MRN ______________________________
(For Office Use Only)

Date _________________________________

PATIENT INFORMATION

Patient Name ____ SS# ________________________
Last First M.I.

Age _____ Date of Birth _______________ Male Female Marital Status _____________ Email ____________________________

Address ____
Street/Apt # City State Zip Code

Phone: Home _________________________ Work _________________________ Cell ______________________

Occupation ______________________________________ Employer ______________________________________

Employer's Address ____
Street City State Zip Code

MSU Student? Yes No If Yes, Student # ___________________________ MSU Athlete? Yes No

Emergency Contact Person #1 ______________________________________ Relationship ____________________

Phone: Home _________________________ Work _________________________ Cell ______________________

Emergency Contact Person #2 ______________________________________ Relationship ____________________

Phone: Home _________________________ Work _________________________ Cell ______________________

Primary Care Physician ______________________________________ Telephone ______________________

Address ____
Street City State Zip Code

Referring Provider (if not PCP) ______________________________________ Telephone ______________________

Address ____
Street City State Zip Code

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR)

Person Responsible for Payment ____
Last First M.I.

Date of Birth _______________ SS# _________________________ Relationship to Patient ______________________

Address – **Same as Patient** ☐ ____
Street/Apt # City State Zip Code

Phone: Home _________________________ Work _________________________ Cell ______________________

Employer ___________________________ Address ____
Street City State Zip Code

Other Parent's Name ____ Date of Birth _______________
Last First M.I.

Other Parent's Address – **Same as Patient** ☐ ____
Street/Apt # City State Zip Code

Other Parent's Phone: Home ______________________ Work ______________________ Cell ______________________

INSURANCE INFORMATION

INSURANCE PLAN ____________________ Effective Date __________ Primary ____ Secondary ____

Insurance Plan Address ____________________

Insurance Plan Phone# __________ Auth/Precert Phone# __________ Customer Service Phone# __________

Name of Policyholder ____________________ Date of Birth __________ Gender _______

Employer & Address ____________________

SSN __________ Relationship to Patient __________

Policyholder Address/Phone # ____________________

Contract/ID/Group # ____________________ Service Plan # __________ Coverage Type __________

Primary Care Copay __________ Specialty Copay __________ Mental Health Copay __________ PT/SP/OT Copay __________

INSURANCE PLAN ____________________ Effective Date __________ Primary ____ Secondary ____

Insurance Plan Address ____________________

Insurance Plan Phone# __________ Auth/Precert Phone# __________ Customer Service Phone# __________

Name of Policyholder ____________________ Date of Birth __________ Gender _______

Employer & Address ____________________

SSN __________ Relationship to Patient __________

Policyholder Address/Phone # ____________________

Contract/ID/Group # ____________________ Service Plan # __________ Coverage Type __________

Primary Care Copay __________ Specialty Copay __________ Mental Health Copay __________ PT/SP/OT Copay __________

INSURANCE PLAN ____________________ Effective Date __________ Primary ____ Secondary ____

Insurance Plan Address ____________________

Insurance Plan Phone# __________ Auth/Precert Phone# __________ Customer Service Phone# __________

Name of Policyholder ____________________ Date of Birth __________ Gender _______

Employer & Address ____________________

SSN __________ Relationship to Patient __________

Policyholder Address/Phone # ____________________

Contract/ID/Group # ____________________ Service Plan # __________ Coverage Type __________

Primary Care Copay __________ Specialty Copay __________ Mental Health Copay __________ PT/SP/OT Copay __________

WORKERS COMPENSATION/AUTO LIABILITY _______ Primary _______ Secondary Authorization Required? Yes No

Carrier ____________________ Case/Claim # __________

Claims Address ____________________

Phone # ____________________ Contact Person ____________________

Date of Injury/Accident ____________________

Personal History

Pt. Name:____________________
MRN:______________________

Name: ______________________ Birth Date: ____________ Age: _____

Ethnicity: ____________ Gender: ___________

Who referred you to our practice? ____________________________

Primary care physician: ____________________ Therapist: ________________

HISTORY OF CURRENT PROBLEM

Please explain why you are coming in to treatment:

____
____
____
____

When did the problem start?

