INSIGHT WELLNESS

Office: 5710 Commons Park, Suite 108, East Syracuse, NY 13057

Name: _____DOB:_____
Sex: _____ Gender Identity:_____
Cell: _____ Email:_____
Address: _____
Therapist:_____ How did you find us: _____

Reason(s) for seeking care:
1. _____
2. _____
3. _____

Check symptom(s) that apply:

( ) Sleep issues	( ) racing thoughts	( ) increased heart rate
( ) Nightmares	( ) Increased Activity	( ) sweating
( ) Loss of Interest	( ) Decreased need for Sleep	( ) Fear
( ) Energy level change	( ) Restlessness	( ) Flashbacks
( ) Concentration	( ) Irritability	( ) easily startled
( ) Appetite	( ) Muscle tension	( ) Hallucinations
( ) Suicidal thoughts	( ) increased heart rate	( ) Delusions
( ) recurrent self-injurious behavior	( ) Loses things	( ) impulsivity
( ) Fear of abandonment	( ) unstable relationships	( ) inappropriate anger

Psychiatric History:
Psychiatric diagnostic History: _____
Hospitalizations: _____
Past Outpatient Treatment History: _____
Current Psychiatric Medications: _____
Safety:
( ) Thoughts of harming others ( ) Suicide Attempts (including self-harm):_____
Childhood: (Pregnancy / delivery / developmental concerns)
_____

Medical History:
_____
Hospitalizations/Surgeries: _____
Last Menstrual Period:
_____
Birth Control: _____
Allergies: _____
Primary Care Physician: _____

admin@insightwellnessnpp.com | Tel: 315.400.1988 | Fax: 315.930.3895

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Pharmacy: _____
Current Non-Psychiatric Medication List:
_____
_____

Family History:
- Psychiatric illnesses: _____
- Family suicide history: _____
- Substance Use: _____
- Medical history: _____

Social/Education:
Who do you lives with _____ Support system includes: _____
Employment: _____
Last grade completed: _____

Substance:
( ) Marijuana:
( ) Crack/Cocaine:
( ) Opioid:
( ) Caffeine:
( ) Hallucinogens:
( ) Alcohol:
( ) Tobacco:

Legal Issues: _____ Military Involvement: _____
Trauma: _____

Discontinued Psychiatric Medication List:
_____
_____

Credit Info: (No Shows)
Name:_____ Credit Card #:_____
Expiration:_____ CVV: _____

Patient Insurance Information:
Primary Insurance Company: _____ Policy #:_____
Group #:_____ Primary Insurance Phone #: _____

Secondary Insurance Company: _____ Policy #:_____
Group #:_____ Secondary Insurance Phone #: _____

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