

TUCKER PSYCHIATRIC CLINIC
New Patient Information Form

Once completed, please email to newpatients@tuckerpsychiatric.com

Demographics:

Patient Name _____ Date of Birth _____ Age _____

SSN _____ Gender _____ If Minor, Legal Guardian _____

Are there custody issues? ___ Yes ___ No

Address _____ City _____ State _____ Zipcode _____

For patients with a Power of Attorney, please include your POA paperwork with this form.

Home Phone _____ Cell Phone _____ Email _____

Primary Insurance: (please include a front and back picture of your insurance card with this form)

Insurance Company _____

Phone Number (on back of card) _____

Subscriber Name _____ Subscriber DOB _____

Subscriber Employer _____ Member ID _____

Group Number _____

Secondary Insurance: (please include a front and back picture of your insurance card with this form)

Insurance Company _____

Phone Number (on back of card) _____

Subscriber Name _____ Subscriber DOB _____

Subscriber Employer _____ Member ID _____

Group Number _____

Tertiary Insurance: (please include a front and back picture of your insurance card with this form)

Insurance Company_____

Phone Number (on back of card) _____

Subscriber Name_____ Subscriber DOB_____

Subscriber Employer_____ Member ID _____

Group Number_____

Emergency Contact:

Name_____ Relationship_____ Phone Number_____

Referral Information:

Referring Provider_____

Reason for Referral_____

Date of Referral_____

Previous Psychiatric Treatment History_____

Preferred/Requested Provider_____

Medical History:

Last psychiatry appointment (if applicable) _____

Last physical_____ Primary Care Physician_____

Therapist (if applicable) _____ Frequency of visits _____

Any current medical problems?

Serious medical problems in the past:

Any past surgery?

Allergies?

Current and Past Medications:

Please note which medications are current and the dosage. If you do not remember the dose or directions, that is okay.

Antidepressants

Medications	Current or Past	Dose	Directions	Side Effects
Elavil (amitriptyline)				
Tofranil (imipramine)				
Sinequan (doxepin)				
Pamelor (nortriptyline)				
Anafranil (clomipramine)				
Nardil (phenelzine)				
Emsam (selegeline patch)				
Prozac (fluoxetine)				
Paxil (paroxetine)				
Zoloft (sertraline)				
Luvox (fluvoxamine)				
Celexa (citalopram)				
Lexapro (escitalopram)				
Effexor (venlafaxine)				
Cymbalta (duloxetine)				
Pristiq (desvenlafaxine)				
Desyrel (trazodone)				
Remeron (mirtazapine)				
Wellbutrin (bupropion)				
Viibryd (vilazodone)				
Fetzima (levomilnacipran)				
Trintellix (vortioxetine)				

Auvelity (dextromethorphan)				
Aplenzin (Bupropion)				

Anti-Anxiety/Sleep Agents

Medications	Current or Past	Dose	Directions	Side Effects
Buspar (buspirone)				
Inderal (propranolol)				
Ativan (lorazepam)				
Valium (diazepam)				
Librium (chlordiazepoxide)				
Klonopin (clonazepam)				
Xanax (alprazolam)				
Tranxene (chlorazepate)				
Restoril (temazepam)				
Ambien (zolpidem)				
Lunesta (eszopiclone)				
Sonata (zaleplon)				
melatonin				

Mood Stabilizers

Medications	Current or Past	Dose	Directions	Side Effects
Lithium				
Depakote (valproic acid)				
Tegretol (carbamazepine)				
Topamax (topiramate)				
Lamictal (lamotrigine)				
Neurontin (gabapentin)				
Trileptal (oxycarbazine)				
Gabitril (tiagabine)				
Carbatrol (carbamazepine)				

Zonegran (zonisamide)				
Lyrica (pregabalin)				

Dopamine Blockers

Medications	Current or Past	Dose	Directions	Side Effects
Thorazine (chlorpromazine)				
Stelazine (trifluoperazine)				
Prolixin (fluphenazine)				
Trilafon (perphenazine)				
Haldol (haloperidol)				
Clozaril (clozapine)				
Zyprexa (olanzapine)				
Risperdal (risperidone)				
Seroquel (quetiapine)				
Geodon (ziprasidone)				
Abilify (aripiprazole)				
Fanapt (iloperidone)				
Saphris (asenapine)				
Latuda (lurasidone)				
Vraylar (cariprazine)				
Caplyta (lumateperone)				
Invega (paliperidone palmitate)				

Attention Deficit Medications

Medications	Current or Past	Dose	Directions	Side Effects
Ritalin (methylphenidate)				
Adderall (amphetamine)				
Dexedrine				

Vyvanse (lisdexamphetamine)				
Strattera (atomoxetine)				
Tenex (guanfacine)				
Catapres (clonidine)				
Concerta (methylphenidate)				

Psychiatric History:

Previous psychiatric diagnoses (if any):

Psychiatric Hospitalizations (If Applicable):

Date of last hospitalization _____ How many hospitalizations: _____

Medication changes in the hospital: _____

If recently hospitalized, please have the discharge paperwork faxed to our office at 804-320-2050.

Current Mental Health:

Briefly explain your reason(s) for seeking help:

Do you have any of the following symptoms / concerns? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Anxiety / Excessive Worry | <input type="checkbox"/> Low energy / motivation |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Extreme fear of something | <input type="checkbox"/> Appetite changes |
| <input type="checkbox"/> Sadness / crying | <input type="checkbox"/> Disordered eating |
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Concentration / focus problems |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Thoughts of death and/or suicide | <input type="checkbox"/> Impulsivity |
| <input type="checkbox"/> Anger / irritability | <input type="checkbox"/> Too much energy |

Making unhealthy decisions

Past Trauma

In your daily life, do you struggle with any of the following issues? (check all that apply)

- Work / Career problems
- Education / School problems
- Legal Problems
- Financial problems
- Parenting problems
- Relationship / marriage problems
- Domestic violence / safety concerns at home
- Grief / Loss
- Gender concerns
- Caregiver stress / burnout
- Chronic pain
- Lack of a social support system

Substance Use History:

Substance	Current Use? (Y/N)	Past Use? (Y/N)	How much are you using now?
Alcohol			
Nicotine (cigarettes, vapes, chewing tobacco, etc)			
Caffeine			
Marijuana / THC			
Opioids / Pain medications that are not prescribed			
Street Drugs (cocaine, heroin, MDMA, acid, LSD, etc)			
Other: _____			

Social History:

Relationship status: _____

of children: _____

Living situation: _____

Employment Status:

Additional Information:

Cultural/Religious Background (optional) _____

Languages Spoken (optional) _____

Goals for Treatment (optional) _____

Additional
Comments/Concerns: _____

Consent and Agreement:

I, _____, consent to the collection and use of the information provided in this form for the purpose of assessment and treatment. I understand that the information disclosed here will be kept confidential except where required by law. I agree to comply with the treatment plan developed in collaboration with my provider.

Signature: _____

