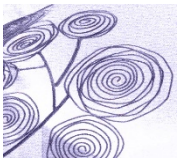

Orr & Associates

Memory & Geriatric Clinic

Dr. William Orr M.D., PH.D. , Patricia "Sue" Bikkie DNP., Rhett Tompkins PA.C.

720 Main Street #204, Mendota Heights, MN. 55118 *----------*490 South Maple Street #204 Waconia, MN. 55387

Patient Intake Form

Today's Date: _____ Social Security #: ____ -____-_____

Patient Name: _____ Age: _____ Date of Birth: _____

Address: _____

Email Address: _____

Telephone Number: (home) _____ (cell) _____

Marital status: _____ Preferred language: _____ Nationality: _____

Facility Name: _____

Facility Address: _____

Facility Contact: _____ Facility Phone Number: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Address: _____

Emergency Contact Email Address: _____

Insurance Information

Primary Insurance: _____ Member Number: _____

Address: _____ Group Number: _____

Phone Number: _____

Secondary Insurance: _____ Member Number: _____

Address: _____ Group Number: _____

Phone Number: _____

Advance Directives: Check which directives apply

DNR/DNI: ___ Living Will: ___ Organ Donor: ___ Power of Attorney: ___ Legal Guardian: _____

Power Of Attorney Name:

_____

Address: _____ Phone Number: _____

Email:

_____

Appointment Information:

What are the problems you're seeking help for today?

_____

List all current medications:

Name: _____ Dosage: _____ Start date: _____

Name: _____ Dosage: _____ Start date: _____

Name: _____ Dosage: _____ Start date: _____

Name: _____ Dosage: _____ Start date: _____

Name: _____ Dosage: _____Start date: _____

List any Drug Allergies:

_____

List Current Pharmacy: Name:

_____

Location: _____ Phone Number: _____

Current Height: _____ Current Weight: _____

Current Medical Problems:

_____

Personal Medical History: (Check any symptoms currently apply or you have a history having.)

Thyroid Disease___ Anemia___ Liver Disease___ Chronic Fatigue___ Kidney Disease___
Diabetes___ Asthma/Respiratory___ Stomach/Intestinal____ Cancer____ Fibromyalgia___
Heart Disease___ Epilepsy or Seizures___ Chronic Pain___ High Cholesterol___
High Blood Pressure___ Head Trauma___ Liver Problems___ Other_____
If there is any history of brain injury, knocked unconscious, or seizures? If yes, please explain: _____

_____

Do you have any problems chewing? _____ Swallowing? _____ Walking? ____ Standing? _____
Do you have any urinary or bowel incontinence? ___Yes ____No ____Both _____
Have you fallen in the last year? When? _____ Where? _____
Primary Care Doctor Name:

_____
Clinic Name:
_____Location:_____
Other Medical Provider Name:

_____
Clinic Name: _____ Location:

_____

Current Symptoms Checklist: (Check once for any symptoms present, twice for major symptoms)

Depressed Mood: ___ Racing Thoughts: ___ Excessive Worry: ___ Unable to Enjoy Activities: ___
Impulsivity: ___ Anxiety Attacks: ___ Sleep Disturbances: ____ Increased Risky Behavior: ___
Avoidance: ___ Loss of Interest: ___ Increased Libido: ___ Hallucinations: ___
Suspiciousness: ___
Concentration/ Forgetfulness: ___ Change in Appetite: ___ Excessive Energy: ___
Excessive Guilt: ___
Increased Irritability: ___ Fatigue: ___ Crying Spells: ___ Decreased Libido: ___ Other: _____

Suicide Risk Assessment:

Over the last 2 weeks, how often have you been bothered by any of the problems?
(Circle the correct number.)

	Not at all	Several days	Some of the days	Most every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or you have let your family down.	0	1	2	3
7. Trouble concentrating on things, such as Reading the newspaper or watching TV.	0	1	2	3
8. Moving or speaking so slowly that other people have noticed. Or being so fidgety or restless that you have been moving around a lot, more than usual.	0	1	2	3
9. Thoughts that you would be better off	0	1	2	3

dead, or of hurting yourself. _____

Total:

Have you ever had feelings or thoughts that you didn't want to live? Yes: ___ No: ___
Do you currently feel that you don't want to live? Yes: ___ No: ___
Have you ever tried to kill yourself before? Yes: ___ No: ___ When?_____

Past Psychiatric History:

Have you had past outpatient treatment? ___Yes ___No. If yes, Please describe for when, by whom, and nature of treatment._____
_____

Have you had any psychiatric hospitalizations? ___Yes ___No. If yes, Please describe for what reason, when, and where you received treatment._____

Past Psychiatric Medication:

If you have ever taken any of the following medications, please indicate by placing a check mark next to the medication.

