TUCKER PSYCHIATRIC CLINIC
New Patient Information Form
Once completed, please email to newpatients@tuckerpsychiatric.com

Demographics:

First Name_____ Middle Initial_____ Last Name_____

Date of Birth _____ Age_____

SSN_____ Gender Assigned at Birth _____

If Minor, Legal Guardian_____

Are there custody issues? ___Yes ___No

Address_____ City_____ State_____ Zipcode_____

Home Phone_____ Cell Phone _____ Email_____

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

Pharmacy Information:

Pharmacy Name:_____
Pharmacy Address:_____
Pharmacy Phone Number:_____

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_____ Relationship to Subscriber_____

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_____ Relationship to Subscriber_____

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_____ Relationship to Subscriber_____

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.

<u>Antidepressants</u>

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 (buproprion)				
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:

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)

- ☐ Anxiety / Excessive Worry
- ☐ Panic attacks
- ☐ Extreme fear of something
- ☐ Sadness / crying
- ☐ Depressed Mood
- ☐ Loneliness
- ☐ Thoughts of death and/or suicide
- ☐ Anger / irritability
- ☐ Low energy / motivation
- ☐ Sleep problems
- ☐ Appetite changes
- ☐ Disordered eating
- ☐ Concentration / focus problems
- ☐ Memory problems
- ☐ Impulsivity
- ☐ 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: Full Time / Part Time / Unemployed / Permanently Disabled

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: _____