Shadid Integrative Psychiatry Evaluation Questionnaire

At Shadid Integrative Psychiatry, we want to provide you with the best level of care and would appreciate you taking the time to complete the following intake or consultation paperwork to the best of your ability. It is recommended that if you have or can obtain any past medical/psychiatric records or labwork, you bring them to your appointment with you to review. Thank you in advance for your cooperation.

Name: _____ Age: _____ Date: _____

Reason for this appointment:

What is your goal in scheduling an appointment with us today?

☐ Seeking on-going treatment ☐ One-time consultation ☐ Diagnostic Evaluation
☐ Pharmacological Evaluation/Medication Management ☐ Psychotherapy/Counseling Services
☐ Nutritional/Supplemental Evaluation ☐ Integrative and Holistic Approaches
☐ Other: (please specify:)

_____
_____

Please list the symptoms that you suffer with (may also see page 2):

_____
_____
_____
_____
_____
_____
_____

How long have you had these symptoms? Are there any particular patterns to these symptoms that you have identified? (seasonal pattern, monthly hormonal pattern, cyclical pattern, after exposure to particular triggers, etc):

_____
_____
_____

What treatments have you tried in the past for these symptoms? (medications, therapy, supplements, alternative approaches, etc): What was the result of this treatment on your symptoms?

_____
_____
_____
_____

Current Psychiatric Diagnosis/Diagnoses (if known):

_____
_____
_____
_____
_____

Please check all symptoms that apply to you:

☐ Depression or sadness
☐ Loss of interest in things that use to give you pleasure or joy
☐ Anxiety or tension
☐ Irritability or agitation
☐ Feeling emotionally numb or flat
☐ Rapid mood cycling from "high to low" and "low to high
☐ Poor self-esteem, self-worth or poor view of self
☐ Grandiose thinking about self or much more confident in self or abilities than usual
☐ Sleep disturbances of too much sleep
☐ Sleep disturbances of too little sleep
☐ Feelings of hopelessness and/or despair
☐ Changes in appetite or weight
☐ Poor energy, feeling tired or fatigued
☐ Overly energetic or hyper
☐ Restlessness or fidgetiness
☐ Feeling slowed down, difficulty with movement
☐ Difficulty concentrating or making decisions
☐ Poor attention or distractibility
☐ Poor motivation or drive
☐ Racing thoughts or inability to slow thoughts down
☐ Increased sexual interest or ability to perform sexually
☐ Decreased sexual interest or ability to perform sexually
☐ Feeling easily rejected, criticized or hurt by others
☐ Obsessional thinking
☐ Compulsive behaviors
☐ Temper, anger, or rage problems
☐ Panic symptoms or attacks
☐ Body aches or pains
☐ Feeling shortness of breath, difficulty breathing, chest tightness
☐ Feeling dizziness, shakiness, feeling faint or light-headed
☐ Feeling heart pounding/racing, hot or cold flashes/flushing
☐ Fear of losing control
☐ Suspiciousness or paranoid thinking
☐ Unable to relax
☐ Self Injurious or self-harming behaviors
☐ Isolation or withdrawal from others/activities
☐ Avoidant behaviors
☐ Increased alcohol, drug or prescription medication use
☐ Risky or impulsive or dangerous behaviors
☐ Suicidal thoughts and/or gestures
☐ Homicidal thoughts and/or gestures
☐ Hallucinations- hearing or seeing things and/or people that others do not
☐ Feeling fearful/scared or hypervigilant
☐ Recurring nightmares
☐ Flashbacks of past traumas
☐ Difficulties with cognition or memory
☐ Learning difficulties
☐ Poor organization and time-management skills
☐ Difficulty with starting and/or finishing tasks

☐ Any other symptom: _____
☐ Any other symptom: _____
☐ Any other symptom: _____
☐ Any other symptom: _____

Past Psychiatric History and Treatment

Have you had any past psychiatric or mental health treatment? ☐ Yes ☐ No

☐ Medication Management ☐ Individual Therapy ☐ Group Therapy ☐ Other Therapy (Family, etc)
☐ Intensive Outpatient ☐ Acute Inpatient ☐ Extended Stay Inpatient
☐ Self Help Group Attendence (12 Step Program, etc) ☐ Other (please specify): _____

If yes, please list type of treatments that have been helpful for you:

_____
_____

Please list why you were you seen, when and for how long you were treated.

