WCT Health & Wellness

Medication Management Intake Form

Name_____ Date of Birth_____

Parent/Legal Guardian (if under 18)_____

Address_____

Phone Number_____ May we leave a message? ( ) Yes ( ) No

Email_____ Date of Birth

_____

Insurance Carrier _____ Insurance ID _____

Current Pharmacy _____ Current Therapist
Counselor_____

Current Symptoms Checklist: (check any symptoms that have been present in the last month)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before?_____

Past Medical History:

Current Weight _____ Height _____

Allergies_____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____
_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements: _____
_____

Current medical problems:

_____
_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____
_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ Was the EKG ( ) normal ( ) abnormal or ( ) unknown**?**

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Personal and Family Medical History:

	You	**Family**	**Which Family Member?**
	( )	( )	_____
	( )	( )	_____
	( )	(	_____
Thyroid Disease ----------	( )	) (	_____
Anemia----------	( )	)	_____
Liver Disease ----------	( )	( )	_____
Chronic Fatigue ----------	( )	( )	_____
Kidney Disease ----------	( )	( )	_____
Diabetes ----------	( ) (	( )	_____
Asthma/respiratory problems ------	)	(	_____
Stomach or intestinal problems ---	( )	) (	_____
Cancer (type) ----------	( )	)	_____
Fibromyalgia ----------	( )	( )	_____
Heart Disease ----------	( )	( )	_____
Epilepsy or seizures ----------	( )	( )	_____
Chronic Pain ----------	( )	( )	_____
High Cholesterol ----------	( )	(	_____
High blood pressure----------		) (	
Head trauma ----------		)	
Liver problems ----------		( )	
Other ----------	( )	( )	_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

_____

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants

Dates Dosage Response/Side-Effects

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Cymbalta (duloxetine) _____

Wellbutrin (bupropion) _____

Remeron (mirtazapine) _____

Serzone (nefazodone) _____

Anafranil (clomipramine) _____

Pamelor (nortrptyline) _____

Tofranil (imipramine) _____

Elavil (amitriptyline)

Other

_____

Mood Stabilizers

Tegretol (carbamazepine)_____

Lithium_____

Depakote (valproate) _____ _____

Lamictal (lamotrigine) _____

Tegretol (carbamazepine) _____

Topamax (topiramate) _____

Other _____

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers Dates Dosage Response/Side-Effects

Seroquel (quetiapine) _____
Zyprexa (olanzepine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperidone) _____

Sedative/Hypnotics

Ambien (zolpidem) _____
Sonata (zaleplon)
_____
Rozerem (ramelteon)_____
Restoril (temazepam) _____
Desyrel (trazodone) _____

ADHD medications

Adderall(amphetamine)_____
Concerta(methylphenidate)_____
Ritalin(methylphenidate)_____
Strattera (atomoxetine) _____

Antianxiety medications

Xanax (alprazolam) _____
Ativan (lorazepam) _____
_ Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise_____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No

If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? _____

_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol ( ) Ecstasy	( )	( )	_____
		( )	_____
Medical Marijuana Card			_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? **( )** Yes **( )** No How many packs per day on average? _____ How many years? _____ In the past? **( )** Yes **( )** No How many years did you smoke? _____ When did you quit? _____.

Legal History:

Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you?
( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

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Signature_____Date_____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

OFFICE POLICIES

THIS IS EXTREMELY IMPORTANT THAT YOU READ THESE POLICIES BEFORE INITILING & SIGNING

- **_____ Obtaining medication*** YOU must CALL THE PHARMACY & NOT THE OFFICE TO REFILL YOUR MEDICATION*** Failure to do this WILL RESULT IN DELAY of your medication refill.**

- **_____ Refills*** Prescriptions will be called into the pharmacy of your choice listed on page 1, not through the provider directly. If you change pharmacies, it is your responsibility to tell your provider. Failure to do this WILL RESULT IN DEALYS with your refill.**

- **_____ No Show / Late Cancellation*** I understand that WCT Health and Wellness has a strict no show / late cancellation policy. *If I have 2 no shows or late cancellations, I understand that I will be discharged, and a list of area providers will be given to me. There will be an $85 LATE FEE, if 24 hours' notice is NOT given.***

- **_____ Appointments*** I understand that if I fail to schedule and/ or come to my appointments that are part of my treatment plan this WILL RESULT IN A DELAY OF MY PERSCRIPTIONS.**

- **_____ HIPAA*** I understand that my records will be kept safe and confidential at WCT Health and Wellness. My records will NOT be released without my written consent unless I am hospitalized or need some type of urgent care.**

- **_____ Insurance*** I allow WCT Health and Wellness to bill my insurance for dates of service or any additional filing paperwork fees. It is my responsibility to make sure that WCT Health and Wellness knows of any changes to my insurance, home address or phone number. If insurance denies due to insured's negligence, the client will be responsible for charges.**

- **_____ Emergency***If I am experiencing a MEDICAL EMERGENCY, then I agree and understand that I MUST GO TO THE EMERGENCY DEPARTMENT OR CALL 911. I will NOT call the office. Emergencies are serious and must be treated immediately by the hospital.**

- **_____ Consent*** I understand that at any time during my treatment at WCT Health and Wellness, I may be asked to provide a urine sample. If I decline to submit a urine sample or do not cooperate with my treatment plan and office polices, then I may be terminated from all services at WCT Health and Wellness.**

- **_____ Court*** If a therapist or medication provider is required to show up in court on your behalf, the client will be charged $300/hour.**

  ******* By initialing above and signing below, I acknowledge and agree that I have read and fully understand the office policies listed above*****

- **Signature:_____ Date _____**