Appointment Date | Time | NP

LPS Behavioral Health, LLC
Patient Information
(Please fill out before your appointment)

First Name | Middle Name / MI | Last Name

Date of Birth | Custodial Parent or Guardian

Patient Address Line 1 | Patient Address Line 2

City | State | Zip

Home Phone | Race | Primary Medical Provider | Primary Medical Provider's Clinic Name or Address

Social Security Number | Marital Status | Marital Status: Other | Name of Spouse or Partner

Number of children | Number living with you now | Ages of your children | Professional Title

May we contact you by text? ○ Yes ○ No | Cell Phone | May we contact you by email? ○ Yes ○ No | Email

Mental Health History

Have you received Outpatient or Inpatient mental health services in the past?
○ Yes ○ No

If yes, please enter when and where you received those services:

Inpatient (I) Or Outpatient (O)
○ I ○ O

Dates of Service | Facility or Clinic | Location (City, State) | Condition(s) Treated

Inpatient (I) Or Outpatient (O)
○ I ○ O

Dates of Service | Facility or Clinic | Location (City, State) | Condition(s) Treated

Inpatient (I) Or Outpatient (O)
○ I ○ O

Dates of Service | Facility or Clinic | Location (City, State) | Condition(s) Treated

Inpatient (I) Or Outpatient (O)
○ I ○ O

Dates of Service **Facility or Clinic** **Location (City, State)** **Condition(s) Treated**

Inpatient (I) Or Outpatient (O)

◯ I ◯ O

Dates of Service **Facility or Clinic** **Location (City, State)** **Condition(s) Treated**

Inpatient (I) Or Outpatient (O)

◯ I ◯ O

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Inpatient (I) Or Outpatient (O)

◯ I ◯ O

Dates of Service **Facility or Clinic** **Location (City, State)** **Condition(s) Treated**

Below, please list all the **medications** you are prescribed **now,** *whether or not you actually take them*. Please enter the dose and number of times taken daily for each medication. Please include over-the counter medications, herbal products, and supplements.

Medication	Dose	Number of doses daily (or weekly, monthly)
–	–	–
–	–	–
–	–	–
–	–	–
–	–	–
–	–	–
–	–	–
–	–	–
–	–	–

Do you take a CBD product?

◯ Yes ◯ No

If Yes, list brand and daily dose

Do you take a folic acid product?

◯ Yes ◯ No

If so, list brand and daily dose

Have you had a genetic test for medication compatibility in the past?

◯ Yes ◯ No

If Yes, test date

_____

(If Yes, please bring your profile printout to your first appointment if possible).

Do you have Medication allergies? If yes, please list below

○ Yes ○ No

Medication	**Reaction**	**Medication**	**Reaction**
Medication	**Reaction**	**Medication**	**Reaction**

General Health History

Please list all medical providers, general and specialists, that you see currently. List your primary care provider first. Include any complementary and/or alternative practitioners you see or have seen in the past (i.e., chiropractor, acupuncturist, naturopath, massage therapist, spiritual healer, etc.)

Name	**Address**	**Specialty, or condition that is being treated**

Current Medical Problems:

1.	**4.**	**7.**
2.	**5.**	**8.**
3.	**6.**	**9.**

Past Medical History: List any *major* past illnesses, hospitalizations (include year or date if known).

Condition	**Date**	**Condition**	**Date**

Past Surgical History: List any past surgeries and what year they occurred.

	Date		Date
	Date		Date
	Date		Date

Family History: Have your close relatives (parent, brother or sister, child, grandparent) had the following?

Heart attack, angina ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
Stroke ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
High blood pressure ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
High Cholesterol ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
Diabetes ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
Thyroid disease ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
Breast cancer ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
Other Cancer ○ Yes ○ No	what type?	If yes, which relative(s)?	Age(s) at Diagnosis?
Kidney Disease ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
Osteoporosis ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
Rheumatoid Arthritis ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
Asthma ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
Mental Health Disorder ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
Substance Abuse ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	
Autism, Asperger's Disorders ○ Yes ○ No	If yes, which relative(s)?	Age(s) at Diagnosis	

Suicide
○ Yes ○ No

If yes, which relative(s)?

Age(s) at Diagnosis

Past Gyn/Obstetrical History:

Vaginal Births

Miscarriage/Still births

Caesarian Sections

Pregnancy Terminations

Abnormal PAP tests

Other GYN Procedures

Please enter your use of the following (past or present):

Tobacco ○ Current ○ Past	**Quantity Per Day**	**Quantity Per Week**	**Have you been treated for addiction to this substance** ○ Yes ○ No
Alcohol ○ Current ○ Past	**Quantity Per Day**	**Quantity Per Week**	**Have you been treated for addiction to this substance** ○ Yes ○ No
Caffeine ○ Current ○ Past	**Quantity Per Day**	**Quantity Per Week**	**Have you been treated for addiction to this substance** ○ Yes ○ No
Amphetamines or "Meth" ○ Current ○ Past	**Quantity Per Day**	**Quantity Per Week**	**Have you been treated for addiction to this substance** ○ Yes ○ No
Opiates, including heroin ○ Current ○ Past	**Quantity Per Day**	**Quantity Per Week**	**Have you been treated for addiction to this substance** ○ Yes ○ No
Hallucingens ○ Current ○ Past	**Quantity Per Day**	**Quantity Per Week**	**Have you been treated for addiction to this substance** ○ Yes ○ No
Other recreational drugs ○ Current ○ Past	**Quantity Per Day**	**Quantity Per Week**	**Have you been treated for addiction to this substance** ○ Yes ○ No

