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Pre-psychiatric evaluation questionnaire

(Please try to write legibly since it gets faxed out before it gets read by the psychiatrist. If you need additional space, write at the end of this form with the number of the question quoted. Try your best to answer as much as you can. Use additional blank papers as needed.)

Full Name: _____ **Date of birth**: _____ **Ethnicity**: _____
Marital status: _____
Phone # of a relative who knows you well whom we can call for information: _____
(You will have to sign a release of information in case we have to call)

1: What are your current problems that you want to see a psychiatrist for? _____
_____
_____

2: List your current or most recent psych meds (name/dosage/frequency) _____
_____

3: **Symptoms review:** (Check the one(s) that you might have)
Please check any symptoms or experiences that you have had in the last month:

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning
- ☐ Average hours of sleep per night: _____
- ☐ sleeping during daytime
- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Depressed Mood
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Fear of certain objects or situations; if so, Describe:
  _____
  _____
  _____
- ☐ Repetitive behaviors or mental acts [i.e., counting, checking doors, washing hands]
- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Changes in eating
- ☐ Voluntary vomiting
- ☐ Recent Weight gain or loss: ___ lbs.
- ☐ Difficulty catching your breath
- ☐ Increase muscle tension
- ☐ Unusual sweating
- ☐ Feeling "jumpy"
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Tremor
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations others don't have
- ☐ Racing thoughts Intrusive memories
- ☐ Difficulty concentrating or thinking
- ☐ Large gaps in memory
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Thoughts about harming or killing someone else
- ☐ Feeling as if you were outside yourself, detached, observing what you are doing
- ☐ Feeling puzzled as to what is real and unreal
- ☐ Persistent, repetitive, intrusive thoughts, impulses, or images
- ☐ Unusual visual experiences such as flashes of light, shadows
- ☐ Hear voices when no one else is present
- ☐ Feeling that your thoughts are controlled or placed in your mind
- ☐ Feeling that the television or the radio is communicating with you

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- ☐ Difficulty problem solving
- ☐ Difficulty meeting role expectations
- ☐ Dependency on others
- ☐ Other symptoms_____
  _____
  _____
- ☐ Manipulation of others to fulfill your own desires
- ☐ Inappropriate expression of anger
- ☐ craving to use alcohol/drugs
- ☐ Concerns about your sexuality

4: **Past Psychiatric illness:**
(Please sign the release form and give to Jailer if you want us to contact your prior provider get the records)

- When were you first diagnosed to have some mental illness? When was the first time you started treatment?
  _____
  _____
- While in school were you diagnosed to have Attention deficit or behavioral issues? If so, what age? What meds? _____
- Were you in regular class or special classes (if so specify type)
  _____
- Did you have disciplinary problems at school? _____
- Were you ever **officially** diagnosed by mental health provider with (Please circle them and elaborate):
  (Major Depression) (Bipolar disorder) (Schizophrenia) (Autism) (PTSD) (Eating disorder) (Sexual disorder) (Anxiety disorder) (Panic disorder) (OCD) (Sleep disorder) (Personality disorders) (Substance abuse disorder)
  _____
  _____
  _____
- Have you ever been hospitalized in psychiatric facility/Mental health Institutes? Yes/No
  - If yes, list the total number of admissions, starting from the earliest age onwards, to the most recent ones. Also list the names of places you were hospitalized.
    _____
    _____
    _____
- Did you receive treatment during prior incarceration? _____
- Any ECT or other types of treatments? _____

5: **Prior meds** you have tried (Check the ones you can recall. Please elaborate on whether the checked meds helped, or if you had problems)

- ☐ Prozac (fluoxetine)
- ☐ Zoloft (sertraline)
- ☐ Luvox (fluvoxamine)
- ☐ Paxil (paroxetine)
- ☐ Celexa (citalopram)
- ☐ Lexapro (escitalopram)
- ☐ Effexor (venlafaxine)
- ☐ Cymbalta (duloxetine)
- ☐ Wellbutrin (bupropion)
- ☐ Remeron (mirtazapine)
- ☐ Serzone (nefazodone)
- ☐ Anafranil (clomipramine)
- ☐ Pamelor (nortriptyline)

