PSYCHIATRIC ASSOCIATES OF ARKANSAS, PLLC

9601 BAPTIST HEALTH DRIVE, SUITE 1050
LITTLE ROCK, AR 72205

Patient Name: _____ Social Security Number: ___-___-____

Date of Birth: ___/___/___ Sex: M / F (Circle one) Married / Single / Divorced / Widow

Language: _____ Race: _____ Ethnicity: Hispanic / Non-Hispanic / Other

Address: _____
(Street) (City/State/Zip)

Primary Phone: (___) _____-_____ Secondary Phone: (___) _____-_____

Would you be interested in having communications sent to you via your email? (examples: appointment reminders, administrative updates and health bulletins)

Yes No

Email: _____

Employer Name: _____ Phone: (___) _____-_____

Employer Address: _____
(Street) (City/State/Zip)

Primary Care Physician: _____ _____
(Name) (Phone)

How did you hear about our practice? _____

Pharmacy Name: _____
(Phone)

Person responsible for bill or parent/guardian *(Complete only if different from patient)*

Guarantor Name: _____ Social Security Number: ___-___-____

Relationship to Patient: (please check) ( ) self ( ) spouse ( ) parent Date of Birth: ___/___/___

Address: _____
(Street) (City/State/Zip)

Phone: (___) _____-_____ Email: _____

Employer Name: _____ Phone: (___) _____-_____

Employer Address: _____
(Street) (City/State/Zip)

Who to call for an emergency? *(Not at same address as patient)*

Name: _____ Relationship to Patient: _____

Primary Phone: (___) _____-_____ Secondary Phone: (___) _____-_____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Psychiatric Associates of Arkansas, PLLC. I further acknowledge that I am financially responsible for payment whether or not service is covered by my insurance policy.

_____ _____
Signature of Patient or Personal Representative Date

PSYCHIATRIC ASSOCIATES OF ARKANSAS

9601 Baptist Health Dr., Suite 1050
Little Rock, AR 72205
(501) 228-7400

NEW PATIENT HISTORY FORM

NAME:				DATE:		
Referring physician:			*Consent to send evaluation?*		□ YES	□ NO
Consent for PAA to use e-prescribing for transmitting prescriptions to your pharmacy:					□ YES	□ NO
Signature for the consents listed above:						
GENERAL INFORMATION						
***Instructions**: Please fill this out as fully as you comfortably can. The more information we have about you, the better we can serve you.*						
Date of Birth			Age			
Male □	Female □	Single □	Married □	Partner □	Divorced□	Widow/er □
Height	Weight		Blood Pressure (last known)			
LIST MEDICATION ALLERGIES & TYPES OF REACTIONS TO THEM:						
Are you pregnant? □yes □no			If yes, are you taking folic acid (800 mcg daily)? □yes □no			
If applicable, list birth control method:						
Contacts and Contact Information:						
Please list the phone number(s) or email address we may use to leave a message for you or contact you:						
Phone number(s), including area codes:						
Email address(es):						
Due to HIPAA regulations about protecting your health information, please list the people (spouse, adult child, care-giver, etc.) you give us permission to talk with regarding your health issues:						
Current Problem(s)						
Please write briefly what problems you are having and what you we can do for you:						
Have you had thoughts of suicide? □yes □no If yes, please explain:						

Please place a check mark by any of the following you have been having problems with:		
◻ Difficulty sleeping	◻ Decreased appetite	◻ Increased appetite
◻ Loss of sense of humor	◻ Less ability to enjoy regular activities	◻ Tearfulness
◻ Lack of concentration	◻ Irritability	◻ Loss of energy
◻ Lowered self esteem	◻ Less interest in daily grooming (bathing, shaving, wash hair, etc)	◻ Generalized anxiety
◻ Anxiety/ panic attacks	◻ Mania	◻ Hearing voices
◻ Eating disorder	◻ Obsessive thoughts	◻ Compulsive behavior

Are any of the following areas of your life particularly stressful to you? (Check all that apply)			
◻ Marriage/relationship	◻ Health	◻ Legal problems	◻ Employment
◻ Financial problems	◻ Family problems	◻ Sexual issues	◻ Violence

Please explain:

Psychiatric History

Have you ever been treated for a psychiatric illness (depression, anxiety, bipolar, etc.?)	◻ YES	◻ NO
Have you ever been treated in a psychiatric hospital or inpatient unit?	◻ YES	◻ NO

If yes to either of the above questions, please list doctor's names, hospitals, and dates of treatment:

Psychiatric History, continued

Have you had any of the following?

