FLORIDA FIRST PSYCHIATRY SPECIALIST

Patient Information for Medical Records

Please fill out all applicable areas

Today's Date: _____

SS#: _____ Patient's Name: _____ Marital Status: ☐Married

Address: _____ ☐Separated ☐Divorced

_____ ☐Single ☐Widowed

List only contact numbers where we will be able to leave a detailed message, to include treatment, appointment and billing information:

Home Phone: _____ Cell Phone: _____ Sex: ☐ M ☐ F

DOB:_____

Email Address: _____ Communication Preference:

Emergency Contact Name: _____ ☐Home Phone ☐Cell Phone

Relationship to PT _____ Phone #: _____ ☐Work Phone ☐Letter

Language Preference: _____

Pharmacy Name: _____ Phone #: _____

Location: _____ Fax #: _____

Patient's Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Specify

Patient's Race:
☐White
☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Other Pacific Islander
☐Hispanic or Latino
☐Decline to Specify

Primary Care Physician: _____ Phone: _____ Last Seen: _____

Please sign and date below if you authorize the release of information regarding your psychiatric evaluation, treatment plan and medication recommendations to your primary care physician for coordination of care.

_____ _____

Patient or legally authorized individual signature Patient name

Other Physician(s)/Therapist(s) Involved in Your Care:

1._____ Last Seen: _____

2._____ Last Seen: _____

Patient's Employment

Employer Name: _____ ☐Full-time ☐Part-time

Student: _____ ☐Full-time ☐Part-time

Address: _____ Work Phone: _____

Permission to Treat

I, _____, give permission for all employees/contracted employees of Prasanti Tatini, M.D. (Florida First Psychiatry Specialist, LLC) to provide me with services. I also assign directly to Prasanti Tatini, M.D. (Florida First Psychiatry Specialist, LLC) to provide me with services. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the physician to release all information necessary to secure payment for benefits. I also understand it is my responsibility to verify my insurance company has received a claim for services rendered.

_____ _____

Patient or legally authorized individual signature Print name

_____ _____

Relationship (parent, legal, guardian, personal representative, etc.) Date

Please review and initial our office policies below:

	Initial
All payments/co-payments are to be paid on the appointment day. Special circumstances require management authorization.	_____
Appointment cancelations require one business day notice prior to the scheduled appointment time.	_____
Failure to give 24-business hour notice for a cancelation of appointment will result in a "no show" fee of $45.	_____
Please contact us by 12:00 PM on Friday to cancel an appointment scheduled on a Monday.	_____
A "late cancelation" fee of $45 will be assessed if an appointment is rescheduled due to tardiness.	_____
Children are required to be with the accompanied guardian at all times.	_____
Try to request prescription refills in 48-hours before prescription is out.	_____
Please notify both the front office staff and your practitioner of any changes to your preferred pharmacy to avoid interruption of medication.	_____
Patients on controlled substances must be seen (minimum – Dr.'s discretion) every three months.	_____
There is a fee of $25 per form that must be completed by a practitioner, and it is due at time of pick-up.	_____
Requests for a change of medication (type or dosage) or adding a medication require an appointment.	_____
More than two no shows to standing appointments will result in cancelation of all standing appointments.	_____
An outstanding balance of $1000 must setup on a payment plan before the next scheduled visit.	_____
Depositions and court appearances made by any of the practitioners are charged at a rate of $450 per hour with a one hour minimum.	_____
Please note that reminder calls are provided by our office, as a courtesy, one business day prior to your appointment; however, itis ultimately your responsibility to remember the time and date of your appointment.	_____
All appointments must be scheduled, rescheduled or canceled by the patient.	_____
There is a fee of $1.00 per page for the first 25 pages, and $0.25 for each page thereafter, for medical records released to the patient, due at the time of pick up.	_____

Please sign below to indicate that you are aware that a copy of our Notice of Health Information (Privacy) Practices is displayed in our office for your review. A copy of these policies can be made available to you at your request.

_____ _____

Patient or legally authorized individual signature Print Name

_____ _____

Relationship (parent, legal, guardian, personal representative, etc.) Date

Mental Health Questionnaire - Please complete all information on this form and bring it to the first visit.

