
____	____	Do you ever feel guilty about your drinking?
____	____	Do you ever use alcohol first thing in the morning?
____	____	Do you use tobacco? If yes, how much?
____	____	Do you use cocaine/marijuana or other illegal drugs?
____	____	Have you ever been arrested?
____	_____	Have you ever been through detox or rehab?

It likely will be to your advantage to look at different clinical scales available for you. Please take a moment to review ones that are most appropriate to your clinical symptoms and fill them out. Please do not forget to bring them with you at time of your appointment.