MONARCH
Psychiatry of Alaska llc

4600 DeBarr Road, Suite 150
Anchorage, AK 99508
Phn 907-885-1089 Fax 907-885-1059
Email: contact@monarchpsychiatry.com
Web: www.monarchpsychiatry.com

**PSYCHIATRIC MEDICATION ADULT PATIENT INFORMATION FORM**

Today's Date:

Name:

Date of Birth:

Nickname/Preferred Name:

## History of Present Illness and Reason for Visit

I would like to discuss the following symptoms or concerns in my initial visit with my provider:

Approximately when did these symptoms first begin?

Have these symptoms worsened recently?

How do these symptoms impair your ability to function, work, or relate to other people?

Has anything happened in the last year or so that has been very stressful for you such as serious health problems in your home or a family member, death of a close friend or family member, work stress, loss of job, loss of home, financial problems, legal issues, physical or sexual assault?

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## Current Medications

IF YOU ARE TAKING ANY PSYCHIATRIC MEDICATIONS, WE MUST HAVE A RELEASE OF INFORMATION FOR RECORDS FROM THE MOST RECENT PRESCRIBER.

Please list all of your current medications and supplements in the table below:

| Medication: | Dose: | When: | Side Effects: | Helpful: |
|---|---|---|---|---|
| Example | 1mg | morning and night | headache | Yes |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Allergies**

Please list all medication allergies:

_____

_____

_____

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**Releases of Information**

In order for us to provide the best care to you, we will need you to complete Release of Information forms to review records and possibly discuss your care with current and past health care providers. Release of Information forms can be found with our front desk staff or on our website.

1. Are you currently seeing a therapist?
   (If yes, complete a release of Information to exchange information with your therapist.)

2. Have you ever been psychiatrically hospitalized?
   (If yes, complete a release of Information for the most recent hospitalization.)

Please list all psychiatric hospitalizations starting with the most recent:

Hospital: Approximate Dates of Hospitalization:

_____ _____

_____ _____

3. Have you ever been in chemical dependency treatment?
   (If yes, complete a release of Information for the most recent treatment program).

Please list all chemical dependency programs starting with the most recent:

Chemical Dependency Program: Approximate Dates:

_____ _____

_____ _____

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**Medication History**

Please indicate if you have ever taken any of the following psychotropic medications, the highest dose you remember taking, and the approximate dates it was prescribed:

**DEPRESSION AND ANXIETY MEDICATIONS**

Anafranil/clomipramine Trintellix/vortioxetine Celexa/citalopram Cymbalta/duloxetine Desyrel/trazodone Effexor/venlafaxine Elavil/amitriptyline Emsam/selegiline Fetzima/levomilnacipran Lexapro/escitalopram Luvox/fluvoxamine Marplan/isocarboxazid Nardil/phenelzine Norpamin/desipramine Pamelor/nortriptyline Parnate/tranylcypromine Paxil/paroxetine Pristiq/desvenlafaxine Prozac/fluoxetine Remeron/mirtazapine Sarafem/fluoxetine Savella/milnacipran Serzone/nefazodone Sinequan/doxepin Surmontil/trimipramine Tofranil/imipramine Viibryd/vilazodone Vivactil/protriptyline Wellbutrin/bupropion Zoloft/sertraline

**ALCOHOL ABSTINENCE MEDICATIONS**

Revia/naltrexone Antabuse/disulfiram Campral/acamprosate Vivitrol/naltrexone

**ADHD MEDICATIONS**

Please note: Our providers may require ADHD testing with a psychologist before we can prescribe these medications. Monarch Psychiatry of Alaska can provide this testing if needed.

Adderall/amphetamine Adderall XR/amphetamine ER Concerta/methlylphenidate ER Dexedrine/dextroamphetamine Dextrostat/dextroamphetamine Focalin/dexmethylphenidate Focalin XR/dexmethylphenidate ER Intuniv/guanfacine Metadate/methylphenidate Methylin/methylphenidate Ritalin/methylphenidate Ritalin SR/methylphenidate ER Ritalin LA/methylphenidate LA Strattera/atomoxetine Vyvanse/lisdexamfetamine Mydayis/amphetamine mixed salts

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**ANTIANXIETY MEDICATIONS**

Please note: Our providers may not prescribe these medications if you are taking narcotic pain medications, methadone, suboxone, or ADHD medication.

Ativan/lorazepam Buspar/buspirone Catapres/clonidine Inderal/propranolol Klonopin/clonazepam Librium/chlordiazepoxide Serax/oxazepam Tranxene/clorazepate Valium/diazepam Vistaril/hydroxyzine Xanax/alprazolam

**ANTIPSYCHOTICS**

Abilify/aripiprazole Clozaril/clozapine Fanapt/iloperidol Haldol/haloperidol Geodon/zyprasidone Invega/paliperidone Latuda/lurasidone Loxitane/loxapine Mellaril/thioridazine Moban/molindone Navane/thiothixine Prolixin/fluphenazine Rexulti/brexpiprazole Risperidal/risperidone Saphris/asenapine Seroquel/quetiapine Seroquel XR/quetiapine XR Stelazine/trifluoperazine Thorazine/chlorpromazine Trilafon/perphenazine Vraylar/cariprazine Zyprexa/olanzapine

**MOOD STABILIZERS AND ANTICONVULSANT MEDICATIONS**

Depakote/valproate Keppra/levetiracetam Lithium/Eskalith/Lithiobid Lamictal/lamotrigine Symbyax Neurontin/gabapentin Tegretol/carbamazine Topomax/topiramate Trileptal/oxcarbazepine Zonegran/zonisamide

