For provider use only

Dx:

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Please complete this form and return it to Dr. Ross at info@rachelrossmd.com prior to your first appointment.

PATIENT INFORMATION

Full Name	Birth Date	Age	
Name you prefer to be called			
Mailing Address	City	State	ZIP
Email	Phone		
Marital Status:	Spouse Name (if applicable):		
Do you have children? ☐Yes ☐No	If Yes, what are their names and ages?		
Occupation			
Do you identify with any religious or spiritual affiliations? ☐Yes ☐No If yes, please tell me more:			
Primary Care Physician	Phone ( )	May We Contact This Person? ☐Yes ☐No	
Psychiatrist or Therapist	Phone ( )	May We Contact This Person? ☐Yes ☐No	
Referred By	Phone ( )	May We Contact This Person? ☐Yes ☐No	
Emergency Contact	Phone ( )	May We Contact This Person? ☐Yes ☐No	
Preferred Pharmacy (Name and Address)	Phone ( )		

MEDICAL AND PSYCHIATRIC HISTORY

Do you have a current therapist, or have you ever been in psychotherapy/counseling? ☐Yes ☐No
If yes, please tell me more:

What psychiatric conditions (if any) have you been treated for?
☐ I am not aware of any prior psychiatric conditions.

Have you ever been admitted to a psychiatric hospital? ☐Yes ☐No
If yes, please tell me more:

Have you ever attempted suicide? ☐Yes ☐No
If yes, when:

What medical conditions do you have?
☐ I am not aware of any ongoing medical issues.

Please list all medications, herbals, or supplements you currently taking in the table below.

Medication/Supplement	Daily Dosage

Please list any allergies or negative reactions to medication.
☐ I am not aware of any allergies to medication.

Medication	Allergy or Negative Reaction

EMOTIONAL/BEHAVIORAL SYMPTOMS

Current Major Stressors: ☐Personal ☐Marital ☐Family ☐Financial ☐Occupational ☐Legal ☐Other

What is the reason you are seeking treatment at this time?

Give a brief account of how the symptom(s) developed (onset to present)

Have you experienced any of these symptoms over the past few months?							
SYMPTOMS	No	Some what	Very much	If yes, how long has it been a problem for you?			
				Days	Weeks	Months	Years
1. Feeling lonely							
2. Feeling angry or frustrated							
3. Difficulty Sleeping							
4. Sleeping too much							
5. Recurrent nightmare(s)							
6. Decreased appetite							
7. Eating when not hungry							
8. Difficulty concentrating							
9. Lack of motivation							
10. Loss of interest in pleasurable activities							
11. Loss of pleasure from usual activities							
12. Recurrent bad memories							
13. Feeling sad most of the time							
14. Feeling worthless/helpless/or feeling guilty							
15. Thoughts of harming yourself							
16. Worrying excessively							
17. Feeling anxious/tense/panicky							
18. Fear of closed in spaces, heights, crowds, etc.							
19. Fear of losing mind/fear of dying							
20. Unusual experiences, such as hearing voices or seeing visions							
21. Alcohol abuse/excessive drinking							
22. Drug abuse/experimentation							
23. Use of tobacco products							
24. Angry outburst/short temper							
25. Physical altercation(s) or other violence							
26. Conflict with authority							
27. Legal difficulties/arrest							

FAMILY BACKGROUND

Has anyone in your immediate family (mother, father, sibling or spouse) received psychiatric treatment or were admitted to a hospital for mental illness or alcohol/drug problem? ☐Yes ☐No

Illness	No	One family member	More than one family member	Your age when it happened
Depression				
Anxiety disorder				
Alcoholism				
Drug abuse				
Schizophrenia				
Manic-depressive disorder				
Post-traumatic stress disorder				
Other:				

TREATMENT GOALS

What are your goals for treatment?

What strengths do you have to help you achieve these goals?