WaKeeney Family Care Center Ph: 785-743-2124 Fax: 785-261-9606

333 N 14th - WaKeeney, KS 67672 **Name**: ______________________DOB:________

List all persons living in your home:		
Cell:	May we leave voicemails on this line? **messages will always be brief & respect privacy*	Yes / No
Other:	May we leave voicemails on this line? **messages will always be brief & respect privacy*	Yes / No

Gender & Pronoun	(circle): Male (he/him) Female (she/her) Other:_____________________________
Marital:	(circle): Single Married ___time(s) Divorced ___time(s) Widowed ___time(s) If married, what year: _______ Spouse's name: ______________________________
Children:	____ Biological daughters ____ Biological sons _____Stepchildren ____Adopted
Fertility:	Are you currently pregnant? YES NO Are you currently breast feeding? YES NO Currently using birth control? YES NO If yes, what type: _______________________ Is future pregnancy possible? YES NO If no, why not?:_________________________

Employer:	Occupation:	Years employed:
Currently on or seeking: Medical disability Psychological disability Year Approved: _______		
Military service: None Active Retired Branch:________________ for _____yrs. Honorable Discharge: Y / N Position:________________________ Service related trauma: Y / N		

High School	(circle): Graduated Dropped Out Year: _____ (circle): Diploma or GED
College	(circle): Graduated Dropped Out Year: _____ Degree: ____________________
	Specialized training or licenses held? ____

Name of the person completing this form: __________________________ Relationship:_______________

Briefly describe why you are seeking care (depression, anxiety, trauma, relationships, stress etc.):

____

____

____

How long has this issue concerned you?____

Did something specific cause these symptoms? (death, trauma, job loss, accident etc.):_____________

____

____

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Circle any prior or current mental health diagnoses:

Anxiety or Panic	ADHD / ADD	Addiction	Autism Spectrum	Bipolar
Borderline Personality	Dementia	Depression	Eating Disorders	Hallucinations
Homicidal Attempts	Homicidal Thoughts	Insomnia	Obsessive-Compulsive	Paranoia
PTSD	Rage or Anger	Schizophrenia	Suicidal Thoughts	Suicide Attempt

Other: ____

Please list any mental health care from other facilities including facility, reason, & approx. year.
Include outpatient & psychiatric admissions for mental health crisis or addiction:

Facility: ____________________________ Reason: ______________________ Year: ________

Facility: ____________________________ Reason: ______________________ Year: ________

Facility: ____________________________ Reason: ______________________ Year: ________

Any history of arrest or law enforcement involvement?: YES NO If yes, please list charge & year:

____

____

Alcohol & substance use review. Please consider any time in your lifetime for the following:

Alcohol	(circle): None Current Recreational Current Problematic Past Problematic Sobriety date: _____________ Interest in quitting or support? YES NO
Tobacco Nicotine	(circle): Never Former (Quit year):_____ Current Interest in quitting? YES NO (circle): Cigarettes Cigars Chew Snuff Vape _____pack/can/pkg per day
Substance Use	(circle): **prior use**. Include prescription meds taken incorrectly or without valid order): Marijuana THC K2 Cocaine Crack Opiates Fentanyl Heroin Cough Syrup Mushrooms PCP LSD Acid Methamphetamine ADHD Stimulants Bath Salts MDMA Molly Ecstasy Benzodiazepines Huffing fumes Canned "Duster" "Whippets" Any history of IV drug use: YES NO Sobriety date: ____________
	CURRENTLY using:____ Interest in quitting or support? YES NO

Please list or attach your current medications. Include prescription, herbal, OTC & supplements.

DRUG NAME, STRENGTH, & DIRECTION	PROVIDER NAME

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List all previously attempted psychiatric meds (antidepressants, antipsychotics, mood stabilizers etc.). Include OTC, herbal & prescription. Attach additional pages as needed.

DRUG NAME, STRENGTH, & DIRECTION	EFFECT OR REACTION

List medication allergies & reaction type if possible. Attach additional pages as needed.

DRUG	REACTION

Please circle & list any current or prior health diagnoses. Attach additional pages as needed.

Heart Disease A-fib Hypertension Stroke High Cholesterol Heart Attack Diabetes Cancer

Lung disease COPD Asthma Sleep apnea Liver disease Hepatitis Kidney disease UTI

Thyroid disease Diabetes Seizure Migraine Concussion Osteoporosis Chronic pain IBS

Other:

Surgeries:

Current primary care provider: ________________________ **Facility**:____________________________

Please list family mental health issues. Include conditions like ADHD, anxiety, panic, autism, bipolar, depression, addiction, OCD, PTSD, insomnia, schizophrenia, suicidal-homicidal behaviors, & rage.

Mother	
Father	
Grandparents	
Siblings	
Aunts/Uncles	
Children	
Other	

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Name: ______________________DOB:________

Circle any of the following symptoms you've experienced in the **last 3 months**.

Excessive sadness
Crying
Feeling empty or lonely
Anger or irritability
Thoughts of death or suicide
Thoughts of harming others
Reduced interest in activity
Unintended weight loss or gain
Sleeping too much
Trouble falling or staying asleep
Nightmares
Restlessness or fidgeting
Too much energy
Feeling tired or drained
Hopeless or worthlessness
Impaired concentration
Distraction or poor focus
Being forgetful
Poor self-care
Talking too much or too fast
Racing thoughts or confusion
Impulsivity
Reckless or risky behaviors
Hallucination or paranoia
Mood swings
Being withdrawn or less social
Less interest in sexual activity
More interest in sexual activity
Excessive spending or gambling
Hoarding or trouble throwing things away
Legal trouble or arrests
Specific fears or phobias
Muscle movements or twitching

Excessive worry
Nervousness
Panic attacks
Muscle tension
Flashbacks
Intrusive thoughts or memories
Startle easily or jumpy
Excessively watchful in public
Negative self-opinion or low self-esteem
Hair pulling
Nail biting
Skin picking
Obsessive or compulsive behaviors
Self-injury (biting, burning, cutting)
Eating more than usual
Eating less than usual
Vomiting or restricting food
Using drugs to cope
Using alcohol to cope
Fire starting
Cruelty to animals
Witness to domestic abuse
Experienced abuse or neglect

-

Medical Symptoms:

Acute pain (less than 6 months)
Chronic pain (longer than 6 months)
Illness or fever (in the last 14 days)
COVID (in the last 6 months)
Strep throat (in the last 6 months)
Broken, decaying, painful teeth
New major medical conditions

Other symptoms not listed:____

____