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- ☐ Tofranil (imipramine)
- ☐ Elavil (amitriptyline)
- ☐ Viibryd (vilazodone)
- ☐ Pristiq (desvenlafaxine)
- ☐ Fetzima (levomilnacipran)
- ☐ Tegretol (carbamazepine)
- ☐ Lithium
- ☐ Depakote (valproate)
- ☐ Lamictal (lamotrigine)
- ☐ Tegretol (carbamazepine)
- ☐ Topamax (topiramate)
- ☐ Neurontin (gabapentin)
- ☐ Lyrica (pregabalin)
- ☐ Trileptal (oxcarbazepine)
- ☐ Gabitril (tiagabine)
- ☐ Zonegran (zonisamide)
- ☐ Seroquel (quetiapine)
- ☐ Zyprexa (olanzapine)
- ☐ Geodon (ziprasidone)
- ☐ Abilify (aripiprazole)
- ☐ Invega (paliperidone)
- ☐ Fanapt (lloperidone)
- ☐ Latuda (lurasidone)
- ☐ Rexulti (brexpiprazole)
- ☐ Saphris (asenapine)
- ☐ Vryalar (cariprazine)
- ☐ Clozaril (clozapine)
- ☐ Haldol (haloperidol)
- ☐ Prolixin (fluphenazine)
- ☐ Risperdal (risperidone)
- ☐ Thorazine (Chlorpromazine)
- ☐ Ambien (zolpidem)
- ☐ Sonata (zaleplon)
- ☐ Rozerem (ramelteon)
- ☐ Restoril (temazepam)
- ☐ Librium (chlordiazepoxide)
- ☐ Desyrel (trazodone)
- ☐ Adderall (amphetamine)
- ☐ Concerta (methylphenidate)
- ☐ Ritalin (methylphenidate)
- ☐ Vyvanse (lisdexamfetamine)
- ☐ Nuvigil (armodafinil)
- ☐ Intuniv/Tenex (guanfacine)
- ☐ Focalin (dexmethylphenidate)
- ☐ Strattera (atomoxetine)
- ☐ Xanax (alprazolam)
- ☐ Ativan (lorazepam)
- ☐ Klonopin (clonazepam)
- ☐ Valium (diazepam)
- ☐ Tranxene (clorazepate)
- ☐ Buspar (buspirone)
- ☐ Vistaril (hydroxyzine)
- ☐ Antabuse (disulfiram)
- ☐ Campral (acamprosate)
- ☐ Chantix (varenicline)
- ☐ Dolophine (methadone)
- ☐ Suboxone (buprenorphine + naloxone)
- ☐ Subutex (buprenorphine)
- ☐ Vivitrol (naltrexone)
- ☐ Inderal (propranolol)
- ☐ Prazosin (Minipress)
- ☐ Have you been on long term injectable meds:
  - Abilify Maintena
  - Haldol Decanoate
  - Invega Sustenna
  - Invega Trinza
  - Prolixin Decanoate
  - Risperdal Consta
  - Zyprexa Relprevv

☐ Other meds:_____

_____

_____

6: **Suicide:** (please circle and elaborate as needed)

- Do you have current suicidal ideation: No/Yes
- If you do have suicidal ideation, what are your specific plans?

  _____
- What is there in your life you care about to keep on living for?

  _____

  _____
- Do you hear any commanding voices to kill yourself? Yes/No
- Any prior history of suicidal attempt/s? Yes/No.

- If yes to prior attempts, please provide details on number of attempts, method used, last attempt:

  _____

  _____

- Any family history of suicide or attempts: Yes/No
- Any self-injurious/self-mutilation or high-risk behaviors? Yes/No

  _____

- Would you ask for help if you feel like hurting yourself while in jail?