Antidepressants:

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 (Nortriptyline) ___ Tofranil (Imipramine) ___ Elavil (Amitriptyline___

Mood Stabilizers:

Tegretol (Carbamazepine) ___ Lithium___ Depakote (Valproate) ___ Lamictal (Lamotrigine) ___
Topamax (Topiramate) ___

Antipsychotics:

Seroquel (Quetiapine) ___ Zyprexa (Olanzapine) ___ Geodon (Ziprasidone) ___ Abilify (Aripiprazole) ___
Clozaril (Clozapine) ___ Haldol (Haloperidol) ___ Prolixin (Fluphenazine) ___

Sedatives/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) ___

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:
Bipolar Disorder___ Depression___ Anxiety___ Schizophrenia___ Post-Traumatic Stress___ Violence___
Alcohol Abuse___ Other Substance Abuse Issues___ Suicide___
If yes, who had what problems? _____

_____

Has any family member been treated with a psychiatric medication? ___Yes ___No. If yes, who was treated and when? _____

_____

Substance Use:

Do you drink coffee? ___Yes ___No. If yes, how many cups a day? _____
Do you drink Alcohol? ___Yes ___No. If yes, how much a day/week? _____
Have you ever been treated for alcohol or drug use or abuse? ___Yes ___No
If yes, for what substances? _____
If yes, were you ever treated and when? _____
Are you currently using any alcohol, recreational drugs, or misusing prescription medications? ___Yes ___No.
If yes, please describe: _____

Tobacco History:

Do you currently use any tobacco products such as cigarettes, cigars, pipes, or chewing tobacco? If yes, how much and how often? _____

Trauma History:

Do you have a history of being emotionally, sexually, and physically or by neglect? ____Yes ____No
If yes, when and at what age, please describe: _____

Educational History:

Any history of learning problems or tutoring? ___Yes ___No. What age? _____
What is your highest level of education or degree attained?

_____

Occupational History:

Are you currently: __Working __Not working by choice __ Unemployed __Disabled __Retired
What is/was your occupation? _____
Have you ever served in the military? ___Yes ___No. If yes, what branch and dates served: _____

_____
Honorable discharge? ___Yes ___No. Other type of discharge_____

Relationship History and Current Family:

Are you currently: Married ___ Divorced ___ Single ____ Widowed_____ Partnered_____ How long? ___
Have you had prior marriages? Yes___ No___ If so, how many? _____ How long? _____
What is your spouse or significant other's occupation? _____
Do you have children? Yes ___ No___ If yes, list ages and gender: _____

Spirituality/Religion:

Do you practice a religion or are you a spiritual person? ___Yes ___No. What affiliation? _____

Does it play a part in your coping treatment? ___Yes ___No.

Legal:

Have you ever been arrested? ___Yes ___No. If so, what for: _____ when?_____

Do you have and pending legal problems? _____

Daily Activities:

Do you need assistance with any of the following?

	NO	SOME	TOTALLY
DEPENDENT			
1. Grocery Shopping	____	_____	____
2. Balancing Checkbook	____	_____	____
3. Paying Bills	____	_____	____
4. Housework	____	_____	____
5. Meal Preparation	_____	_____	____
6. Dressing	_____	_____	_____
7. Eating	_____	_____	_____
8. Personal Hygiene	_____	_____	_____

Memory:

Briefly describe ant significant memory problems (forgetting important appointments, taking medications, familiar directions, cooking accidents, other- dates?):_____

_____

If retired, what do you do most of your days? _____

_____

Driving:

Are you still driving? Yes___ No ___ do you limit your driving in any way?_____

_____

Have you had any recent problems driving? (Tickets, getting lost, accidents, when?):_____

_____

Is there anything else you would like your provider to know? _____

_____

Form filled out by: _____ Date: _____

Signature of patient: _____ Date: _____