CONFIDENTIAL

Transcultural Care
Olamide Alabi, PMHNP-BC
415 Highway 6 West, Oxford, MS 38655
Phone 662 234 5317 Fax 662 638 3880
Email: info@transcultural-care.com

Initial visit health history form

Patient's name: _____ **Date of birth**: _____ **Date completed:**_____

In a few sentences, please tell me what is bothering you and how long this problem has been going on:

_____

Was there a recent change or situation that convinced you to make this appointment?

_____

Have you ever been treated before by a mental health specialist (therapist, nurse practitioner, psychiatrist, psychologist)?

If so, please list their name and city/state._____

Are you seeing any of these professionals currently? Which ones _____

Is it okay if I contact any of these people to obtain records? _____

Have you ever considered or attempted suicide? If so when and how? _____

_____

Been hospitalized for mental health reasons? If so, when, where, and why? _____

_____

Had violent behavior toward another person? Please describe circumstances: _____

_____

Does anyone in your family have a history of mental health issues? If so, please specify the condition and their relationship to you: _____

Are you currently ☐ working ☐ student ☐ unemployed ☐ disabled ☐ retired

What is/was your occupation? _____

Who are you currently living with? _____

Highest level of education you have achieved: _____

Are you receiving or applying for FMLA or any form of short-term disability? Please be aware that you need to be seen at least three times before the provider will fill out any related documents and we cannot complete documents related to long-term disability.

☐ Yes, I am receiving currently ☐ I am in the process of applying and understand the policy ☐ No

Are you currently: ☐ married ☐ partnered ☐ divorced ☐ single ☐ widowed

Please list any allergies or reactions to any medications (example: Penicillin itchy rash):

_____

Please list all prescription medications being taken currently, why, and who is prescribing it.

_____

Past psychiatric medications: If you have ever taken any of the following medications, please write the approximate dates, dose, how helpful they were, and any side effects (if you cannot remember, just do your best):

Antidepressants

Amitriptyline (Elavil)	Emsam (selegiline)	Pamelor (nortriptyline)	Sinequan (Doxepin)
Anafranil (clomipramine)	Lexapro (escitalopram)	Paxil (paroxetine)	Trintellix (vortioxetine)
Celexa (citalopram)	Luvox (fluvoxamine)	Pristiq (desvenlafaxine)	Viibryd (vilazodone)
Cymbalta (duloxetine)	Nardil (phenelzine)	Prozac (fluoxetine)	Wellbutrin (bupropion)
Effexor (venlafaxine)	Norpramin (desipramine)	Remeron (mirtazapine)	Zoloft (sertraline)

Mood stabilizers

Depakote (valproate)	Lithium (lithium carbonate)	Topamax (topiramate)	
Lamictal (lamotrigine)	Tegretol (carbamazepine)	Trileptal (oxcarbazepine)	

Antipsychotics/mood stabilizers

Abilify (aripiprazole)	Haldol (haloperidol)	Riperdal (risperidone)	Zyprexa (olanzapine)
Clozaril (clozapine)	Latuda (lurasidone)	Saphris (asenapine)	
Geodon (ziprasidone)	Rexulti (brexpiprazole)	Seroquel (quetiapine)	

Sedatives/hypnotics

Ambien (zolpidem)	Desyrel (trazodone)	Restoril (temazepam)	Sonata (zaleplon)
Belsomra (suvorexant)	Lunesta (eszopiclone)	Rozerem (ramelteon)	

Anxiety medications

Ativan (lorazepam)	Kapvay (clonidine)	Neurontin (gabapentin)	Xanax (alprazolam)
Buspar (buspirone)	Klonopin (clonazepam)	Valium (diazepam)	
Inderal (propranolol)	Minipress (prazosin)	Vistaril (hydroxyzine)	

ADHD medications

Adderall XR (amphetamine)	Strattera (atomoxetine)	Intuniv (guanfacine)	
Ritalin (methylphenidate)	Concerta (methylphenidate)		
Vyvanse (lisdexamfetamine)	Kapvay (clonidine)		

Other psychiatric medications taken not mentioned above:

_____

Over the counter medications, herbs, supplements, or vitamins being taken:

_____

Do you follow any particular diet?:_____

The last time blood was drawn for laboratory tests? _____Who ordered it? _____

Why? _____ Were any of the tests abnormal?_____

_____

Who is your primary care provider (PCP)? _____

For women only: Are you nursing, pregnant, or planning on becoming pregnant? ☐ yes ☐ no

Are you using any birth control or contraception? Which? _____

Review of physical health

Do you have any of the following symptoms? If so, please highlight or circle:

General: weakness, fatigue, fever or chills, weight gain, weight loss, increased appetite, decreased appetite

Head ears nose throat: headache, head injury, lightheadedness, vision changes, hearing problems, tinnitus, vertigo, nasal stuffiness, nasal discharge, nosebleeds, sinus trouble, dry mouth, hoarseness

Cardiac: chest pain or discomfort, palpitations, rapid heartbeat, dizziness with position changes, shortness of breath, fainting, swelling in feet/legs

Respiratory: dry cough, productive cough, shortness of breath, wheezing

Gastrointestinal: heartburn, nausea, diarrhea, constipation, abdominal pain, rectal bleeding

Skin: acne, rash, wounds, skin discoloration

Urinary: frequent urination, pain with urination, difficulty fully emptying bladder, incontinence

Sexual health: painful intercourse, difficulty achieving orgasm, low libido, excessive libido, erectile dysfunction

Neurological: seizure, migraine, dizziness, tremor, numbness, tingling

Musculoskeletal: new or worsened muscle pain, new or worsened joint pain, stiffness, involuntary movements

Is your medical provider (PCP) aware of the above issues? ☐ yes ☐ no

History of high blood pressure? _____ High cholesterol? _____ Heart mummer? _____

Irregular heartbeats? _____ Any other heart related concerns? Please specify

_____

History of kidney disease? _____

Lung or breathing difficulties? (e.g., asthma.) _____

History of problems with the thyroid? _____

Problems with blood sugar?_____

Any surgeries? If so what and when?_____

Any other health concerns or history of problems not asked about above? _____

_____

Any unusual or significant medical conditions in blood relatives? _____

_____

Mental health

If you drink caffeine, how many drinks per day? (coffee, tea, energy drinks, soda): _____

If you drink alcohol, what is the most number of alcoholic drinks you'll drink per day? (1 drink is 12oz of beer, 1.5oz of spirits, or 5oz glass of wine): _____ How many days per week do you drink? _____

If you smoke marijuana, how often? _____

Do you use any other substances? How often? (meth, heroin, LSD, non-prescribed medications, etc.) _____

_____

Do you think you may have a problem with alcohol or drug use? ☐ yes ☐ no

Have you ever received treatment for alcohol or substance abuse? ☐ yes ☐ no

If yes, for which substances? _____

Where were you treated and when? _____

_____

Check once for any symptom currently present ✓ Check twice for major symptoms that are very bothersome ✓✓

☐ Depressed mood ☐ Anxiety ☐ Excessive worry ☐ Panic attacks ☐ Difficulty concentrating

☐ Excessive energy ☐ Hallucinations ☐ Decreased need for sleep ☐ Irritability ☐ Issues sleeping

Have you **ever** had feelings or thoughts that you did not want to live? ☐ yes ☐ no

Do you **currently** feel that you do not want to live? ☐ yes ☐ no

I own or have access to firearms ☐ yes ☐ no If yes, is the weapon properly secured? ☐ yes ☐ no

Do you have a history of legal problems? (DUI, domestic violence, arrests, prison, etc.) ☐ yes ☐ no

_____

Do you have or think you have ADHD/ADD? ☐ yes ☐ no

If you were diagnosed with ADHD/ADD, how old were you? _____

Are/were you a survivor of any form of abuse?

Physical abuse ☐ yes ☐ no age of occurrence _____

Sexual abuse ☐ yes ☐ no age of occurrence _____

Emotional abuse ☐ yes ☐ no age of occurrence _____

I feel safe at home and in my relationships ☐ yes ☐ no

What are some activities that help you feel peaceful, content, or relaxed? _____

Please list at least 2 people that you feel you can count on if you are having a difficult time:

_____

Is there anything else that you feel is worth mentioning? _____

_____