Neurological Exam	◻YES	◻ NO
Psychiatric Exam	◻YES	◻ NO
Psychological Testing	◻YES	◻ NO
Professional counseling/psychotherapy	◻YES	◻ NO

If you answered YES to any of the above, please list the names of the doctor or therapist and dates seen:

Psychiatric Evaluation: Psychiatric Medications

Have you ever taken medicines for depression, anxiety, or any other mental illness? ☐YES ☐NO

If yes, please check off psychiatric medicines you have taken in the past or are taking now:

Medication	Dose	Current?	Took when & how long?	Side Effects? What?	Helpful?
Prozac					
Paxil					
Zoloft					
Celexa					
Lexapro					
Effexor					
Wellbutrin					
Symbyax					
Cymbalta					
Remeron					
Serzone					
Pamelor					
Norpramin					
Prestiq					
Trazodone					
Viibryd					
Medication	**Dose**	**Current?**	**Took when & how long?**	**Side Effects? What?**	**Helpful?**
Xanax					
Ativan					
Klonopin					
Valium					
Vistaril					
Tranxene					
Buspar					
Medication	**Dose**	**Current?**	**Took when & how long?**	**Side Effects? What?**	**Helpful?**
Rozerem					
Ambien					
Lunesta					
Sonata					
Restoril					
Amitriptyline					
Medication	**Dose**	**Current?**	**Took when & how long?**	**Side Effects? What?**	**Helpful?**
Adderall					
Vyvanse					
Ritalin					
Concerta					
Strattera					
Nuvigil					
Provigil					
Kapvay					
Medication	**Dose**	**Current?**	**Took when & how long?**	**Side Effects? What?**	**Helpful?**
Lyrica					
Saphris					
Fanapt					
Lithium					
Depakote					
Tegretol					
Lamictal					
Topamax					
Seroquel					
Risperdal					
Zyprexa					
Geodon					
Abilify					
Clozaril					
Latuda					
Medication	**Dose**	**Current?**	**Took when & how long?**	**Side Effects? What?**	**Helpful?**
Namenda					
Aricept					
Exelon					

Medical History

List the names of physicians you have seen recently, what you saw them for and when:

Have you had any recent laboratory work done? ☐YES ☐NO

If yes, who ordered it and when was it done?

List previous medical or surgical hospitalizations:

Year	Hospital	City & State	Reason

Regular Medicines (List)	Dose	Prescribing Doctor

What over-the-counter medicines/vitamins/herbs do you take?

Have you had any serious illnesses? *(Check all that apply)*.

☐ Cancer	☐ Thyroid Problems	☐ Migraine Headaches	☐ Asthma
☐ Diabetes	☐ Bowel Problems	☐ Stomach Ulcers	☐ Hepatitis
☐ HIV	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol
☐ Seizures	☐ Long Term Pain	☐ Stroke	☐ Head Injury

☐ Other:

Family History					
Number of pregnancies:					
Names and ages of children:					
Names and ages of your brothers/sisters:					
Do any of your children or siblings have a problem with a depression, anxiety, or any other psychiatric illness?				☐YES	☐ NO
If yes, who and what illness?					
Do any of your children, or brothers or sisters have a problem with alcohol or other drug abuse?				☐YES	☐ NO
If yes, who and what substances were abused?					
Is your Mother living?	☐YES	☐ NO	Is your Father living?	☐YES	☐ NO
Are they married to each other?	☐YES	☐ NO	Your age, if they divorced?		
Mother: psychiatric problems?	☐YES	☐ NO	Alcohol or substance abuse?	☐YES	☐ NO
Father: psychiatric problems?	☐YES	☐ NO	Alcohol or substance abuse?	☐YES	☐ NO
Please describe:					
Extended family members with psychiatric problems or alcohol/substance abuse?				☐YES	☐ NO
Please describe:					

Social History			
How would you describe your childhood?	☐Happy?	☐Not Happy?	What Happened?

Were you physically abused growing up?	☐YES	☐ NO
If yes, by whom?		
Were you sexually abused growing up?	☐YES	☐ NO
If yes, by whom?		
Highest grade completed in school?		
Did you serve in the military? ☐YES	☐ NO	
What branch? How long?	Type of discharge?	
How many times have you been married?	If currently married, how long?	
Where are you currently employed?		
How long have you worked there?		
If less than one year, where else have you worked and for how long?		
Are you currently on work disability or FMLA?	☐YES	☐ NO
If yes, what doctor has had you out on disability?		
How long have you been off work? (Give specific dates)		
Are you requesting the physician you are seeing today continue this disability?	☐YES	☐ NO

Habits					
Do you smoke cigarettes?	□YES	□ NO	*If yes, how much per day?*		
Do you drink alcoholic beverages?	□YES	□ NO	*If yes, how often do you drink? Check box below:*		
□Daily	□3-5 times per week		□1-2 times per week		
□1-3 times per month	□1-3 times per six months		□1-3 times per year		
If you drink alcoholic beverages, how much will you drink at each event?					
Have you used other drugs? (Crystal methamphetamine, cocaine, marijuana, etc.)				□YES	□ NO
If yes, what drugs, how often, how much?					
Have you ever been in treatment for alcohol or other drug abuse?				□YES	□ NO
If yes, where and when did you receive treatment?					
Have you ever suffered any consequences of alcohol or other drug abuse such as legal problems (DWI, DUI), public intoxication, possession of drugs, dealing drugs, etc.), medical (DT's, seizures, stomach problems, hepatitis, pancreatitis, AIDS, etc.), social (marital problems, job problems, bankruptcy, loss of friends and family, etc.)?				□YES	□ NO
Please explain:					
Do you drink caffeine?	□YES	*If yes, how much per day?*			□ NO

Adult Symptom Screener

Please check the box for the answer that best fits your experience.