____

Explain any associated factors that contributed or precipitated the above problem:

____
____

PAST PSYCHIATRIC TREATMENT

Past Psychiatrists:	Dates:
______________________	______________________
______________________	______________________
Past Therapists:	Dates:
______________________	______________________
______________________	______________________
Past Psychiatric Hospitalizations:	Dates:
______________________	______________________
______________________	______________________
______________________	______________________

Personal History

Pt. Name:____________________

MRN:______________________

CIRCLE MEDICATIONS TRIED:

SSRIs:
Celexa (citalopram)
Lexapro (escitalopram)
Luvox (fluvoxamine)
Paxil (paroxetine)
Prozac (fluoxetine)
Zoloft (sertraline)

SNRIs:
Cymbalta (duloxetine)
Effexor (venlafaxine)
Pristiq (desvenlafaxine)

Other Antidepressants:
Brintellix (vortioxetine)
Remeron (mirtazapine)
Serzone (nefazasone)
Viibryd (vilazodone)
Wellbutrin (bupropion)

TCAs:
Anafranil (clomipramine)
Elavil (amitriptyline)
Norpramin (desipramine)
Pamelor (nortriptyline)
Silenor (doxepin)
Tofranil (imipramine)

MAOIs:
Emsam (selegiline)
Marplan (isocarboxazid)
Nardil (phenelzine)
Parnate (tranylcypromine)

Anticonvulsants / Mood stabilizers:
Depakote (valproic acid)
Keppra (levetiracetam)
Lamictal (lamotrigine)
Lithobid / Eskalith (lithium)
Lyrica (pregabalin)
Neurontin (gabapentin)
Tegretol (carbamazepine)
Trileptal (oxcarbazepine)
Topamax (topiramate)

Anxiolytics :
Atarax / Vistaril (hydroxyzine)
BuSpar (buspirone)

Benzodiazepines:
Xanax (alprazolam)
Ativan (lorazepam)
Klonopin (clonazepam)
Valium (diazepam)

Antipsychotics:
Abilify (aripiprazole)
Clozaril (clozapine)
Fanapt (iloperidone)
Geodon (ziprasidone)
Haldol (haloperidol)
Invega (paliperidone)
Pimozide (Orap)
Prolixin (fluphenazine)
Risperdal (risperidone)
Saphris (asenapine)
Seroquel (quetiapine)
Thorazine (chlorpromazine)
Zyprexa (olanzapine)
Cogentin (benztropine)

Stimulants:
Adderall (amphetamine)
Concerta / Daytrana / Ritalin / Methylin (methylphenidate)
Dexedrine (dextroamphetamine)
Focalin (dexmethylphenidate)
Vyvanse (lisdexamfetamine)

Non stimulant:
Intuniv / Tenex (guanfacine)
Kapvay (clonidine)
Strattera (atomoxetine)

Sleep:
melatonin
Rozerem (ramelteon)
Benadryl (diphenhydramine)
NyQuil / Unisom (doxylamine)
Desyrel (Trazodone)
Ambien (zolpidem)
Lunesta (eszopiclone)
Restoril (temazepam)

Substance treatment:
Zyban (bupropion)
Chantix (varenicline)
Antabuse (disulfiram)
Campral (acomprosate)
Subutex (buprenorphine)
Suboxone (buprenorphine /naloxone)
methadone
Vivitrol / ReVia (Naltrexone)

Thyroid medication

Other(s):____

FOR EACH MEDICATION CIRCLED, PROVIDE ADDITIONAL INFORMATION BELOW:

Medication:	Date Started	Date Ended	Side Effects	Reason For Discontinuation	Helpful?

Personal History

Pt. Name:____________________
MRN:_______________________

DEVELOPMENTAL HISTORY:

Your birth: ☐ Premature ☐ Full Term ☐Post Term

How you were delivered: ☐ Vaginal ☐ C-section ☐ Other: _______________

Did your mother use substances during pregnancy: ☐ No ☐ Yes If Yes, describe: ____________
____

Did you reach milestones (talking, walking, feeding self… etc.) on time?
☐ Yes ☐ No If No, describe: ____

Have you ever received special education accommodations?
☐ No ☐ Yes If Yes, describe: ____

Highest level of education completed? ____

History of being bullied as a child: ☐ No ☐ Yes If Yes, describe: _________________________
____

History of childhood abuse (sexual/emotional/physical): ☐ No ☐ Yes If Yes, describe:
____
____
____

Check the appropriate box below for any family member who had / has a psychiatric diagnosis:

		Paternal (Father) Family:					Maternal (Mother) Family:				
	Sibling	**Father**	Aunt	Uncle	Grandparent	Cousin	**Mother**	Aunt	Uncle	Grandparent	Cousin
Depression											
Anxiety											
Obsessions or Compulsions											
Mania or Bipolar Disorder											
Psychosis or Schizophrenia											
Attention or Concentration Problems											
Hyperactivity Problems											
Learning Problems											
Mental Retardation											
Alcohol Problems											
Drug Use Problems											
Legal Problems											
Abuse or Neglect											
History of Suicide Attempts											
History of Self Harming											
History of Harming Others											
Psychiatric Hospitalizations											
Use of Psychiatric Medications											

