New Patient Form

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Telephone Number: _____

Current Psychiatrist (or NP/PA): _____

Diagnoses (check all that apply):

- ☐ Depression
- ☐ Bipolar disorder
- ☐ Psychotic disorder
- ☐ Obsessive Compulsive disorder
- ☐ Anxiety disorder
- ☐ PTSD
- ☐ ADHD
- ☐ Autism
- ☐ Personality disorder
- ☐ Eating disorder
- ☐ Addiction
- ☐ Memory disorder

Current Meds: _____

_____

Past Antidepressant Trials

	Drug Name	**Max dose**	**Duration**		**Drug Name**	**Max dose**	**Duration**
☐	Prozac (fluoxetine)			☐	Effexor (venlafaxine)		
☐	Paxil (paroxetine)			☐	Cymbalta (duloxetine)		
☐	Zoloft (sertraline)			☐	Pristiq (desvenlafaxine)		
☐	Celexa (citalopram)			☐	Fetzima		
☐	Lexapro (escitalopram)			☐	Nardil		
☐	Luvox (fluvoxamine)			☐	Parnate		
☐	Trintellix			☐	Emsam (patch)		
☐	Viibryd (vilazodone)			☐	Amitriptyline (Elavil)		
☐	Wellbutrin(buproprion)			☐	Nortriptyline (Pamelor)		
☐	Remeron (mirtazapine)			☐	Doxepin (sinequan)		
☐	Trazodone			☐	Imipramine		
☐	Ketamine / Spravato			☐	Clomipramine		
☐	Auvelity			☐	Desipramine		

Augmentation Agents

- ☐ Lithium
- ☐ Lamictal
- ☐ Abilify
- ☐ Seroquel
- ☐ Thyroid Hormone
- ☐ Stimulants _____
- ☐ Other _____

Previous Treatment

	When?	**How Many?**
ECT		
TMS		
Psychotherapy		
Hospitalization		