



Phone: (952) 431-5330
Fax: (952) 431- 5334
3535 Vadnais Center Dr., Suite 150
Vadnais Heights, MN 55110

New Patient Intake Packet

Patient Demographics

Full Name: _____

Date of Birth: _____ Phone Number: _____

Work Phone: _____ Email: _____

Street Address _____

City, State, Zip _____

Gender: _____ Preferred Pronouns: _____

Sexual Orientation: _____

Emergency Contact Information

Emergency Contact Name: _____

Relationship to Patient: _____ Phone: _____

Pharmacy Information

Preferred Pharmacy Name: _____

Phone: _____

Street Address: _____

City, State, Zip: _____

Medical History

What concerns are you seeking care for?

Please select any symptoms that you are currently experiencing:

- | | |
|---|--|
| ☐ Feeling sad or down | ☐ Loss of interest or enjoyment |
| ☐ Feeling guilty or worthless | ☐ Crying often |
| ☐ Feeling irritable or angry | ☐ Low energy or fatigue |
| ☐ Feeling worried or anxious | ☐ High energy |
| ☐ Changes in appetite or weight | ☐ Panic attacks |
| ☐ Avoiding people or situations | ☐ Trouble sleeping |
| ☐ Trouble focusing or remembering | ☐ Sleeping too much or too little |
| ☐ Feeling suspicious | ☐ Racing thoughts |
| ☐ Thoughts of harming others | ☐ Acting without thinking |
| ☐ Thoughts of self-harm | ☐ Libido changes |
| ☐ Hurting yourself on purpose (such as cutting or burning) | |
| ☐ Past suicide attempt(s) | |
| ☐ Feelings or thoughts that you do not want to live | |
| ☐ Hearing or seeing things that other people do not | |

What services are you interested in discussing? (select all that apply)

- | | | |
|-----------------------------------|--|----------------------------------|
| ☐ Ketamine | ☐ Medication Management | ☐ Therapy |
| ☐ Spravato | ☐ Addiction Medication | ☐ |
| ☐ dTMS | ☐ Vagal Nerve Stimulation | |

Medical History

Current Height _____ Current Weight _____

Have you ever had or been treated for any of the following? (Check all that apply):

- ☐ Heart Attack
- ☐ Seziures
- ☐ Head Injury
- ☐ Brain Bleeds
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol

If you have any other medical conditions, please list below:

Please list any major surgeries you have had:

For patients with uterus/ovaries only:

Date of last menstrual period (If applicable): _____

Are you currently pregnant or do you plan on becoming pregnant in the near future?

☐ Yes ☐ No ☐ Unsure

Are you currently breastfeeding?

☐ Yes ☐ No

Current Medications

Please list all **CURRENT** medications (prescription and non-prescription) that you are taking as well as dosage and reason for taking:

Medication	Dosage	Reason

Past Medications

If you have ever taken any of the following medications, please add the dosage as well as approximate dates in which you were on the medication:

Antidepressants	Dosage	Start Date	End Date
Effexor (Venlafaxine)			
Elavil (Amitriptyline)			

Past Medications

Antidepressants	Dosage	Start Date	End Date
Lexapro (Escitalopram)			
Zoloft (Setraline)			
Luvox (Fluvoxamine)			
Pamelor (Nortriptyline)			
Paxil (Paroxetine)			
Prozac (Fluoxetine)			
Remeron (Mirtazapine)			
Serzone (Nefazodone)			
Tofranil (Imipramine)			
Wellbutrin (Bupropion)			
Auvelity (Dextromethorphan Bupropion)			
Viibryd (Vilazodon Hydrochloride)			
Trintellix (Vortioxetine)			
Pristiq (Desvenlafaxine Succinate)			
Anafranil (Clomipramine)			
Celexa (Citalopram)			
Cymbalta (Duloxetine)			

Past Medications

Mood Stabilizer	Dosage	Start Date	End Date
Depakote (Valproate)			
Lamictal (Lamotrigine)			
Lithium Tegretol (Carbamazepine)			
Topomax (Topiramate)			
Antipsychotic Mood Stabilizer	Dosage	Start Date	End Date
Clozaril (Clozapine)			
Haldol (Haloperidol)			
Prolixin (Fluphenazine)			
Seroquel (Quetiapine)			
Zyprexa (Olanzapine)			
Fanapt (Iloperidone)			
Abilify (Aripiprazole)			
Rexulti (Brexpiprazole)			
Vraylar (Cariprazine)			
ADHD	Dosage	Start Date	End Date
Adderall (Amphetamine)			
Concerta (Methylphenidate)			
Ritalin (Methylphenidate)			
Strattera (Atomoxetine)			

Past Medications

Anti-Anxiety	Dosage	Start Date	End Date
Ativan (Lorazepam)			
Buspar (Buspirone)			
Klonopin (Clonazepam)			
Tranxene (Clorazepate)			
Valium (Diazepam)			
Xanax (Alprazolam)			
MAOI	Dosage	Start Date	End Date
Marplan (Isocarboxazid)			
Nardil (Phenelzine)			
Emsam (Selegiline)			
Parnate (Tranylcypromine)			
Sedative/Hypnotic	Dosage	Start Date	End Date
Ambien (Zolpidem)			
Desyrel (Trazodone)			
Restoril (Temazepam)			
Rozerem (Ramelteon)			
Sonata (Zaleplon)			

Medications

Please select any of the following medications that you have used in the past for substance use disorders:

