PSYCHIATRIC SERVICES, P.C.
DR. LUBBERSTEDT PRE-SUPPLEMENTAL INFORMATION

Name	Age

Please fill out this form to the best of your knowledge. It is to aid us in working with you and will be held in strictest confidence.

Do you have any history of neurological problems, such as seizures, head injuries, or migraines? ☐ Yes ☐ No

If yes, please explain ____________________

Do you use nicotine? ☐ Yes ☐ No

If yes, how often and in what quantity ____________________

How many caffeine drinks do you consume in one day? ☐ Coffee ______ ☐ Tea ______ ☐ Soft drinks ______ ☐ Other ______

During the past three months, have you used any drug or other substance, such as sleeping pills, pain killers, illegal drugs (like marijuana, cocaine), in a manner not prescribed or recommended by your doctor? ☐ Yes ☐ No (if yes, Check all that apply)

- ☐ Amphetamines (e.g., diet pills, "speed", "uppers")
- ☐ Barbiturates (sedatives, "downers")
- ☐ Cocaine (crack, powder)
- ☐ Inhalants (glue, gasoline, paint thinner)
- ☐ LSD, mescaline, or other hallucinogens
- ☐ Marijuana or hashish
- ☐ Opioids/heroin/morphine, etc
- ☐ PCP (phencyclidine)
- ☐ Pain killers (e.g., codeine, Demerol)
- ☐ Sleeping pills
- ☐ Solvents, rubbing alcohol, etc
- ☐ Tranquilizers (e.g., valium, Xanax)
- ☐ Other prescription or non-prescription drugs or substances

Have you ever been abused? ☐ Yes ☐ No

If yes, please check: ☐ Sexual ☐ Physical ☐ Verbal

Developmental history (child only):

Any exposures to medication, drugs, tobacco, or alcohol during pregnancy? ☐ Yes ☐ No

If yes, please explain ____________________

Medical complications with the pregnancy? ☐ Yes ☐ No

If yes, please explain ____________________

Any birth complications? ☐ Yes ☐ No

If yes, please explain ____________________

Milestone delays (e.g. walking, talking, toilet training)? ☐ Yes ☐ No

If yes, please explain ____________________

Highest Level of Education:

- ☐ Graduate Professional Training (e.g., MD, PhD, or Master's degree)
- ☐ Standard College or University Graduation (e.g., BA or BS degree)
- ☐ Partial College Training (at least one year completed) or Vocational/Techinical School
- ☐ High School Graduation or GED
- ☐ less than a high school degree, please list grade level and school attended ____________________

Are there any learning issues present and/or an IEP/504 plan in place? ☐ Yes ☐ No

If yes, please explain ____________________

Regarding your safety, do you have access to weapons? ☐ Yes ☐ No

From the following list, mark each item that has concerned you *in the past six months* with an "X" in the appropriate column, based on severity.

	1 = Severe	2 = Moderate	3 = Mild	4 = None		1 = Severe	2 = Moderate	3 = Mild	4 = None
Unable to concentrate					Phobias				
Feeling mind play tricks					Forgetfulness/memory problems				
Thoughts racing					Anger				
Restless/unable to sit still					Verbal fighting with others				
Too much energy					Worried about your weight or appearance				
Anxious or nervous					Compulsions				
Sad or depressed					Obsessions				
Crying spells					Loss of interests				
Gambling					Thoughts of suicide				
Thoughts of harming others					Physical fighting with others				
Stealing					Self-mutilator				
Tension					Defies authority				
Lying					Extreme sibling rivalry				
Social withdrawl					Fire setting				
Destruction of property					Overly sensitive				
Truancy					Sexual acting out				
Overly dependent					Runaway history				
Cruelty to people					Shyness				
Do you see things other people do not see?					Do you think people are spying on you?				
Cruelty to animals					Mood swings				
Bed-wetting					Soiling problems				
Do you hear voices when no one is there?					Sexual problems				
Trouble with sleep					Low energy				

Signature	Date

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