_____
_____
_____

Do you have history of mood symptoms that occurred at an intensity or frequency or duration of time that affected your functioning and well-being:

☐ Depression ☐ Anxiety ☐ Panic attacks ☐ Mood Swings
☐ Anger or outburst ☐ Irritability or Agitation ☐ Emotional Numbing/Flattening

If yes, please describe when you experienced any of these and for how long did these symptoms last:

_____
_____
_____
_____

Has a doctor, therapist, or psychiatrist ever diagnosed you with (check all that apply):

☐ Major Depressive Disorder
☐ Dysthymia
☐ Bipolar Disorder, type 1 or 2
☐ Attention Deficit/Hyperactivity Disorder
☐ Other (please be specific) _____
☐ Other (please be specific) _____
☐ Schizophrenia or Schizoaffective Disorder
☐ Anxiety Disorder with/without Panic Attacks
☐ Obsessive Compulsive Disorder
☐ Post Traumatic Stress Disorder
☐ Personality Disorder
☐ Drug or Alcohol Abuse/Dependence

Have you had any hospitalizations for a psychiatric or mental health condition? ☐ Yes ☐ No
If yes, please explain why you were hospitalized? Where and when you were hospitalized?

_____
_____
_____
_____

Are you currently in psychotherapy/counseling? ☐ Yes ☐ No
If yes, who is your therapist and how long have you seen him/her?

_____
_____

Have you had one or more severely stressful events that have affected your well-being? ☐ Yes ☐ No
If yes, please specify the event, including how long you felt stressed or your well-being was negatively affected:

_____
_____
_____

Have you experienced any assaults or traumas, including physical, emotional, verbal or sexual abuse: ☐ Yes ☐ No
Please specify all that apply: ☐ Physical ☐ Sexual ☐ Emotional ☐ Verbal
Please list the ages which the traumas occurred:

_____
_____
_____

Do you believe these traumas are related to the symptoms you are presenting with today? ☐ Yes ☐ No

Has there been any past history of suicidal ideations or attempts? ☐ Yes ☐ No
Has there been any past history of self-harming or self-mutilation behaviors? ☐ Yes ☐ No
Has there been any past history or risky/dangerous/impulsive behaviors? ☐ Yes ☐ No

If yes, please specify about the attempts or behaviors:

_____
_____
_____

Family Psychiatric History

Is there any family genetic psychiatric history? ☐ Yes ☐ No
If yes, please be specific (who has what type of psychiatric problem? on mother's or father's side?)

Please consider psychiatric hospitalizations, psychiatric treatment, depression, bipolar disorder (manic-depressive illness), anxiety/panic attacks, suicide attempts, "nervous breakdowns", schizophrenia or any unusual behavior:

_____
_____
_____
_____

Are any relatives on psychiatric medications? ☐ Yes ☐ No
If yes, which medications? Were they helpful?

_____
_____

Do any relatives have a history of problems with alcohol or drug abuse? ☐ Yes ☐ No
If yes, which relative(s) and which substances?

_____
_____

Family/Childhood History

While being raised, my parental figures were: ☐ Married ☐ Never Married ☐ Living as Married/Cohabitating
☐ Separated/No longer living as married ☐ Divorced ☐ Widowed

Number of brothers: _____ Ages of brothers: _____
Number of sisters: _____ Ages of sisters: _____

Were you adopted? ☐ Yes ☐ No
What was your overall experience of being raised in your family? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
(Please describe):

_____
_____
_____

Medical History

In general, would you say that your overall health is: ☐ Good ☐ Average ☐ Fair ☐ Poor

Are you experiencing any physical symptoms that concern you? : ☐ Yes ☐ No
If yes, please specify:

_____

_____

Do you have any of the following medical conditions? (check all that apply)