Name_____Date_____

Date of Birth_____Primary Care Physician _____

Current Therapist/Counselor _____

What is/are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist: (please check all that apply)

( ) Depressed Mood	**( ) Racing thoughts**	**( ) Excessive Worry**
( ) Unable to enjoy activities	**( ) Impulsivity**	**( ) Anxiety attacks**
( ) Sleep pattern disturbance	**( ) Increased risky behavior**	**( ) Avoidance**
( ) Loss of interest	**( ) Increased libido**	**( ) Hallucinations**
( ) Concentration/forgetfulness	**( ) Decreased need for sleep**	**( ) Suspiciousness**
( ) Change in appetite	**( ) Excessive energy**	**( ) Decreased libido**
( ) Excessive guilt	**( ) Increased irritability**	
( ) Fatigue	**( ) Crying spells**	

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No If YES, please answer the following. If NO, please skip the next question.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No

Past Psychiatric History:

Outpatient Treatment? ( ) Yes ( ) No If yes, describe nature of treatment, when and by whom:

Reason	Dates Treated	By Whom

Inpatient Treatment/Psychiatric Hospitalization? ( ) Yes ( ) No If yes, describe nature of treatment, when and by whom:

Reason	Dates Treated	By Whom

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants: Dates Dosage Response/Side-Effects

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Cymbalta (duloxetine) _____

Wellbutrin (bupropion) _____

Remeron (mirtazapine) _____

Serzone (nefazodone) _____

Anafranil (clomipramine) _____

Pamelor (nortriptyline) _____

Tofranil (imipramine) _____

Elavil (amitriptyline) _____

Mood Stabilizers:

Tegretol (carbamazepine) _____

Lithium _____

Depakote (valproate) _____

Lamictal (lamotrigine) _____

Topamax (topiramate) _____

Antipsychotics/Mood Stabilizers:

Seroquel (quetiapine) _____

Zyprexa (olanzepine) _____

Geodon (ziprasidone) _____

Abilify (aripiprazole) _____

Clozaril (clozapine) _____

Haldol (haloperidol) _____

Prolixin (fluphenazine) _____

Risperdal (risperidone) _____

Sedative/Hypnotics:

Ambien (zolpidem) _____

Sonata (zaleplon) _____

Dates Dosage Response/Side-Effects

Rozerem (ramelteon) _____

Restoril (temazepam) _____

Desyrel (trazodone) _____

ADHD medications:
Adderall (amphetamine) _____

Concerta (methylphenidate) _____

Ritalin (methylphenidate) _____

Stratterra (atomoxetine) _____

Anti-Anxiety medications:
Xanax (alprazolam) _____

Ativan (lorazepam) _____

Klonopin (clonazepam) _____

Valium (diazepam) _____

Tranxene (clorazepate) _____

Buspar (buspirone) _____

Family Psychiatric History:
Has anyone in your immediate family (parents,grandparents,siblings,children,aunts/uncles) been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-Traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol Abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No		

Substance Use:
Have you ever been treated for alcohol or drug abuse? ( ) Yes ( ) No

If yes, which substances? _____

If yes, where were you treated and when? _____

Have you ever tried the following? (check yes or no)

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain Killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/Sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:
Have you ever smoked cigarettes? ( ) Yes ( ) No Currently? ( ) Yes ( ) No How many years? _____

For past smokers: When did you quit? _____

Pipe, cigars or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No

What kind?_____ How often per day on average? _____ How many years? _____

Medical History:
Allergies _____ Current Weight _____ Height _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No

Date and place of last physical exam: _____

List *ALL current prescription medications* and how often you take them (if none, write 'none'):

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, non-psychiatric hospitalization or surgeries: _____

_____

_____

Women: Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up? _____

List any siblings and their current ages: _____

What is/was your father's occupation? _____

What is/was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Educational History:
Highest grade completed: _____ Where?_____

Did you attend college? ( ) Yes ( ) No Where? _____ Major?_____

What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? ( ) Yes ( ) No If so, what branch and when? _____

Relationship and Current Family History:
Are you currently: ( )Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed For how long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, for how long? _____

What is your spouse/significant other's occupation? _____

Have you had any prior marriages? ( ) Yes ( ) No If yes, how many? _____

Do you have children? ( ) Yes ( ) No If yes, please list ages and gender: _____

_____

Legal History:
Do you have any pending legal problems? ( ) Yes ( ) No _____

Is there anything else you would like us to know?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature _____ Date: _____

Guardian Signature (if under 18) _____ Date: _____

Emergency Contact _____ Phone number: _____