Preventive Health: Please provide the dates when possible:

Pap/pelvic exam (females)	**Mammogram (females)**	**Colonoscopy**	**Test of stool for blood (Stool Guaiac)**
Rectal prostate exam (males)	**Prostate Specific Antigen (males)**	**Bone Density (Dexa)**	**Eye exam**
Cardiovascular stress test	**Tetanus vaccine (specify Td or Tdap)**	**Flu vaccine**	**Pneumonia vaccine**
Zoster (shingles) vaccine	**Hepatitis A**	**Hepatitis B**	**MMR**
Gardasil (HPV vaccine)	**Other**		

Review of Systems: Please check Yes or No for the following current symptoms.

GENERAL

Fever
○ Yes ○ No

Sweats at night
○ Yes ○ No

Hot flashes
○ Yes ○ No

Temperature intolerance
○ Yes ○ No

Excessive thirst
○ Yes ○ No

Fatigue
○ Yes ○ No

Sleep difficulties
○ Yes ○ No

Daytime sleepiness
○ Yes ○ No

Unplanned weight change
○ Yes ○ No

SKIN

Rash
○ Yes ○ No

New or changing moles
○ Yes ○ No

EYES

Pain
○ Yes ○ No

Redness
○ Yes ○ No

Vision change
○ Yes ○ No

EARS, NOSE, THROAT

Hearing loss
○ Yes ○ No

Ringing in ears
○ Yes ○ No

Dizziness or vertigo
○ Yes ○ No

Bleeding gums
○ Yes ○ No

Nosebleeds
○ Yes ○ No

BREAST

Breast Pain
○ Yes ○ No

Masses and/or Lumps
○ Yes ○ No

Nipple discharge
○ Yes ○ No

Skin changes
○ Yes ○ No

CARDIOVASCULAR

Chest pain
○ Yes ○ No

Heart murmur
○ Yes ○ No

Irregular heart beat (palpitations)
○ Yes ○ No

Leg swelling or edema
○ Yes ○ No

PULMONARY

Wheezing or shortness of breath
○ Yes ○ No

Chronic cough
○ Yes ○ No

HEMATOPOIETIC

Swollen lymph glands
○ Yes ○ No

Blood clots
○ Yes ○ No

Excessive bleeding
○ Yes ○ No

Anemia
○ Yes ○ No

GASTROINTESTINAL

Diarrhea/Constipation
○ Yes ○ No

Indigestion/heartburn
○ Yes ○ No

Nausea
○ Yes ○ No

Blood in stool
○ Yes ○ No

GENITOURINARY

Pain or burning on urination
○ Yes ○ No

Frequent urination
○ Yes ○ No

Waking to urinate more than once at night
○ Yes ○ No

Excessive urination
○ Yes ○ No

Difficulty emptying bladder
○ Yes ○ No

Urinary incontinence
○ Yes ○ No

Decreased sexual desire
○ Yes ○ No

Pain with intercourse
○ Yes ○ No

Sexually Transmitted Diseases
○ Yes ○ No

Fertility issues
○ Yes ○ No

Men:

Erectile dysfunction
○ Yes ○ No

Women:

Heavy vaginal discharge
○ Yes ○ No

Heavy menstrual bleeding
○ Yes ○ No

Painful menstrual periods
○ Yes ○ No

Irregular menstrual bleeding
○ Yes ○ No

MUSCULOSKELETAL

Generalized or all-over pain
○ Yes ○ No

Joint pain
○ Yes ○ No

Stiffness
○ Yes ○ No

Joint swelling
○ Yes ○ No

Joint redness
Yes No

Back or neck pain
Yes No

NEUROLOGICAL

Abnormal gait (Trouble Walking) or falls
Yes No

Headache severe and/or frequent
Yes No

Seizures
Yes No

Muscle weakness, TIA or stroke
Yes No

Fainting or loss of consciousness
Yes No

Localized numbness, tingling, neuropathy
Yes No

PSYCHIATRIC

Seeing things others do not seem to see
Yes No

Hearing things others do not seem to hear
Yes No

Memory loss
Yes No

Problems learning new information and skills
Yes No

If you are here for a Social Security, Medicaid, or Veteran's disability examination, you do *not* need to complete the information below. All other patients, please complete the insurance information below.

Are you enrolled in the Medicaid or HIP/HIP-2 program?
Yes No

If Yes: Medicaid Number: _____

Social Security Number: _____

Are you enrolled in Medicare?
Yes No

If Yes: Medicare Number: _____

Social Security Number: _____

Do you have private insurance coverage: If YES: (fill out information below)
Yes No

Primary Insurance Name _____

Primary Subscriber ID _____

Name of Insured _____

Date of Birth _____

Insured's Social Security No: _____

Insurance Address _____

Insurance Phone _____

Secondary Insurance Name _____

Secondary Subscriber ID _____

Name of insured _____

Date of Birth _____

Insured's Social Security No _____

Insurance Address _____

Insurance Phone _____