☐ Allergies
☐ Asthma
☐ Headaches/Migraines
☐ Seizures
☐ Head Injury/Concussion
☐ Stroke
☐ Pain Disorder
☐ Sleep Disorder
☐ Gastrointestinal Disorder
☐ Thyroid Disorder
☐ Cardiac/Heart Disease
☐ High/Low Blood Pressure
☐ Blood Disorder
☐ Cancer
☐ Glandular Disorder
☐ Diabetes
☐ Multiple Sclerosis/Lupus
☐ Osteoarthritis
☐ Autoimmune Disorder
☐ Liver Disorder/Hepatitis
☐ Kidney Disorder
☐ Kidney Infections/Stones
☐ Nervous System Disorder
☐ Respiratory Disorder
☐ Skin Disorder
☐ Peptic Ulcer Disease/GERD
☐ Other: _____
☐ Other: _____

Have you been hospitalized for any medical reasons (not psychiatric)? ☐ Yes ☐ No
If yes, please specify why and when

_____

_____

Have you had any surgeries? ☐ Yes ☐ No
If yes, please specify why and when

_____

_____

When was your most recent physical exam and labwork/bloodwork? Was anything abnormal?

_____

_____

Allergies to Medications: ☐ No known allergies or adverse reactions
_____ ☐ Allergy ☐ Adverse Reaction Please Describe: _____
_____ ☐ Allergy ☐ Adverse Reaction Please Describe: _____

Current medications: (IMPORTANT: Please list any prescription & non-prescription medications, vitamins, supplements or herbs; include name, dose & how often taken)

	Medicine	Dose	Frequency of Med
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Who has been prescribing your meds?

_____

_____

Hormone History

Female Patients:

Menses: ☐ Regular ☐ Irregular ☐ Amenorrhea ☐ Menopausal ☐ Postmenopausal ☐ Not Applicable

Are you taking contraceptives or hormone supplement? ☐ Yes ☐ No ☐ N/A

Do you have any perimenopausal/menopausal symptoms? ☐ Yes ☐ No ☐ N/A

Do you have any PMS/PMDD symptoms? ☐ Yes ☐ No ☐ N/A

Do you believe your moods have been negatively affected by:

☐ Puberty ☐ Menstrual Cycles ☐ Pregnancy(s) ☐ Menopause

If yes, how disruptive to your mood that these been: ☐ Mildly ☐ Moderately ☐ Severely

If yes, please describe:

_____

_____

Have you ever been evaluated for any hormonal dysfunctions, such as thyroid and/or adrenal gland dysfunctions?

If yes, please describe which ones, and what treatment occurred? ☐ Yes ☐ No

_____

_____

Male Patients:

Have you ever been evaluated for any hormonal dysfunctions, such as testosterone deficiencies or thyroid gland dysfunctions? If yes, please describe which ones, and what treatment occurred? ☐ Yes ☐ No

_____

_____

Diet/Nutrition History

How would you describe your diet/nutrition? What do you typically eat?

_____

_____

Are you currently on a restricted diet? (vegan, high protein only, etc) ☐ Yes ☐ No

If yes, please describe:

_____

_____

Do you take any diet/vitamin supplements? ☐ Yes ☐ No

If yes, what types, for how long?

_____

_____

Do you have any Food Allergies/Sensitivities? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Do you suffer or have your suffered from anorexia, bulimia or any other eating disorder? ☐ Yes ☐ No

If yes, which type, for how long, any treatment received?

_____

_____

Do you regularly have caffeine intake? ☐ Yes ☐ No

If so, how much consumption daily, what types? (energy drinks, coffee, tea):

_____

_____

Sleep Pattern History

Do you have any sleep disturbances (falling asleep, staying asleep)? ☐ Yes ☐ No
If yes, how long does it take you to fall asleep or fall back asleep?

_____

_____

If yes, how long have you suffered with sleep problems? What treatments have you tried in the past for sleep?

_____

_____

_____

On average, how many hours do you sleep per night? _____
Have you ever had a sleep study? ☐ Yes ☐ No
If yes, when and what were the results?

_____

_____

Do you have history of: ☐ Heavy Snoring ☐ Sleep Apnea ☐ Sleepwalking ☐Recurrent Dreams ☐Grinding Teeth

Do you take medications, herbals, OTC treatments for sleep disturbances? ☐ Yes ☐ No
If yes, which types and for how long?

_____

_____

Substance Use History

Do you use alcohol? ☐ Yes ☐ No
If yes, how many drinks per night, and how many nights per week?

_____

_____

In the last 12 months, have you drank more than you meant to or felt your drinking patterns were excessive or out of control for you? Have you wanted to cut down on your drinking patterns? ☐ Yes ☐ No

Do you use nicotine? ☐ Yes ☐ No
If yes, how much/often?

