GENERAL INTAKE FORM

NAME: _____

HOW DID YOU HEAR ABOUT US: _____

IF BY PHYSICIAN, PLEASE PROVIDE DOCTOR'S NAME AND PHONE NUMBER: _____

_____

AGE: _____ SEX: M F MARITAL STATUS: _____

NAME OF SPOUSE: _____

NAME (S) AND AGE (S) OF CHILDREN: _____

_____

_____

EDUCATION: _____

_____

OCCUPATION: _____ SPOUSE'S OCCUPATION: _____

WHAT PROBLEM DID YOU COME IN FOR TODAY? : _____

_____

WHEN DID THIS PROBLEM START? : _____

PLEASE STATE EVERYTHING THAT YOU WOULD LIKE TO TELL THE DOCTOR ABOUT THIS PROBLEM: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HAVE YOU HAD A CAT SCAN IN THE PAST? _____ IF SO, WHEN? _____

HAVE YOU HAD AN MRI IN THE PAST? _____ IF SO, WHEN? _____

HAVE YOU HAD BLOOD TESTS IN THE PAST YEAR? _____ WERE THEY NORMAL? _____

WHICH DOCTORS HAVE YOU SEEN FOR THIS PROBLEM, IF ANY? _____

_____

(Continued on next page)

WHAT MEDICATIONS HAVE YOU TRIED FOR THIS PROBLEM?	DID IT HELP?

DO YOU SMOKE CIGARETTES? _____ IF YES HOW MANY? _____ WEEK
DO YOU DRINK ALCOHOL? _____ IF YES HOW MANY? _____ WEEK
HAVE YOU HAD ANY TYPE OF PROBLEM WITH ADDICTIVE DRUGS IN THE PAST?
_____
DO YOU TEND TO BE ANXIOUS OR NERVOUS? _____
IS THE ANXIETY: _____ MILD, _____ MODERATE, OR _____ SEVERE?
DO YOU HAVE TROUBLE __ SLEEPING ___ GOING TO SLEEP ___ STAYING ASLEEP?
DO YOU TEND TO BE DEPRESSED VERY OFTEN? _____
HAVE YOU BEEN DEPRESSED LATELY? _____
HAVE YOU BEEN IRRITABLE / EDGY / ANGRY LATELY? _____
_____

OTHER PAST MEDICAL HISTORY:
OPERATIONS: _____
_____
NECK PAIN: _____
ULCERS OR STOMACH PROBLEMS: _____
SIDE EFFECTS OR ALLERGIES TO ANY MEDICATIONS: _____
_____
ASTHMA: _____
ANY OTHER MEDICAL PROBLEMS: _____
_____
WHAT MEDICATIONS ARE YOU CURRENTLY TAKING: _____
_____

FAMILY HISTORY (LIST AGE AND MEDICAL CONDITION):
MOTHER: _____
FATHER: _____
SIBLINGS: _____

HAVE YOU TRIED ANY OTHER TREATMENT APPROACHES? :

_____ BOTOX _____ TRIGGER POINT INJECTIONS

_____ ACCUPUNCTURE _____ MASSAGE _____ CHIROPRACTIC

_____ OTHER

STRESS FORM

T. Gokani, M.D.

NAME: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

IF REFERRED, NAME & PHONE NO. OF REFERRING PHYSICIAN: _____

EDUCATION:

OCCUPATION: _____ SPOUSES OCCUPATION: _____

BROTHERS/SISTERS AND AGES (IF APPLICABLE): _____
_____

DESCRIBE BRIEFLY (PERSONALITY TRAITS, MEDICAL PROBLEMS, ETC.):
A. FATHER: _____
B. MOTHER: _____

LIST SEVERAL PERSONALITY TRAITS WHICH BEST DESCRIBE YOUR PERSONALITY: _____
_____
_____
_____

PRIOR CLINICAL/COUNSELING INTERVENTION: _____YES _____NO

INPATIENT _____ OUTPATIENT _____

DATES: _____
(MONTH,YEAR)

CURRENTLY ONGOING: _____ Yes _____ No

PRIMARY THERAPIST WAS/IS:
_____ PSYCHIATRIST
_____ PSYCHOLOGIST
_____ SOCIAL WORKER
_____ MARRIAGE COUNSELOR
_____ OTHER (PLEASE DESCRIBE)

NATURE OF PROBLEMS: _____
_____
_____
_____

IF APPLICABLE, MEDICATION PRESCRIBED: _____
_____
_____
_____

(Continued)

CURRENT AREAS IN WHICH I AM UNDER STRESS INCLUDE THE FOLLOWING:

_____ WORK ____ FINANCIAL PRESSURE ____MARRIAGE _____ TIME MANAGEMENT

_____ RELATIONSHIP / INTERACTIONS W/ CHILDREN ____NONE OF THE ABOVE

_____ RELATIONSHIP / INTERACTIONS W/ PARENTS___OTHER (PLEASE DESCRIBE)

PLEASE ELABORATE BRIEFLY ON ANY ITEMS CHECKED ABOVE: _____
_____
_____

PLEASE NOTE IF ANY OF THE FOLLOWING APPLY TO YOU:

_____ HISTORY OF ALCOHOLISM IN FAMILY
_____ EMOTIONAL ABUSE AS A CHILD
_____ PHYSICALLY ABUSED AS A CHILD
_____ EARLY OR RECENT HEAD INJURY
_____ SUICIDAL THOUGHTS (PAST OR PRESENT)
_____ FRIENDS AND FAMILY MEMBERS DO NOT UNDERSTAND OR APPRECIATE
_____ THE NATURE OF YOUR HEADACHES

PLEASE ELABORATE BRIEFLY ON ANY ITEMS CHECKED ABOVE: _____
_____
_____

LIST ANY OTHER PREVIOUS/CURRENT MEDICAL PROBLEMS OR ISSUES WHICH YOU FEEL ARE RELATED TO OR CONTRIBUTE TO YOUR HEADACHES: _____
_____
_____
_____
_____

PATIENT QUESTIONNAIRE – PHQ 9
Nine Symptom Check list

Patient Name: _____ Date: _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More Than half the days	Nearly Every Day
	0	1	2	3
a. Little interest or pleasure in doing things.				
b. Feeling down, depressed or hopeless				
c. Trouble falling / staying asleep, sleeping too much.				
d. Feeling tired or having little energy				
e. Poor appetite or overeating.				
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down.				
g. Trouble concentrating on things such as reading the newspaper or watching television.				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless, that you have been moving around a lot more than usual.				
i. Thoughts that you would be better off dead or of hurting yourself in some way.				

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all	Somewhat difficult	Very Difficult	Extremely Difficult

Rate each of the following symptoms based on your typical health profile for the **Past month**

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe* **3**—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

HEAD	Headaches
	Faintness /Dizziness
	Seizures/shaking/Numbness/Loss of conciousness
	Insomnia
EYES	Watery or itchy eyes
	Swollen, reddened or sticky eyelids
	Bags or dark circles under eyes
	Blurred or tunnel vision
EARS	Itchy ears
	Earaches, ear infections
	Drainage from ear
	Ringing in ears, hearing loss
NOSE	Stuffy nose
	Sinus problems
	Hay fever
	Sneezing attacks
	Excessive mucus formation
MOUTH / THROAT	Gagging, frequent need to clear throat
	Sore throat, hoarseness, loss of voice
	Swollen or discolored tongue, gums, lips
	Chronic coughing
	Canker sores
SKIN	Acne , Allergic reaction
	Hives, rashes, dry skin
	Hair loss
	Flushing, hot flashes
	Excessive sweating
HEART	Chest pain , High Blood pressure
	Irregular or skipped heartbeat
	Leg pain/ankle swelling
	Rapid or pounding heartbea t
LUNGS	Difficulty breathing
	Chest congestion
	Asthma, bronchitis , wheezing
	Shortness of breath

DIGESTIVE TRACT	Nausea, vomiting
	Diarrhea
	Constipation
	Bloated feeling
	Belching, passing gas
	Heartburn
	Intestinal/stomach pain
JOINTS/ MUSCLE	Pain or aches in joints, swelling/redness
	Cold Hands/Feet
	Arthritis
	Stiffness or limitation of movement
	Feeling of weakness or tiredness
	Pain or aches in muscles
WEIGHT	Binge eating/drinking
	Craving certain foods
	Excessive weight/Underweight
	Water retention
	Compulsive eating
ENERGY / ACTIVITY	Fatigue, sluggishness,
	Apathy, lethargy, Hyperactivity,
	Fever
	Restlessness
MIND	Poor memory
	Confusion, poor comprehension
	Difficulty in making decisions
	Stuttering or stammering
	Slurred speech , Poor physical coordination
	Learning disabilities
	Poor concentration
	Daytime sleepiness
EMOTIONS	Pregnancy, Menopause, Irregular cycles
	Anxiety, fear, nervousness , panic attacks
	Anger, irritability, aggressiveness
	Depression , Mood Swings
OTHER	Frequent illness, Anemia , Sexual dysfunction,
	Frequent or urgent urination ; Bleeding, Clotting, Bruising, Thyroid disorder
	Genital itch or discharge –all other systems negative----------