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

Name		Age

Date Completed (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

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: _____

_____

_____

_____

Are you currently on any medications? ..... ☐ Yes ☐ No

Please indicate current medications you are now using and all medications you have used within the last six months.

Medication	Dosage	Date Begun	Reason Prescribed	Date Discontinued	Reason Discontinued

Are you currently using any *nonprescription* medications or drugs? ..... ☐ Yes ☐ No

If yes, please indicate current medications and medications you have used in the last six months.

Medication	Dosage	Date Begun	Reason Prescribed	Date Discontinued	Reason Discontinued

Are you allergic or sensitive to any medications or drugs? ..... ☐ Yes ☐ No

If yes, please list medication name and reaction _____

_____

_____

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 tranquillizer or sedative, such as: (please check)

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

Continued on back

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? _____

_____

_____

How many days/times in the past three months have you been treated in the following settings for mental health or for alcohol/substance use problems? (if none, code "000" in allotted space)

	Mental Health		Alcohol/Substance Use	
	Past 3 months	If ever	Past 3 months	If ever
Partial Hospital/Day Treatment/IOP	☐☐☐	☐ Yes ☐ No	☐☐☐	☐ Yes ☐ No
Outpatient (number of visits)	☐☐☐	☐ Yes ☐ No	☐☐☐	☐ Yes ☐ No
Rehabilitation Center	☐☐☐	☐ Yes ☐ No	☐☐☐	☐ Yes ☐ No
Residential Treatment Facility	☐☐☐	☐ Yes ☐ No	☐☐☐	☐ Yes ☐ No

Does anyone in your family have nervous or mental disorders? ☐ Yes ☐ No

If yes, please explain _____

_____

List any significant surgical and/or hospitalizations for a medical reason you have had in the last five years.

_____

_____

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

If yes, please explain _____

_____

Do you use tobacco? ☐ Yes ☐ No

If yes, how often and 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

Medical complications with the pregnancy? ☐ Yes ☐ No

Any birth complications? ☐ Yes ☐ No

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

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/Technical School

☐ High School Graduation or GED

If less than a high school degree, please list grade level and school _____

_____

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

PERSONAL MEDICATION FORM continued

Name of Medicine	Dose (mg. units, puffs)	Route (by mouth, eye drops)	Directions	Purpose Why do you take it?

Past Surgeries (Operations)	Year

Contact Information:

Doctor's name:_____ **Dr. Phone: (____)** _____

Pharmacy name:_____ **Pharmacy phone: (____)** _____

Emergency contact: Name:_____ **Phone: (____)** _____