Phoenix Health, PLLC

7405 Shallowford Rd, Suite 230
Chattanooga, TN 37421
Phone 423-208-8099
Fax 855-305-1008
www.phoenixhealth.info

Patient Information - 2021

Name

Date of Birth

Email Address

Address

City

State.

ZIP Code

Current/Previous Occupation __Employed __Unemployed __Student __Disability __Retired

Primary Phone Number

Secondary Phone Number

Emergency Contact Name and Relationship

Emergency Contact Phone Number

Pharmacy Name and Phone Number

Primary Care Physician

Insurance Carrier

Insurance Member ID Number

Any other important information:

Phoenix Health, PLLC
7045 Shallowford Rd, Suite 230
Chattanooga, TN 37421
Phone 423-208-8099/Fax 855-305-1008
www.phoenixhealth.info

New Patient Intake Form - 2021

Name:________________________ DOB: _____ Primary Care Provider(PCP)/Referring Provider _______________

Food or medical allergies and reaction:____ Height:___ Weight:______

Type of treatment requested: Medication Management ____ Counseling ___ EMDR____ Trauma Therapy____

Treatment goals: ____

Are you a First Responder? Y/N If so, which department and length of service: _______________________________

Have you served in the military? Y/N If so, when and what branch:____

Currently: __Married __Partnered __Divorced __Single __Widowed How long:____________________________

Previous marriages? Y/N If so, how many and how long? ____

Do you have any children? Y/N If so, please list genders and ages____

List everyone who currently lives with you:____

Current legal issues:_________________________________ Previous legal issues:____________________________

Educational/Work History

Highest grade completed____ Degree/Certification obtained: ____

Current Symptoms Checklist

__ Depressed Mood __Unable to enjoy activities __Sleep pattern disturbance __Loss of interest

__Forgetfulness __Difficulty concentrating __Change in appetite __Excessive guilt

__Fatigue __Decreased libido __Racing thoughts __Impulsivity

__Risky behavior __Excessive energy __Change in substance use __Irritability

__Crying spells __Excessive worry __Anxiety attacks __Avoidance

__Isolating __Hallucinations __Paranoia

__Other____

__Pain – Please describe when it started, location(s), type of pain, etc.______________________________________

____

Are you currently treated by Pain Management? Y/N Provider name and number: ____________________________

Any other important information:

Suicide Risk Assessment

Have you ever had feelings, thoughts, or plans that you didn't or don't want to live? Yes/No

How often do you have these thoughts?________________ When was the most recent time? ____________________

Do you feel hopeless?______________________ Have you ever attempted to self-injure or kill yourself? If so, when and what method?____

Do you have a plan to self-injure or kill yourself?________________ Do you have access to guns or weapons?________

Do you have a safety plan? Y/N Please describe: ____

Medical History

Mental Health Care – Counselors/Therapists, Treatment Facilities/Hospitalizations: List Providers and dates:

____

Current medical problems:____

Previous medical problems:____

Hospitalizations/Surgeries:____

Family medical problems:____

Current Medications

Medication Name	Dosage	Reason	Estimated Start Date	Prescriber

Trauma History

Have you ever experienced or witnessed any type of trauma, including but not limited to, emotional, physical, sexual, military, first responder, domestic violence, neglect, workplace violence, bullying, or other. If so, please describe:

____

____

____

____

____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for any of the following:

__Bipolar disorder __Depression __Anxiety __Anger __Schizophrenia __Violence __Post traumatic stress

__Alcohol abuse __Other substance abuse __Suicide – If yes, who and when?__________________________________

Any other important information:

Previous Medications:

Antidepressants

__Prozac (fluoxetine) __Zoloft (sertraline) __Luvox (fluvoxamine) __Paxil (Paroxetine) __Trintellix (Vortioxetine)

__Lexapro (escitalopram) __Effexor (venlafaxine) __Cymbalta (duloxetine) __Wellbutrin (bupropion) __Viibryd (Vilazodone)

__Celexa (citalopram) __Remeron (mirtazapine) __Serzone (nefazodone) __Anafranil (clomipramine) __Doxepin

__Pamelor (nortriptyline) __Tofranil (imipramine) __Elavil (amitriptyline) __Pristiq (desvenlafaxine) __Other___________

Antipsychotics/Mood Stabilizers

__Seroquel (quetiapine) __Zyprexa (Olanzepine) __Geodon (ziprasidone) __Abilify (aripiprazole) __Vraylar (cariprazine)

__Clozaril (clozapine) __Haldol(haloperidol) __Prolixin (fluphenazine) __Risperdal (risperidal) __Rexulti (brexpiprazole)

__Latuda (lurasidone) __Tegretol (carbamazepine) __Lithium __Lamictal (lamotrigine) __Saphris (asenapine)

__Depakote (divalproex) __Topamax (topiramate) __Other________

Sedative/Hypnotica/Anti-anxiety Medications

__Ambien (zolpidem) __Sonata (zaleplon) __Rozerem (ramelteon) __Desyrel (trazodone) __Propranolol

__Restoril (temazepam) __Lunesta (eszopiclone) __Tranxene (clorazepate) __Buspar (buspirone) __Vistaril (hydroxyzine)

__Xanax (alprazolam) __Ativan (lorazepam) __Klonopin (clonazepam) __Valium (diazepam) __Prazosin

ADHD Medications:

__Adderall (amphetamine) __Concerta (methylphenidate) __Ritalin (methylphenidate) __Straterra (atomoxetine)

__Vyvanse (Lisdexamfetamine) __Focalin (dexmethylphenidate) __Intuniv (Guanfacine) __Other_____

Substance Use

Have you ever been treated for alcohol or drug use/abuse/dependence? Yes/No

If yes, what substance, where were you treated, where, and when? ____

How many days per week do you drink alcohol? __________ How much? ___________ How often?____________

Do you think you may have a problem with alcohol or other substances? __________________________________

Have you ever tried and/or use the following:

Alcohol Yes/No When and how long?____

Methamphetamine Yes/No When and how long?____

Cocaine Yes/No When and how long?____

Stimulants (pills) Yes/No When and how long?____

Heroin Yes/No When and how long?____

LSD/Hallucinogens Yes/No When and how long?____

Marijuana Yes/No When and how long?____

Opiates(not prescribed) Yes/No When and how long?____

Methadone Yes/No When and how long?____

Tranquilizers Yes/No When and how long?____

Ecstasy Yes/No When and how long?____

Tobacco Yes/No When and how long?____

Caffeine Yes/No When and how long?____

Signature:____ Date:________________________

Any other important information: