ULLA KRISTIINA LAAKSO, MD

PLEASE PRINT AND ANSWER ALL QUESTIONS DATE OF VISIT_____

LAST NAME_____ FIRST_____ M.I._____ AGE:_____

Address_____ Apt.____City_____ State_____ Zip_____

Date of Birth_____ SS# _____ Tel: Home_____ Work _____ Cell:_____

Single Married (___Times) Divorced (___Times) Separated Living with Partner Roommate Widow(er)

No. of Brothers____ No. of Sisters____ Your Occupation_____ Employer_____

Disabled: Yes No If yes, since:_____ Your Children and Ages_____

Emergency Contact _____ Relationship_____

Telephone_____ Address_____

Insurance Co. _____ Group ID#_____

Main Reason for Visit_____

Referred by _____Tel._____

Current Therapist_____ Tel._____

Primary Care Doctor_____ Tel _____

Date of last complete physical examination_____ ( ) Normal ( )Abnormal

If Abnormal, explain _____

Please list ALL CURRENT Medications with
Dose:_____

_____

_____

_____

Height _____ Weight_____ Are you trying to lose weight? Yes No

Please state how long you had to wait for an appointment _____

Was this satisfactory? Yes No Too Long? Yes No

Have you ever had any of the following problems?
Diabetes High Blood Pressure Heart Trouble Lung Trouble Kidney or Urine Trouble Seizures Ulcers

Cancer Arthritis Medication Allergies Other Allergies Thyroid Disease Head Injury HIV / AIDS Migraines

Explain: _____

_____ ***NONE (no health problems)***

Stressful Life Events in Past 12 Months (circle all that apply)

None Marital Problems Financial Problems Legal Problems Sexual Difficulties Retired Lost Job

Death of _____ Break-Up of Important Relationship Difficulties with: School Work

NAME_____ **DATE**_____

Difficulties with Sleep, Appetite, Concentration, Energy, Sex Drive (circle)

Falling Asleep Awakening 3-5 AM Decreased Concentration Decreased Appetite

Increased Appetite Decreased Sex Drive Increased Sex Drive Decreased Energy

Do you worry more than other people? Yes No **Do you ever become anxious for no clear reason?** Yes No

Do you ever become depressed for no clear reason? Yes No

Have you ever had Panic Attacks? Yes No From age_____ to age_____ Is it ongoing? _____

Each attack lasts how long?_____ **Do you or others describe you as moody?** Yes No

Are you more impulsive than other people? Yes No

Have you ever suffered from Bulemia? Yes No From age_____ to age _____

Have you every suffered from Anorexia? Yes No From age_____ to age_____

Smoking: Never Rarely Packs/Day _____ Age Began _____ Age Quit _____

Amount of Alcohol Intake: None Little Moderate Large Blackouts DT's

How often do you consume alcohol? _____ Quantity_____

Were you ever referred to AA? Yes No Did you attend? If yes, when?
_____

Have you ever used Drugs? Yes No If yes, please circle the ones you took::

Marijuana Cocaine Crack Amphetamine Heroine Opiates PCP LSD Hallucinogens

Barbiturates Sedatives Other _____When did you last use drugs?_____

Which Drug?_____ Were you ever referred to Drug Abuse treatment? Yes No

Describe: _____

Have you ever seen a therapist? Yes No At what age was first visit?
_____

For what problem? _____

Have you been hospitalized for psychiatric problems? Yes No

How many times? _____ Last hospitalization?
_____

Year	Problem	Hospital

Have you ever thought of Suicide? Yes No Attempted it? Yes No Thinking about it now? Yes No

How many times? _____ Method _____ When was the last time?_____

NAME_____ **DATE**_____

Has any *BIOLOGICAL* family member ever attempted suicide? Yes No Who?_____

Has any *BIOLOGICAL* family member committed suicide? Yes No

Who?

_____

How?

_____

Have you ever physically hurt another person? Yes No Thinking about it now? Yes No

Have you ever been prescribed psychiatric medication? Yes No

If yes, please list in order, starting with the first medication you ever took.

Include the medication even if you only took it once, or for one day.

Age	*Medication*	*Dosage*	*For How Long?*	*Did it Work*	*Side Effects*

Did any medication work at first, then stopped working? If yes, which one?_____ No

Did any medication make you 'hyper' or anxious? If yes, which one?_____ No

Office Policy, Authorization to Release of Information and Privacy Statement

All patients are to be aware and acknowledge that there is a cancellation fee for missed or cancelled appointments without at least 3 days prior notice.

The fee charged will be the total of the insurance payment plus the co-payment. Please be aware that insurance companies cannot be billed for these missed visits. These fees are your responsibility.

I agree to this office providing my medical information to my Primary Care Physician and Therapist, including medication and diagnosis, as required by my insurance company.

By signing your name below, you acknowledge and confirm that you understand and accept this policy, as well as receiving the notice of privacy practices for protected health information.

_____ _____

Signature of Patient or Representative Date

_____

Name of Patient Printed

_____

Name of Patient Representative and Relationship (if applicable)