PART 1: In the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Little interest or pleasure in doing things	☐	☐	☐	☐

PART 2: In the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐

PART 3: The following questions relate to your experiences over the last 6 months.

	Yes	No
In the past 6 months, did you ever have a spell or an attack when all of sudden you felt frightened, anxious or very uneasy?	☐	☐
In the past 6 months, did you ever have a spell or attack when for no reason your heart suddenly began to race, you felt faint, or you couldn't catch your breath?	☐	☐
Did any of these spells or attacks ever happen in a situation when you were not in danger or not the center of attention?	☐	☐

PART 4: Please respond to the degree that the following problems have bothered you during the past week.

	Not at all	A little bit	Somewhat	Very much	Extremely
Fear of embarrassment causes me to avoid doing things or speaking to people.	☐	☐	☐	☐	☐
I avoid activities in which I am the center of attention.	☐	☐	☐	☐	☐
Being embarrassed or looking stupid are among my worst fears.	☐	☐	☐	☐	☐

PART 5: Please answer each question to the best of your ability.

	Yes	No
Have you experienced any of the following traumatic events: natural disaster (e.g. flood, hurricane, tornado, earthquake), fire, explosion, or industrial accident; transportation accident (e.g. car accident, plane crash); physical assault (e.g. being attached, beaten up); sexual assault (e.g. rape, attempted rape, made to perform any type of sexual act through force or threat of harm); captivity or exposure to a warzone; life threatening illness or injury; sudden, unexpected death of or injury to someone close to you; or serious injury, harm, or death to someone else that you witnessed or caused?	☐	☐
Has this event caused any significant problems or symptoms that lasted for more than a month?	☐	☐

PART 6: Please answer each question to the best of your ability.

Has there ever been a period of time when you were not your usual self and...	Yes	No
...you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐

PART 7: The following questions relate to your eating habits.

	Yes	No
When you eat, do you make yourself sick because you feel uncomfortably full?	☐	☐
Do you ever worry that you have lost control over how much you eat?	☐	☐
Have you recently lost more than 14 pounds in a 3-month period?	☐	☐
Do you believe yourself to be fat when others say you are too thin?	☐	☐
Would you say that food dominates your life?	☐	☐

PART 8: Please answer the following question to the best of your ability.

	Yes	No
Have you ever been bothered by having to perform some ritual or act over and over that does not make sense?	☐	☐

PART 9: The following questions relate to your alcohol and substance use.

	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
How often do you have a drink of Alcohol?	☐	☐	☐	☐	☐

	1 to 2	3 to 4	5 to 6	7 to 9	10 or more
How many drinks containing alcohol do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often do you have 6 or more drinks on one occasion?	☐	☐	☐	☐	☐

PART 10: Please answer the following question to the best of your ability.

	Yes	No
In the past year have you used an illegal drug or used a prescription medication for non-medical reasons?	☐	☐

PART 11: Please answer the questions below, rating yourself on each of the criteria shown using the scale provided. As you answer each question, select the option that best describes how you have felt and conducted yourself over the past 6 months.

	Never	Rarely	Sometimes	Often	Very Often

How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐
How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐
How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐

PART 12: The questions listed below relate to your thoughts and feelings. If the way you have been in recent weeks or months differs from the way you usually are, please answer based on when you were your usual self.

	Yes	No
Do you find that most people will take advantage of you if you let them know too much about you?	☐	☐
Do you generally feel nervous or anxious around people?	☐	☐
Do you avoid situations where you have to meet new people?	☐	☐
Do you avoid getting to know people because you're worried that they may not like you?	☐	☐
Has avoidance of getting to know people due to fear of being disliked affected the number of friends that you have?	☐	☐
Do you keep changing the way you present yourself to people because you don't know who you really are?	☐	☐
Do you often feel like your beliefs change so much that you don't know what you believe any more?	☐	☐
Do you often get angry or irritated because people don't recognize your special talents or achievements as much as they should?	☐	☐

PART 13: Please answer the following questions to the best of your ability.

	Yes	No
Have you had any unusual experiences such as hearing voices, seeing visions, or having ideas you later found out were not true?	☐	☐
Have you had any other experiences, such as mind reading, ESP, thoughts being controlled by others, seeing things on TV that refer to you specifically?	☐	☐

Patient Health Questionnaire (PHQ)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○