



Mind Rejuvenation, LLC

Iftikhar Hussain, MD | Mical Pacheco, MSN, APRN, PMHNP-BC

INITIAL INTAKE

Patient Name _____ DOB _____
 Address _____ Gender: Male Female Other _____
 City _____ State _____ Zip _____ Who referred you? _____
 Phone: _____ Cell Home Work Phone: _____ Cell Home Work _____

Cultural Consideration Ethnicity Background

Ethnicity: _____ Caucasian _____ Hispanic or Latino _____ African American
 _____ American Indian _____ Other _____ Prefer not to answer _____

Other cultural concerns or preferences: _____
 What would you say gives your life meaning or purpose? _____

Insurance

Primary Insurance

Insurance Name _____ Policy No. _____
 Policy Holder _____ Group No. _____
 Policy Holder's DOB _____ Social Security No. _____

Secondary Insurance

Insurance Name _____ Policy No. _____
 Policy Holder _____ Group No. _____
 Policy Holder's DOB _____ Social Security No. _____

Other Insurance

Insurance Name _____ Policy No. _____
 Policy Holder _____ Group No. _____
 Policy Holder's DOB _____ Social Security No. _____

Physician History

Please list any physicians you see and the reason why you see them

Physician	Reason for seeing
Referring Provider:	
Primary Care:	

******* IMPORTANT *******

PHARMACY

Name _____ Phone _____
 Address _____

Reason for Visit

Reason for Visit: _____ Medication Management _____ ADHD _____ Spravato _____ Ketamine
 _____ PTSD _____ OCD _____ Bipolar _____ Other: _____

What do you hope to achieve through this visit? _____



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Psychological

History of: Depressed mood Irritability Anger Violence
 Violent History: Tantrums Hurt others Cruelty to animals Destroys property
 Other: _____
 Other: _____

Sleep Pattern: Number of hours per day? _____ Time to onset of sleep? _____
 Normal Sleeping too much Sleeping too little

Ability to Concentrate: Normal Difficulty concentrating

Energy Level: Low Average/Normal High

Self-Harm Behaviors History

Have you ever intentionally harmed yourself with or without suicidal thinking? Yes No

Have you ever attempted suicide? Yes No

If yes, when? _____

Do you consider yourself a high risk to attempt suicide in the near future? Yes No

Have you ever considered or thought about suicide? Yes No

If yes, when? _____

Have you ever attempted to harm someone other than yourself? Yes No

Have you ever considered hurting someone else? Yes No

Are you dealing with any of these thoughts currently? Yes No

Addictive Behaviors

Gambling Addiction? Yes No

At what age behavior began? _____ How often do you gamble? _____

How much money spent in the last month? _____ Last 6 months? _____

Problematic / disordered eating (e.g., overeating, undereating, atypical eating)

Have you or others expressed concerns about your eating patterns? Yes No

Have you had any previous treatment for eating disorder symptoms? Yes No

If yes, please give details _____

Problematic / disordered eating (e.g., overeating, undereating, atypical eating)

Have you or others expressed concerns about your eating patterns? Yes No

If yes, age this was first noticed? _____

Excessive Exercise? Yes No If yes, what age problem behavior began? _____

How much time is spent weekly in exercise? _____

Please note which of the areas above have contributed to problems or conflict in your life. _____



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Addictive Behaviors (Cont....)

Sexual Behavior Addiction? _____ Yes _____ No If yes, what age problem behavior began? _____

Internet Addiction? _____ Yes _____ No If yes, what age problem behavior began? _____

Substance Use

Substance	Age first use	Current weekly use
Alcohol		
Sedatives (anxiety & sleep meds, benzodiazepines, barbiturates, soma, Fioricet, etc.)		
Pain meds (opiates, prescription pain meds, heroin)		
Marijuana (inc. synthetic cannabinoids)		
Stimulants (Prescription, Methamphetamine, Cocaine, etc.)		
Hallucinogens (LSD, PCP, mushrooms, peyote, DMT, 2C-B, salvia, etc.)		
Club drugs (GHB, Ketamine, Methoxetamine, etc.)		
Inhalants (glue, spray paint, nitrous oxide, amyl nitrate, "poppers", etc.)		
Steroids		
Caffeine		
Tobacco		
Others (Kratom, Ibogaine, etc.)		

