Name: _____ **Date:** _____
Date of Birth: _____ **Age:** _____

It is very important to complete ALL sections. This form will help you prepare for the initial assessment as trying to remember past episodes and treatments during the actual interview can be difficult. In turn, it helps me understand your illness as the medical chart is not enough. If necessary, your Counsellor is available to help you complete the form.

1) Your expectations from the initial assessment / future meetings with Psychiatrist Dr. Bhargava.

Initial assessment:
Future meetings:

2) This is an opportunity to describe your history in your own words, rather than a medical chart describing you. Please note page 3 lists some of the more common medications.

Psychiatric diagnoses. (e.g. panic disorder, alcohol dependence):
When did the current episode start:
Were there any situational stressors?
Describe your current illness.
Describe how the illness has affected your ability to function at home and at your job.

Year of the very first episode (even if undiagnosed):
Describe the original episode. Have they changed over the years?
Description of the various episodes over the years. Including approximate dates, even if too many to count. Were they associates with situational stressor?

Date	

3) Over your lifetime, who has provided you treatment for mental illness - (e.g. Family Physician, Social Worker, Psychiatrist). How long, and type of therapy (medication, counselling, or both).

Name	Profession	Where (city)	Duration (m/y – m/y)		Type of therapy	Helpful (Y/N)

4) What has worked, and what has not?

Worked:
Definitely not worked:

5) It is VITAL we review past medical treatment, to avoid repeating past failures and ensure beneficial options are not discarded. Your pharmacy can provide a record of all past medications. Please bring a copy from ALL your past pharmacies. On the last page is a letter to give to the pharmacist. Note, I am requesting prescription history, not payment history.

Medication	Started (M/Y)	Until (M/Y)	Max. Dose	Response Y/N/Partial	Side Effects
Epival (divalproex)					
Lamictal (lamotrigine)					
Lithium (lithium carbonate)					
Tegretol (carbamazepine)					
Topamax (toperimate)					
Trileptal (oxcarbamazepine)					
BuSpar (buspirone)					
Celexa (citalopram)					
Cipralex (escitalopram)					
Cymbalta (duloxetine)					
Effexor (venlafaxine)					
Manerix (moclobemide)					
Nardil (phenelzine)					
Parnate (tranylcypromine)					
Paxil (paroxetine)					
Pristiq (desvenlafaxine)					
Prozac (fluoxetine)					
Remeron (mirtazapine)					
Wellbutrin (bupropion)					
Zoloft (sertraline)					
Imovane (zoplicone)					
Desyrel (trazodone)					
Ativan (lorazepam)					
Restoril (temazepam)					
Rivotril (clonazepam)					
Valium (diazepam)					
Xanax (alprazolam)					
Abilify (aripiprazole)					
Haldol (haloperidol)					
Risperidol (risperidone)					
Seroquel (quetiapine)					
Zeldox (ziprasidone)					
Zyprexa, Zydis (olanzapine)					
Adderall					
Concerta (methylphenidate)					
Dexedrine					
Ritalin (methylphenidate)					
Statterra (atomoxetine)					
ECT					
Others:					

6) **Have you ever made a suicide attempt or other self-mutilative behaviour in the past? Please list approximate date, method, circumstance, and if you sought / received follow-up treatment.**

Date (M/Y)	Method	Circumstance	Treatment

7) **Please list ALL physical illnesses (e.g. hypertension, diabetic, seizure etc).**

8) **Please describe all past hospitalizations.**

Date and duration	Reason for hospitalization	Location

9) **Present medications regimen (including non-psychiatric and over the counter).**

Medication Allergies: Yes / No Please list			
Pharmacy and Location:			
Medication	Daily Dose	Medication	Daily Dose
Describe Alternative medication and treatment used in the past:			

10) Substance Use, and Addictions (including Gambling).

Present Age:	Date last used	Present use (per week)	Quantity at peak use (amount per week)	Year and age of peak use	Age of first use
Alcohol					
Cannabis					
Cocaine					
Oxycontin					
LSD					
Ritalin					
IV Drugs					
Caffeine					
Nicotine					
Others:					
Drug of choice (including alcohol):					
Gambling History					
Addiction Counselling / Groups		Where		Dates	
Detox for:		Where		Dates	
Rehab for:		Where		Dates	
AA: Yes / No		NA: Yes / No		GA: Yes / No	
Dates where your have maintained sobriety from everything:					
Does your partner use? Yes / No What?					

11) Family history of mental illness, suicide attempts, and alcohol / illicit drug abuse. What medications have they found helpful.

Family Member	Mental Illness /suicide / alcohol / drugs	Medications they found helpful

12) Social History.

Completed High School? Yes / No	Special-Ed classes? Yes / No
Any behavioural difficulties in school? Yes / No	Please describe
Repeated grades? Yes / No. Which	
University	Community College
Brothers / sister, and their age:	
Children, and their age:	

Describe your childhood and adolescence (relationship with parents/ brothers, sister/ friends) and difficulties in your early years:
Present relationship with friends / family:
Main source of emotional support.
Describe your personality and any changes over the years:

13) Past and present significant relationships (boyfriends, marriage, divorce, common-law).

From (m/y)	Until (m/y)	

14) Employment history including approximate dates. Were you ever fired?

Present source of income:		

15) Past legal problems and dates (including driving while intoxicated).

Please give your pharmacist the following letter.

Dear Pharmacist,

Please provide to your patient a copy of their psychotropic prescription history (not payment history) in a chronological order as far back as possible, so that I have an accurate history of past medication trials.

Thank you.

M. Bhargava, MD

Bring all paperwork, prescription history, etc. along with this document to your appointment.

If you do not show for your appointment and have not followed the cancelation policy, you will be charged a no show fee.

If you cannot make your appointment please contact the Student Health Centre **24 hours in advance to cancel**, by emailing **shc@unb.ca**. This allows us to utilize the Specialists time to see another patient.
Student Health Centre (Feb/11)