PSYCHIATRIC SERVICES, P.C.
DR. LUBBERSTEDT PRE-REGISTRATION 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.

Why are you seeking services today?

_____

_____

_____

_____

Have you been treated as an outpatient by a mental health therapist, psychologist, or psychiatrist? ..... ☐ Yes ☐ No

If yes, please list diagnosis, provider, and dates: _____

_____

_____

_____

Have you ever been on an antidepressant, such as: (please check)

☐ Elavil ☐ Pristiq ☐ Pamelor ☐ Norpramin ☐ Viibryd ☐ Desyrel ☐ Remeron ☐ Tegretol ☐ Serzone
☐ Prozac ☐ Celexa ☐ Paxil ☐ Luvox ☐ Wellbutrin ☐ Effexor ☐ Depakote ☐ Lithium ☐ Zoloft
☐ Abilify ☐ Cymbalta ☐ Geodon ☐ Lamictal ☐ Lexapro ☐ Seroquel

Have you ever taken a neuroleptic such as: (please check)

☐ Thorazine ☐ Mellaril ☐ Serentil ☐ Stelazine ☐ Haldol ☐ Prolixin ☐ Loxitane ☐ Clozaril
☐ Latuda ☐ Navane ☐ Zyprexa ☐ Saphris ☐ Risperdal ☐ Other _____

Have you ever taken a minor tranquilizer or sedative, such as: (please check)

☐ Valium ☐ Librium ☐ Tranxene ☐ Serax ☐ Ativan ☐ Xanax ☐ Ambien ☐ Doral ☐ ProSom
☐ Dalmane ☐ Meprobamate ☐ Quaalude ☐ Other _____

Have you ever taken an ADHD agent, such as: (please check)

☐ Strattera ☐ Dexedrine ☐ Cylert ☐ Adderall ☐ Intuniv ☐ Clonidine ☐ Methylphenidate
☐ Vyvanse ☐ Concerta ☐ Guanfacine ☐ Focalin

How many times were you hospitalized for mental health, alcohol/substance use problems, or physical health problems in the past three months? (if none, code "00" in allotted space)

Number of times hospitalized for mental health problems			Number of times hospitalized for alcohol or drug problems			Number of times hospitalized for physical health problems		
Past 3 months	If ever		Past 3 months	If ever		Past 3 months	If ever	
☐☐	☐ Yes ☐ No		☐☐	☐ Yes ☐ No		☐☐	☐ Yes ☐ No	

Date of last hospitalization? _____

For what? _____

_____

_____

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

If yes, please explain _____

_____

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

Medical complications with the pregnancy? ..... ☐ Yes ☐ No

Any birth complications? ..... ☐ Yes ☐ No

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

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

In regard to your safety, do you have access to weapons? ..... ☐ Yes ☐ No

In the past three months, have you been incarcerated (put in prison or jail)? ..... ☐ Yes ☐ No

From the following list, mark each item which has concerned you in the past six months with a rating of 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 withdrawal					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