Ever injected drugs? _____ Yes _____ No Which ones? _____

Drug of choice? _____

Consequences as a result of drug/alcohol use (select all that apply)

- | | | | |
|----------------------|------------------|--------------------|--|
| _____ Hangovers | _____ DTs/Shakes | _____ GI Bleeding | _____ Liver Disease |
| _____ Overdoses | _____ Seizures | _____ Assaults | _____ Left School |
| _____ Sleep Problems | _____ DUIs | _____ Binges | _____ Relationship Problems |
| _____ Lost Job | _____ Homicide | _____ Arrests | _____ Increased Tolerance-need more for a high |
| _____ Incarcerations | _____ Blackouts | _____ Other: _____ | |

Longest period of sobriety? _____ How long ago? _____

Triggers to use (list all that apply): _____

Allergies

Please list all known allergies: _____



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Family & Social Relations

Current Situation

_____ Single _____ Married _____ Divorced _____ Never married

Living Situation

_____ Alone _____ With spouse _____ With family _____ With significant other _____ Homeless

Does the client have children?

Name	Age	DOB	Sex	Custody Y/N	Additional Information

Who lives in the home?

Name	Age	Relationship

Perceived level of support for treatment? (scale 1-5 with 5 being the most supportive) _____

Primary support person/system? _____

Leisure & Recreation

Which of the following does the client do? (Select all that apply)

Leisure	Y/N	How often weekly	Leisure	Y/N	How Often weekly
Spend time with friends			Sports / Exercise		
Classes			Dancing		
Spend time with family			Hobbies		
Work part-time			Watch movies / TV		
Go "Downtown"			Stay at home		
Listen to music			Spend time at clubs/bars		
Go to Casinos			Other:		

What limits the client's leisure/recreational activities?

Nutrition

Nutritional Status: Current Weight _____ Current Height _____ BMI _____

Appetite: _____ Good _____ Fair _____ Poor, Please explain below

_____ Recently _____ gained/ _____ lost significant weight



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Review of Medical History

Please elaborate on any condition you have.

Allergy	General	ENT
<input type="checkbox"/> Runny Nose <input type="checkbox"/> Scratchy Throat <input type="checkbox"/> Itchy Eyes <input type="checkbox"/> Sneezing <input type="checkbox"/> Ear Fullness <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Sinus Drainage <input type="checkbox"/> Itchy Nose	<input type="checkbox"/> Weight Gain <input type="checkbox"/> Weakness <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Fever <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Cold <input type="checkbox"/> Cough <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Change in Voice <input type="checkbox"/> Sore Throat <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Sinus Pain/Headaches
Respiratory	Endocrinology	Cardiology
<input type="checkbox"/> Chest Pain <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chest Congestion <input type="checkbox"/> Dyspnea <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Difficult to breath lying down	<input type="checkbox"/> Fatigue <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Weight Loss <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Dizziness <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Rapid Heart Rate <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Leg Edema <input type="checkbox"/> Leg Pain
Gastroenterology	Urology	Neurology
<input type="checkbox"/> Nausea <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Vomiting <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Constipation	<input type="checkbox"/> Recurring UTI <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Difficult Urinating <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Nocturia <input type="checkbox"/> Ulcerative/Interstitial Cystitis <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Headache <input type="checkbox"/> Seizures <input type="checkbox"/> Insomnia <input type="checkbox"/> Tic/Twitching <input type="checkbox"/> Memory Changes <input type="checkbox"/> Tingling/ Numbness' <input type="checkbox"/> Dizziness <input type="checkbox"/> Other: _____
Hematology	Psychology	Other
<input type="checkbox"/> History of Anemia <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> High Stress <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Agitation/Irritable <input type="checkbox"/> Other: _____	<input type="checkbox"/> Aneurysmal Vascular Disease or Arteriovenous Malformation <input type="checkbox"/> **including Thoracic or abdominal aorta, Intracranial & peripheral arterial vessels** <input type="checkbox"/> Hypersensitivity to Ketamine, or any other excipients <input type="checkbox"/> Intracerebral Hemorrhage <input type="checkbox"/> Intracerebral Hemorrhage



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Past Medical Health Treatment

Have you been diagnosed with mental health issues in the past? _____ Yes _____ No

If yes, what diagnosis have you had? _____

At what age were you first evaluated and/or treated for this? _____

Have you been treated for mental health issues with medications? _____ Yes _____ No

Have you had any of the following alternative treatments for mental health symptoms?

_____ ECT _____ Transcranial Stimulation Vagal Nerve Stimulator _____ Psychotherapy

_____ Other _____

Have you ever seen a therapist for mental health symptoms? _____ Yes _____ No

If yes, please provide the approximate date and name of provider _____

What mental health symptom were you seen by a therapist? _____

Do you feel it was productive for your mental health needs? _____ Yes _____ No

If no, explain: _____

Additional information you would like to share with your provider:

SIGNATURE (Person completing the form)

Name

Relationship to patient

Signature

Date