_____

Do you use any recreational drugs? ☐ Yes ☐ No
If yes, which ones and how often?

_____

_____

Do you have a history of drug use? ☐ Yes ☐ No
If yes, which substances and for how long did you use them?

_____

_____

Do you have a history of taking a larger amount (higher dose) or more frequent use of a medication than was originally prescribed by your provider? ☐ Yes ☐ No
If yes, which substances and for how long did you use them?

_____

_____

Does your use of any of these substances play a part in the reason for your appointment today? ☐ Yes ☐ No
If yes, please explain: _____

_____

Have you ever been treated for substance abuse in the past? Had to attend detox or rehab program? ☐ Yes ☐ No
If yes, when and what type of treatment did you receive?

_____

_____

Stress Management

What current stressors do you have in your life? Please explain what type of stressors, for how long they have occurred, and how much distress do these stressors cause you?

_____
_____
_____
_____
_____

Has your ability to handle stress and pressure decreased? ☐ Yes ☐ No
Do you experience constant stress in your life or work? ☐ Yes ☐ No
Are any of your relationships at work and/or home unhappy? ☐ Yes ☐ No
Do you feel overwhelmed and have little control over your life? ☐ Yes ☐ No
Do most events feel like a chore? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No If so, what type of exercise and how many days a week?

_____
_____

Do you feel that you have a support system? ☐ Yes ☐ No
If you were to need help with your current difficulties, who are the people you could rely on the most to help/support you?
☐ Family ☐ Friends ☐ Coworkers ☐ Therapist/Counselor ☐ Other: _____
If so, who?

_____
_____

Are there any cultural or spiritual or religious beliefs that you would like to tell us about?

_____
_____

How do you typically cope with stressors in your life? ☐ Very Well ☐ Fair ☐ Not Very Well
Please specify techniques/skills that are helpful for you:

_____
_____

What hobbies or activities do you enjoy? How often do you get to do these activities?

_____
_____

Additional notes that Dr. Shadid should know about me:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Social/Background History

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ In a Relationship
Do you consider yourself: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other: _____
Are you currently involved in a significant relationship? ☐ Yes ☐ No
If yes, are you satisfied with this relationship? ☐ Yes ☐ No

Current living situation (relationship of person(s) with whom patient resides)?
☐ Self ☐ Spouse/family ☐ Roommate(s) ☐ Group Home or Assisted Living Facility
☐ Other (please specify)
_____
_____

How many dependents do you have excluding yourself?

☐ Number or sons: _____ ☐ Age of sons: _____
☐ Number or daughters: _____ ☐ Age of daughters: _____

What is highest level of education/degree you have received?

☐ None ☐ High School Diploma ☐ GED (General Equivalency Degree for HS) ☐ Some College
☐ Associate Degree/Technical Degree ☐ College Degree (Bachelors Degree) ☐ Masters Degree
☐ Doctorate or Professional Degree (MD, JD, PhD)

Are you currently employed?

☐ Yes, full time ☐ Yes, part time ☐ Retired ☐ Student ☐ Disabled ☐ Homemaker
If working, current occupation: _____
If not working, former occupation: _____

Have you ever had any legal problems including jail, prison, lawsuits, probation, etc.? ☐ Yes ☐ No
If yes, please explain:
_____
_____

Have you ever served in the military? ☐ Yes ☐ No
If yes, what branch of the military? When did you serve? What type of discharge did you receive?
_____
_____

Do you have any spiritual or religious or affiliation that you identify with?
☐ Christian ☐ Muslim ☐ Jewish ☐ Buddhist ☐ Spiritual but not religious
☐ Seeking/Undecided ☐ None ☐ Other (please specify): _____

How important is spirituality/religious practice in your life? ☐ Very Important ☐ Important ☐ Not Very Important

MEDICATION REFERENCE SHEET

ANTIDEPRESSANTS

Celexa (citalopram)	**Lexapro (escitalpram)**	**Prozac (fluoxetine)**	**Zoloft (sertraline)**	**Paxil (paroxetine)**
Luvox (fluvoxamine)	**Cymbalta (duloxetine)**	**Effexor (venlafaxine)**	**Pristiq (desvenlafaxine)**	**Fetzima (levomilnacipran)**
Trintillex (vortioxetine)	**Wellbutrin (buprobion)**	**Viibryd (vilazodone)**	**Desyral (trazodone)**	**Remeron (mirtazapine)**