  _____

- How bad is your depression now?

  _____

- Have you ever done anything, started to do anything, or prepared to do anything to end your life?

  _____

  _____

- Are you impulsive? Or you loved one said you are short tempered?
  Yes/No_____
- Where you diagnosed to have Personality disorders?
  Yes/No_____
- Do you have chronic pain that you can't cope?
  Yes/No_____
- Do you have poor coping skills?
  Yes/No_____
- Any recent significant loss? Divorce/deaths of loved ones/relationship breakup (Circle and elaborate)

  _____

- Prior to incarceration, any recent loss of job: Yes/No
- Prior to incarceration, any recent loss of housing:
  Yes/No_____
- Prior to incarceration, any recent loss of property/business:
  Yes/No_____
- Prior to incarceration, any recent cut off from family/friend support: Yes/No
- Any children under 18 years of age?
  Yes/No_____

- What is your future goals in life?

  _____

  _____

- Does your Spiritual/religious belief have opposition to suicide?
  Yes/No_____
- Does your cultural belief have opposition to suicide?
  Yes/No_____
- Do you see a resolution to the legal issues in near future? What is the worst scenario? When is the next court date and what happens if it does not go in favor of you?

  _____

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7: **Substance usage:**
(Please include for each substance: ***Name of the drug, quantity/frequency, when first started using and the last day of usage***)

- Alcohol_____
- Marijuana_____
- Methamphetamine_____
- Cocaine_____
- Heroin / Pain pills_____
- If used opioid, whether were you in Methadone/Suboxone program? Whether resuscitated with naloxone after overdose?_____
- Hallucinogens: LSD/PCP/Molly/Club drugs_____
- Sedative pills like Xanax/Klonopin_____
- Bath salt/Flakka/Others_____
- Cigarette smoking: How many packs/day for how many years_____
- Chewing tobacco/Vapor_____
- *Caffeinated drinks_____
- Inhalants/aerosol _____
- Have you been shooting (IV) any of the street drugs?_____
- Have you been in substance rehab? How many times_____
- Longest duration of sobriety_____
- Legal issues related to substance usage?_____
- Medical problems related to substance usage?_____
- Any non substance addiction: (like Gambling)_____
- Have you been in pain management program_____
- Any major withdrawal symptoms like DTs/seizures withdrawal from substance?
  _____
  _____

8: **Review of medical issues:** Place a check mark if you have any and elaborate on it.

- ☐ ***Allergic reactions*** to medications?_____
- ☐ Allergic reaction to food/environment objects?_____
- ☐ Your height:____ weight____
- ☐ When was the last time you had a Full Physical Exam? Who is your Primary care doctor and Clinic name_____
- ☐ When was the last time you had routine labs done? Anything abnormal?_____
- ☐ Irritable bowel issues?_____
- ☐ Gastric reflux?_____
- ☐ History of chest pain/heart attacks?_____
- ☐ Stroke?_____
- ☐ Hypertension?_____
- ☐ Diabetes?_____
- ☐ Thyroid issues?_____
- ☐ Eating disorder?_____
- ☐ Cancer?_____

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- ☐ Urinary track problems?_____
- ☐ Arthritis?_____
- ☐ Fibromyalgia?_____
- ☐ Sexual dysfunction?_____
- ☐ Asthma?_____
- ☐ Sleep apnea?_____
- ☐ Acne or skin conditions?_____
- ☐ Seizure disorder?_____
- ☐ Head injuries/concussions?_____
- ☐ Any fractures?_____
- ☐ Any sexually transmitted diseases? HIV, Hepatitis?_____
- ☐ Headaches?_____
- ☐ Dental problems: Toothache/bleeding gums/chewing problems/others_____
- ☐ Problems with vision?_____
- ☐ Problems with hearing?_____
- ☐ Other?_____

