DEMOGRAPHIC & INTAKE INFORMATION

Farrah Thornsberry, PMHNP-BC
2815 Taylorsville Road, Suite 102
Louisville, KY 40205
Fax (502) 618-3344

CLIENT NAME (Last, First, MI):			**DATE OF BIRTH:**
PREFERRED NAME or NICKNAME:			**SOCIAL SECURITY NUMBER:** (By law certain medications require KASPER report to be done & this requires a person's SSN)
MARITAL STATUS:	**AGE**:	**SEX**: Male Female	**GENDER**: Male Female Non-Binary Transgender
PERSON COMPLETING FORM:			**RELATIONSHIP TO CLIENT:**
CHILD/ADOLESCENT ONLY			
Do both parents live in the same home?			**If not, what is the court ordered custody agreement?**
Current/Open Legal or Court Proceedings			
HOME ADDRESS:			**BILLING ADDRESS SAME**: Yes or No (If different add below)
Street:			
Apt/Unit:			
City/State/Zip:			
CELL PHONE NUMBER:			**PREFERRED CONTACT NUMBER**:
EMAIL ADDRESS:			**Can Messages (Text & Voice) be left on preferred number?** Yes or No
EMPLOYMENT INFORMATION			
EMPLOYED: Yes or No			**CURRENT EMPLOYER:**
TITLE/ROLE AT JOB:		**FULL or PART TIME:**	**TIME W/COMPANY:**
WHO REFERRED YOU:			
PHARMACY NAME:	**ADDRESS**:		**PHONE NUMBER:**
EMERGENCY CONTACT INFORMATION			
NAME:	**CONTACT NUMBER/S**		**RELATIONSHIP TO CLIENT:**
INSURANCE INFORMATION			
INSURANCE PROVIDER:	**MEMBER ID:**		**GROUP ID:**
POLICY HOLDER'S NAME:			**RELATIONSHIP TO POLICY HOLDER:**
POLICY HOLDER DOB:			
SECONDARY INSURANCE:			

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REASON FOR VISIT:

CURRENT SYMPTOMS CHECKLIST

(Please rate all that apply currently or within the last month. You do not have to rate a symptom if it is not a problem)

Symptom	Mild 1-3	Moderate 4-7	Severe 8-10	Symptom	Mild 1-3	Moderate 4-7	Severe 8-10
Aggression				Irritability			
Agitation				Judgement Errors			
Anger				Lack of Hygiene/Bathing			
Anxiety				Loneliness			
Appetite Change				Loss of Interest			
Change in Libido				Memory Impairment			
Compulsions				Mood Swings			
Crying/Tearful				Motivation Poor			
Cyber Addiction				Obsessive Thoughts			
Delusions				Oppositional Behavior			
Depression				Panic Attacks			
Disorientation				Paranoia			
Disassociation				Phobias/Fears			
Difficulty Getting Out of Bed				Physical Trauma/History			
Difficulty Making Decisions				Poor Attention			
Distractibility				Poor Focus			
Eating Disorder				Poor Concentration			
Elevated Mood				Racing Thoughts			
Emotional Trauma/History				Recurring Thoughts			
Excessive Energy				Reoccurring Nightmares			
Excessive Spending				Sexual Difficulties			
Fatigue				Self-harm/mutilation			
Frequent Checking				Sexually Acting Out			
Grief				Sexual Trauma/History			
Gambling				Sleep Problems			
Hallucinations				Speech Problems			
Hearing Voices				Social Isolation			
Heart Palpitations				Startles Easily			
Helplessness				Substance Abuse			
Hopelessness				Suicidal Thoughts			
Hyperactivity				Weight Changes			
Impulsivity				Worry Excessively			
Intrusive Thoughts				Worthlessness			

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MEDICAL HISTORY

Current Medications (Psychiatric & Medical):

Name of Medication	Dose & Frequency (i.e., 10 mg 3 times a day)	Reason for taking medication

Vitamins or Supplements:

Name of Vitamin/Supplement	Dose & Frequency (i.e., 10 mg 3 times a day)	Reason for taking

List any known **allergies** (Medication, Food, Environment) and Reaction:

ALLERGY	REACTION

PAST NON-PSYCHIATRIC HOSPITALIZATIONS

(Overnight/Greater than 23 hours)

REASON FOR HOSPITALIZATION	DATE/YEAR

Do you/client exercise regularly? Yes or No

Type of Routine Exercise: _____ How many days a week: _____

How would you describe your diet/nutritional intake? _____

Describe current physical health: ____ Good ____ Fair ____ Poor

Do you have a Primary Care Provider (PCP)? _____ If yes, who is your PCP _____

PCP Phone Number/Location: _____

When was the last time you saw your PCP? _____ For what reason? _____

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PERSONAL & FAMILY MEDICAL HISTORY

(Have you or a family member ever have any of the following? If family member, please specify)

Illness	You	Family	Who	Illness	You	Family	Who
Alzheimer's/Dementia				Glaucoma			
Anemia				Head Injury			
Angina				Heart Attack			
Arthritis				Heart Disease			
Asthma				High Blood Pressure			
Autoimmune Disease/Illness				High Cholesterol			
Birth Defects				HIV Positive or AIDS			
Cancer				Huntington's Disease			
Cardiac Problems				Hashimoto's Disease			
Chronic Fatigue				Insomnia			
Chronic Pain				Irritable Bowel Syndrome			
Diabetes				Kidney Problems			
Ear/Nose/Throat Problems				Liver Problems/Hepatitis			
Eating Disorder				Lung Disease			
Endocrine/Hormone Problems				Migraine or Cluster Headaches			
Epilepsy or Seizures				Murmur			
Eye Problems				Neurological Problems			
Fibromyalgia				Skin Disease or Problems			
Gastrointestinal Problems				Sleep Apnea			
Genital/Gynecological Problems				Stroke			
Grave's Disease				Thyroid Disease			
Genetic Disorder/Illness				Viral Illness/Herpes			

PAST SURGICAL HISTORY

SURGERY/PROCEDURES	DATE (Month/Year)

PSYCHIATIRC HISTORY

Prior Outpatient Treatment: ____ Yes ____ No If yes, please explain.

Reason	Dates Treated	Treating Provider/Therapist

Past Inpatient Treatment (for psychiatric, emotional, or substance use problems): ____ Yes ____ No

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If yes, please explain.

Reason	Dates Hospitalized	Where

SUBSTANCE USE HISTORY

Substance Use Status:

___ No history of abuse ___ Active Abuse ___ Early Full Remission ___ Sustained Full Remission ___ Sustained Partial Remission

Substance Use Treatment History:

___ Outpatient ___ Inpatient ___ 12-Step Program ___ Stopped on Own ___ Other: _____

If you have received substance use treatment, when and where did you receive it?

Substances Used (Please check all that apply)

Ever Used	Age 1st Used	Age Last Use	Currently Using	Frequency	Amount
___ Alcohol			____Yes ____ No		
___ Amphetamine			____Yes ____ No		
___ Barbiturates			___ Yes ____ No		
___ Caffeine			___ Yes ____ No		
___ Crack/Cocaine			___ Yes ____ No		
___ Ecstasy			___ Yes ____ No		
___ Hallucinogens (LSD)			____ Yes ____No		
___ Heroin			___ Yes ____ No		
___ Inhalants			____ Yes ____No		
___ Marijuana			___ Yes ____ No		
___ Methadone			____ Yes ____No		
___ Methamphetamine			___ Yes ____ No		
___ Painkillers			____ Yes ____No		
___ Molly			___ Yes ____ No		
___ Nicotine/Tobacco			____ Yes ____No		
___ PCP			___ Yes ____ No		
___ Spice			____ Yes ____No		
___ Other			___ Yes ____ No		

FAMILY PSYCHIATRIC HISTORY

Psychiatric Illness	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparen

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Depression			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Anxiety			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Panic Attacks			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Post-Traumatic Stress			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Bipolar/Manic-Depression			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Eating Disorder			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
ADHD/ADD			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Schizophrenia			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Alcohol Problems			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Drug Problems			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Suicide Attempts			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Completed Suicide			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Psychiatric Hospitalization			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal
Obsessive Compulsive D/O			__Maternal __Paternal	__Maternal __Paternal				Maternal __Paternal
OTHER:			__Maternal __Paternal	__Maternal __Paternal				__Maternal __Paternal

PAST PSYCHIATRIC MEDICATIONS

Medication Name	Symptom	When	Dosage	Did it help	Any Side Effects

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_____Client/Guardian Signature Date: _____