Personal History

Pt. Name:____________________
MRN:______________________

MEDICAL HISTORY

Medical problems:

____

____

Surgeries:

____

____

Medication allergies:

____

____

Current medications:

____

____

Other providers you see:

____

____

SOCIAL HISTORY

Marital Status – (please circle):

Single   Dating   Married/Partner   Married for second or more times

Divorced – not remarried   Separated   Widowed/er

Who lives in your household:

____

List ages of your children:

____

Current occupation: ____

Past occupation (s): ____

List and explain any legal problems:

____

____

Michigan State University
Department of Psychiatry

Personal History

Pt. Name:____________________

MRN:______________________

SUBSTANCE USE

Drug Type or Name	Age of First Use	Amount Used at Height of Use	Current Amount Used and Frequency	Last Use	Never Used
Marijuana					
Alcohol					
Nicotine					
Cocaine					
Heroin					
LSD					
PCP					
Stimulants					
Pain Medications (List below): ______ ______					
Other: ______					

REVIEW OF SYSTEMS

Please check box marked YES if you have experienced any of the following:

Yes **CONSTITUTIONAL**
- ☐ Fevers/ chills
- ☐ Weight loss/ gain
- ☐ Changes to energy level
- ☐ Sleep problems

Yes **HEENT**
- ☐ Glasses
- ☐ Double vision
- ☐ Hearing problems
- ☐ Ear infections/ ear pain
- ☐ Seasonal / environmental allergies
- ☐ Strep throat
- ☐ Sinus problems

Yes **NEUROLOGY**
- ☐ Vision changes or problems
- ☐ Head injury/ concussion
- ☐ Trouble walking / clumsiness
- ☐ Seizures
- ☐ Headaches
- ☐ Numbness/ tingling

Yes **CARDIOVASCULAR**
- ☐ Chest pain
- ☐ Fainting
- ☐ Feeling heart beating or racing
- ☐ Problems with blood pressure
- ☐ Heart murmur

Yes **PULMONARY**
- ☐ Wheezing or asthma
- ☐ Trouble breathing

Yes **ENDOCRINE**
- ☐ Intolerance to heat or cold
- ☐ Unusual weight changes
- ☐ Problems with blood sugar
- ☐ History of diabetes
- ☐ Change in hair or nails

Yes **HEMATOLOGY**
- ☐ Bleeding problems
- ☐ Abnormal bruising

Yes **GASTROENTEROLOGY**
- ☐ Frequent stomach aches
- ☐ Nausea and/or vomiting
- ☐ Diarrhea
- ☐ Constipation

Yes **GENITOURINARY**
- ☐ Problems urinating
- ☐ Bladder or kidney infections
- ☐ Incontinence

Yes **MUSCULOSKELETAL**
- ☐ Joint pain / swelling
- ☐ Muscle weakness

Yes **SKIN**
- ☐ Rashes
- ☐ Picking
- ☐ Large or unusual birthmarks

Patient	
MRN	

MSU Psychiatry Clinic

No-Show Policy

Quality care for our patients is our top priority. Please take a few minutes to review our No-Show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a No-Show Appointment

MSU Psychiatry Clinic defines a No-Show appointment as any scheduled appointment in which the patient either:
- Does not arrive to the appointment.
- Cancels with less than 24 hours' notice.
- Arrives more than 10 minutes late and is consequently unable to be seen.

Impact of a No Show Appointment

No-show appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient fails to show up for a scheduled appointment it:
- Potentially jeopardizes the health of the patient.
- Is unfair (and frustrating) to other patients who would have taken the appointment slot.
- Is disrespectful of the provider's time.

How to Avoid Getting a No-Show

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours'** notice to cancel appointment

1. Appointment Confirmation

MSU Psychiatry Clinic will attempt to contact you 2-3 business days before your scheduled appointment to confirm your visit. If our automated system is unable to confirm with you over the phone, we will leave a message with your appointment date and time.

2. Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our clinic 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions, and to complete any necessary paperwork before the scheduled visit.

3. Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or reschedule an appointment, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care, as well as giving us the opportunity to rebook the vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call at 517-353-3070.

Consequences of No-Show Appointments

1. You will be charged a $50 no-show fee for each missed appointment.
2. If you miss 3 or more appointments within a year, you will be discharged from the clinic.
3. If you are discharged from the clinic, your remaining scheduled appointments will be cancelled.
4. Only emergency medical treatment will be offered within the first 30 days of discharge.

I have read and understand the MSU Psychiatry Clinic No Show policy as described above.

Patient/Guardian Signature

Date