HPR
TREATMENT CENTERS

New Patient Intake Form

PATIENT INFORMATION
Please attach copy front/back- Insurance Card

First Name_____MI_____Last__ _____
Date of Birth:_____

Have you experienced any of the following? (Please check all that apply)

☐ Depression ☐ Lost of Interest in Activities ☐ Feeling Hopeless, worthless ☐ Poor energy ☐ Poor self esteem ☐ Acting impulsively (excessively spending) ☐ Constant fatigue ☐ Poor focus ☐ Problems going to sleep ☐ Periods of euphoria or unusually high energy ☐ Thoughts of not wanting to be a live ☐ Going days without needing sleep	☐Worrying excessively ☐Tense muscles ☐So anxious you feel you cannot rest ☐Having panic attacks ☐Traumatic events that comeback in nightmares or flashbacks ☐Feeling Awkward in public ☐Repetitive or compulsive behaviors ☐Hyperactive or fidgety ☐Grunts, tics, or jerks ☐Inattentiveness at work or school ☐Thoughts that replay ☐Phobias or fears	☐Hearing Voices ☐Seeing Things ☐Feeling people were trying to watch you ☐Concerns about alcohol use ☐Drug use ☐Increased appetite ☐Decreased appetite ☐Memory problems ☐Getting lost easily ☐Forgetting how to do routine tasks ☐Problems finding words ☐Problems caring for yourself (cooking, cleaning) ☐Poor hygiene

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Have you ever been treated with any of the following medications? Circle all that apply and list positive or negative effect.

Medication	Dates/Dosage	Positive/Negative	Medication	Positive/Negative	Medication	Dates/Dosage
Abilify			Haldol		Ritalin	
Ambien			Klonopin		Saphris	
Adderall			Invega		Serax	
Anafranil			Lamictal		Seroquel	
Antabuse			Latuda		Serzone	
Ascendin			Lexapro		Soma	
Atarax			Librium		Sonata	
Ativan			Lithium		Stelazine	
Buspar			Lunesta		Strattera	
Campral			Luvox		Suboxone/ subutex	
Celexa			Marplan		Symmetrel	
Chloral hydrate			Mellaril		Tegretol	
Clonidine			Methadone		Thorazine	
Clozaril			Miltown		Tofranil	
Cogentin			Nardil		Topomax	
Concerta			Norpramine		Traxene	
Cymbalta			Orap		Trazodone	
Dalmane			Pamelor		Trileptal	
Depakote			Parnate		Valium	
Dexedrine			Paxil		Vibryd	
Doral			Prosom		Vistraril	
Effexor			Pristiq		Vivitrol	
Elavil			Prolixin		Wellbutrin	
Fanapt			Remeron		Xanax	
Geodon			Restoril		Zoloft	
Halcion			Risperdal		Zyprexa	

Please list all medications you are currently taking, including over-the-counter medications, herbals, and supplements. Who is currently prescribing you medications? **PCP/Psychiatrist**

Doctor's Name_____**Phone Number** _____

Dates/Dosage	Dates/Dosage

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Substance Use History

	Last Use?	Frequency	Amount Used?
Tobacco			
Alcohol			
Marijuana			
Cocaine			
Heroin			
Opiates (e.g. Heroin, morphine, Percocet,			
Benzodiazepines (e.g. Xanax, Klonopin, Valium)			
PCP or LSD			
Others			

Past Medical Care

Do you have a primary care doctor? Yes / No _____

Name_____Date last seen?_____

What medical illnesses do you have?

_____
_____
_____

What surgeries have you had?

_____
_____
_____

Do you have any implanted devices Are there any immovable metal objects above your chest? (exclude dental fillings, crowns, implants e.g., pacemaker, cochlear implant): Yes / No If yes, please explain_____

_____
_____

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Past Psychiatric Care

Type of Therapy (ex: ECT, Neuro Feedback)	Year	Outcome

Have you ever been diagnosed with a mental health condition by a medical provider (e.g. depression, bipolar, schizophrenia, ADHD)? If so, please list.

_____

_____

Have you ever been seen by a psychiatrist or therapist/counselor? Please list and describe.

Psychiatrist/Therapist	Treatment	Dates: From/To

Have you ever been hospitalized for psychiatric care? Please list and describe.

Hospital	Treatment	Dates: From/To

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Patient Health Questionnaire (PHQ-9)

Patient name:_____Date: _____

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

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (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 TV.	☐	☐	☐	☐
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 more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

❒ 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

TOTAL SCORE _____

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question.

You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
Over 40	Extreme depression