**SLEEP / WAKE MEDICATIONS**

Ambien/zolpidem Ambien CR/zolpidem ER Belsomra Dalmane/flurazepam Desyrel/trazodone Gabitril/tiagabine Halcion/triazolam Intermezzo Lunesta/eszoplicone Nuvigil/armodafinil Periactin/cyproheptadine Provigil/modafinil Restoril/temazepam Rozerem/ramelteon Silenor/doxepin Sinequan/doxepin Sonata/zaleplon Xyrem/sodium oxybate

**MEDICATIONS USED FOR SIDE EFFECTS**

Cogentin/benzotropine Benadryl Artane/trihexyphenidyl Inderal/propranolol Atenolol

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**Psychiatric History**

Have you ever received treatment for psychiatric reasons?

If yes, circle the types of treatments you have participated in and state if they were helpful or not:

Individual Therapy

Group Therapy

Couples Therapy

Family Therapy

Day Treatment

DBT

EMDR

Biofeedback

ECT, TMS, or VNS?

Have you ever attempted suicide or engaged in self-injurious behavior?

If yes, when and by what means? (Overdose, cutting yourself, etc.)

Means: Year:

_____ _____

_____ _____

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**Social History**

Where were you born? _____

What is your highest level of education? Please circle below:

High school graduate

GED

Vocational School

Some College

Bachelor's Degree

Advanced Degree

If you did not finish high school please explain:

Dropped out in _____ grade because of _____

Have you ever been in the military?

Place of residence: Please circle below:

Home

Apartment

Group Home: _____

Who lives with you?

My current job, occupation, or career:

I am currently disabled. I have been disabled since _____ (year).

My prior occupation before becoming disabled:

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Whom do you rely on for social support?

Relationship Status: Please circle below:

Never Married

Casually Dating

Seriously Dating

Married years

Cohabitating

Separated

Divorced - Number of previous marriages:

Widowed

What is your current marital/relationship satisfaction?

-Good or Poor

_____ My partner/spouse abuses chemicals/alcohol

_____ There has been abuse in my relationship

Names and ages of children:

Do you have custody of children? (Yes or no)

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**Legal History**

Have you ever been charged with a serious crime?

If yes, what were you charged with?

_____

Do you have a history of serving jail or prison time?

If yes, at what facility? _____ For how long? _____

Are you currently on probation?

If yes, I am on probation until _____

**Family History**

Did your parents remain married?

If not, how old were you when they separated? _____

How many brothers and sisters do you have? _____

What is the order of your birth? (e.g. oldest, youngest, 2nd of 5) _____

Please complete the table below regarding any type of abuse you may have experienced:

Type of Abuse: Verbal Physical Sexual Emotional

If yes, by whom? How long did the abuse take place?

Do any blood relatives have a history of a mental illness or chemical dependency?

If yes, please describe who below and their RELATIONSHIP TO YOU (e.g. mother, father, brother, sister, grandfather, cousin, aunt, etc.).

Illness:

ADD/ADHD-

ANXIETY, PANIC DISORDER, PTSD, OCD-

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BIPOLAR DISORDER-

DEPRESSION-

DRUG ABUSE or ALCOHOLISM-

LEARNING DISABILITY OR LOW IQ-

SCHIZOPHRENIA OR PSYCHOSIS-

SUICIDE ATTEMPTS-

**Medical History**

Please list all of your physical medical illnesses/conditions (problems with your heart, lungs, liver, stomach, bowel, skin, joints, thyroid, etc. including if you are currently pregnant).

| Condition: | Year Diagnosed: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

How often do you exercise? _____ times per week.

Have you ever had a seizure or have you ever been diagnosed with epilepsy?

Are you or is there a chance you may be pregnant?

Have you ever had a period of unconsciousness (coma, knocked out, brain injury, concussion)?

If yes, please describe what happened and how long you were unconscious:

_____

_____

_____

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**Surgical History**

Please list all surgeries you have had:

Surgical Procedure: Year:

_____ _____

_____ _____

_____ _____

Additional Comments:

_____

_____

_____

**Substance Use History**

Do you use any alcohol or have you ever used or abused any drugs?

If yes, please complete the information below:

Drug:

Alcohol, Marijuana, Methamphetamine, Cocaine, Crack, Heroin, Ecstasy, Speed, Shrooms, K2, Spice, LSD or others: _____

Pain Medications- (oxycodone, oxycontin, Percocet, codeine, morphine, Fentanyl, Vicodin)

Benzos- (Xanax, Valium, Ativan, Klonopin)

Stimulants- (Ritalin, Adderall, Concerta, etc.)

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Typical Amount Used: _____

Date of Last Use: _____

How Many Times Per Week or Month Do You Use: _____

STATEMENT:

_____ I feel the need to reduce my use of alcohol or drugs.

_____ People have complained to me about my use of alcohol or drugs.

_____ I feel guilty about my use of alcohol or drugs.

_____ I have used alcohol or drugs to help me get through the day.

Caffeine/Tobacco Use:

How many caffeinated beverages do you have per day? _____

Do you use tobacco? Yes or No

If yes, what type of tobacco do you use (chewing tobacco, cigarettes, etc.)? _____

How much per day? _____

**I consent to undergo psychiatric treatment at Monarch Psychiatry of Alaska, LLC.**

**Printed Name: _____ Date: _____**

**Signature: _____ Date: _____**