- | | |
|---|---|
| ☐ Revia (Naltrexone) | ☐ Gabapentin |
| ☐ Antabuse (Disulfiram) | ☐ Campral (Acamprosate) |
| ☐ Suboxone/Subutex | ☐ Methadone |
| ☐ Nicotine Replacement | ☐ Zyban (Bupropion) |
| ☐ Sublocade (Injectable) | ☐ Vivitrol (Naltrexone Inj.) |
| ☐ Chantix (Varenicline) | ☐ Topomax (Topiramate) |
| ☐ Kratom | |

Please list any medication, food, or contact allergies (ex: latex, etc.):

Allergy Name:	Reaction	Severity (Mild/Moderate/Severe)
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Psychiatric Information

Please check any of the following psychiatric diagnoses that you have been given:

- | | | |
|---|--|---|
| ☐ Depression | ☐ Schizophrenia | ☐ Nicotine Dependence |
| ☐ Anxiety | ☐ Schizoaffective | ☐ PTSD |
| ☐ ADHD/ADD | ☐ Eating Disorder | ☐ OCD |
| ☐ Phobia | ☐ Learning Disorder | ☐ Autism Spectrum Disorder |
| ☐ Panic Disorder | ☐ Gender Dysphoria | ☐ Substance/ Addiction |
| ☐ Bipolar Disorder | ☐ Personality Disorder | ☐ Other |
| ☐ Psychotic Disorder | ☐ Neurocognitive Disorder | |

If not listed above, please list:



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Psychiatric Information

Current outpatient psychiatric medication prescriber:

Name: _____ Phone Number: _____

Clinic: _____

Current outpatient primary care provider

Name: _____ Phone Number: _____

Clinic: _____

Current therapy provider:

Name: _____ Phone Number: _____

Clinic: _____

Prior modalities of therapy that you have done:

☐ CBT ☐ EMDR ☐ Family or Couples ☐ Other _____
☐ DBT ☐ ART ☐ Psychodynamic ☐ Not sure
☐ ACT ☐ Trauma-Focused ☐ Substance Use Counseling

History of participation in Intensive Outpatient Program (IOP) or Partial Hospitalization Program (PHP):

Year	Name of Hospital	Reason for Admission
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History or inpatient psychiatric hospitalization:

Year	Name of Hospital	Reason for Admission
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Psychiatric Information

History of suicide attempt

☐ Yes ☐ No

If yes, date of last attempt: _____

History of self-injurious behavior

☐ Yes ☐ No

If yes, date of last engagement: _____

History of abuse/trauma

☐ Yes ☐ No

If yes, what type of abuse? _____

Have you ever been treated with ECT (Electro-Convulsive Therapy)?

☐ Yes ☐ No

If yes, date(s) of treatment: _____

Have you been treated with TMS (Transcranial Magnetic Stimulation)?

☐ Yes ☐ No

If yes, please list the device type and date(s) of treatment:

Have you been treated with any form of Ketamine?

☐ Yes ☐ No

If yes, when and what form (nasal, IV infusion, swallowed, under tongue?)

Psychiatric Information

Please circle any member(s) of your family that have been diagnosed or have experienced the following:

Depression	☐ Child	☐ Parent	☐ Sibling	☐ Grandparent
Anxiety	☐ Child	☐ Parent	☐ Sibling	☐ Grandparent
Post Traumatic Stress Disorder	☐ Child	☐ Parent	☐ Sibling	☐ Grandparent
Bipolar Disorder	☐ Child	☐ Parent	☐ Sibling	☐ Grandparent
Schizophrenia/Schizoaffective Disorder	☐ Child	☐ Parent	☐ Sibling	☐ Grandparent
ADD/ADHD	☐ Child	☐ Parent	☐ Sibling	☐ Grandparent
Alcohol Abuse	☐ Child	☐ Parent	☐ Sibling	☐ Grandparent
Substance Abuse	☐ Child	☐ Parent	☐ Sibling	☐ Grandparent
Suicide	☐ Child	☐ Parent	☐ Sibling	☐ Grandparent
Self- Harm	☐ Child	☐ Parent	☐ Sibling	☐ Grandparent

Substance Use History

Have you ever had problems related to alcohol or drug use?

☐ Yes ☐ No

If yes, please check all that apply:

- ☐ Alcohol
- ☐ Marijuana
- ☐ Opioids (pain medications, heroin, fentanyl, etc.)
- ☐ Stimulants (cocaine, methamphetamine, ADHD medications, etc.)
- ☐ Sedatives (sleep or anxiety medications)
- ☐ Nicotine
- ☐ Other _____

Do you currently use alcohol or other substances?

☐ Yes ☐ No

If yes, please check all that apply:

- ☐ Alcohol
- ☐ Marijuana
- ☐ Opioids (pain medications, heroin, fentanyl, etc.)
- ☐ Stimulants (cocaine, methamphetamine, ADHD medications, etc.)
- ☐ Sedatives (sleep or anxiety medications)
- ☐ Nicotine
- ☐ Other _____

Regarding any alcohol/substance use listed above, please answer the following:

Have you ever felt you should cut down on your alcohol/substance use?

☐ Yes ☐ No

Have people ever annoyed you by criticizing your alcohol/substance use?

☐ Yes ☐ No

Have you felt bad or guilty about your alcohol or substance use?

☐ Yes ☐ No

Have you ever used alcohol or a substance first thing in the morning to steady your nerves or to start the day? (an "eye opener")

☐ Yes ☐ No

Substance Use History

Do you attend Alcohol Anonymous (AA), Narcotics Anonymous (NA), or any other peer support groups for substance?

☐ Yes ☐ No

Are you currently participating in alcohol/ substance use disorder treatment?

☐ Yes ☐ No

If yes, please provide details below:

Type(s) of substance	Date(s) of last use	Name of Treatment Center	Type of Treatment Center	Length of Treatment
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