TRICYCLIC ANTIDEPRESSANTS (TCAs) / MONOAMINE OXIDASE INHIBITORS (MAOIs)

Anafranil (clomipramine)	**Elavil (amitriptyline)**	**Sinequan/Adapin (doxepin)**	**Tofranil (imipramine)**	**Pamelor/Aventyl (nortriptyline)**
Norpramin (desipramine)	**EMSAM (selegiline)**	**Marplan (isocarboxazid)**	**Nardil (phenelzine)**	**Parnate (tranylcypromine)**

STIMULANTS / NONSTIMULANTS FOR ADHD

Adderall IR/XR (amphetamine mixture)	**Ritalin IR/SR/LA (methylphenidate)**	**Focalin IR/XR (dexmethylphenidate)**	**Daytrana (methylphenidate transdermal)**	**Concerta (methylphenidate ER)**
Dexedrine (dextroamphetamine)	**Metadate IR/CR (methylphenidate ER)**	**Vyvanse (lisdexamfetamine)**	**Strattera (atomoxetine)**	**Provigil (modafinil)**
Nuvigil (armodafanil)	**Dexedrine Spansules /DetroStat (dextroamphetamine)**	**Intuniv / Tenex (guanfacine)**	**Cylert (premoline)**	**Catapres (clonidine)**

MOOD STABILIZERS

Depakote IR/ER (divalproex sodium)	**Depakene (valproic acid)**	**Lithium Eskalith/Lithobid (lithium carbonate)**	**Lamictal IR/XR (lamotrigine)**	**Neurontin (gabapentin)**
Lyrica (pregabalin)	**Tegretol IR/XR (carbamazepine)**	**Trileptal (oxcarbazepine)**	**Topamax (topiramate)**	**Keppra (levetiracetam)**

ANTI-ANXIETY MEDICATIONS / SEDATIVE-HYPNOTICS/ SLEEP MEDICATIONS

Ativan (lorazepam)	**Klonopin (clonazepam)**	**Xanax (alprazolam)**	**Valium (diazepam)**	**Serax (oxazepam)**
Restoril (temazepam)	**Halcion (triazolam)**	**Librium (chlordiazepoxinde)**	**Vistaril / Atarax (hydroxyzine)**	**Benadryl (diphenhydramine)**
Ambien (zolpidem)	**Sonata (zaleplon)**	**Lunesta (eszopiclone)**	**Rozerem (ramalteon)**	**Prosom (estazolam)**
Tranxene (clorazepate)	**Buspar (buspirone)**	**Desyral (trazodone)**	**Unisom (doxylamine**	**Dalmane (flurazepam)**

ATYPICALS / ANTI-PSYCHOTIC / STABILIZING MEDICATIONS

Abilify (aripiprazole)	**Geodon (ziprazodone)**	**Risperdal (risperidone)**	**Invega (paliperidone)**	**Seroquel (quetiapine)**
Zyprexa (olanzapine)	**Saphris (asenapine)**	**Latuda (lurasidone)**	**Haldol (haloperidol)**	**Clozaril (clozapine)**
Loxitane (loxapine)	**Mellaril (thioridazine)**	**Navane (thiothixene)**	**Prolixin (fluphenazine)**	**Sonazine / Thorazine (chlorpromazine)**

PLEASE CIRCLE ALL OF THE MEDICATIONS YOU HAVE TRIED IN THE PAST AND PROVIDE MORE INFORMATION ABOUT THESE MEDICATION TRIALS IN THE PAST. PLEASE BE AS SPECIFIC AS YOU CAN ABOUT THE DOSES, HOW LONG YOU TOOK THE MEDICATION, AND THE RESPONSES TO YOUR SYMPTOMS, OR ANY POSITIVE/NEGATIVE EFFECTS OF MEDS.

Medication 1: _____

Medication 2: _____

Medication 3: _____

Medication 4: _____

Medication 5: _____

Medication 6: _____

Medication 7: _____

Medication 8: _____

Medication 9: _____

Medication 10:_____