_____

_____

- ☐ List surgical procedures done?_____
- ☐ Current medical (non-psych) medications you are taking_____
- ☐ Any Herbal/over the counter meds you are taking:_____

9: **Legal:**

- ➢ Details of the reason you are in jail this time_____
- ➢ Prior arrest history_____

_____

_____

- ➢ Been in juvenile facilities, half way houses?_____
- ➢ Have you been in prison system? If so, how many times and total years spend so far_____
- ➢ Do you have anger problems that the police were called on you before?_____
- ➢ Have been involved with DCF investigation before?_____

10: **Family history** of mental illness. If yes, specify details_____

_____

11: **Social H/O:**

- ➢ Where were you born and raised?_____
- ➢ Where you raised by both parents? _____
- ➢ Any abuse issues while growing up? If so specify whether physical, emotional, sexual_____
- ➢ Any problems with your development milestone?_____
- ➢ What is your highest level of education?_____
- ➢ Your relationship/marriage information?_____
- ➢ Any children? How many?_____

- Sexual orientation: Heterosexual/Homosexual/Bisexual/Others
- Employment history- types of job held, longest duration to hold on to a job_____
  _____
- Did you serve in military, if so type of discharge?_____
- Hobbies/interests:_____
- Any religious affiliations? _____
- Are you on Social security income or filed for_____
- Your housing status prior to coming to jail?_____

12: **Gynecological-Female Only** Circle and elaborate on them

- Pregnancies/Caesarean/Miscarriage/Abortion/Post Partum Depression
- Is there a possibility you might be pregnant now?_____
- Last Menstrual Period: _____
- Birth Control Pills/IUDs/Tubal ligation_____
- Any gynecological procedures*?*_____
- Are you on menopause; if so any mood swings, hot flashes?_____

13: **Men only**: Prostatic problem?_____

- Any sexual problems/urinary problems?_____

Thank you for completing the form. Any other comments?

_____
_____
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Release of information

I hereby authorize Integrated Telehealth Partners to OBTAIN and/or RELEASE documentation contained in the record for:

Inmate Name:
DOB:

Release Information To: _____
Name of the Family/Doctor/Hospital/Clinic:
Telephone #:_____

For The Purpose Of: Continuity of care, Determine need for additional services, Confirm my status in the program.
Information To Be Released: Entire
My Entire Record Including: Psychological/Psychiatric, Substance Abuse, HIV/AIDS Related (Including Test Result)
I Authorize The Following Forms In Which The Information Should Be Released: Verbal, Written, Telephonic, Faxed, Electronic Transmission

I authorize the release of documents and information prior to the date signed as well as any documents generated or information that may occur in the course of my treatment, now and in the future, up to the expiration date of this release.

I understand that this consent may be revoked upon written notice to the company, except to the extent that action by the company has been taken as a result of this authorization, and that this consent will remain in force for a reasonable time in order to effect the purpose for which it is given. Psychiatric, Alcohol/Drug Abuse, of HIV/AIDS information disclosed from records whose confidentiality is protected by state and federal laws (FS, 394, 397, & 381; 42CFR, Part II; and 45CFR, Parts 160 and 164,) may be subject to re-disclosure by the recipient and no longer protected. Further disclosure of information received by Telehealth Partners and Dr. K. X. Antony, MD will not be produced without the specific written consent of the authorized individual, or as otherwise permitted by such regulations.

Signing of this form is voluntary and Telehealth Partners and Dr. K. X. Antony, MD does not condition treatment on whether or not an individual authorizes the release of the above information. If you have executed a consent for Telehealth Partners and Dr. K. X. Antony, MD to release confidential information in connection with a criminal justice system referral, you acknowledge and agree that such consent will supersede this consent.

Note to Requesting Party: We follow established guidelines and costs for copying of records. Your signature on this form indicated our knowledge of this statement.
Expiration Date or Event (not to exceed 12 months).
Date signed: _____

Signature of inmate:

_____