# Integrative Mind Body Psychiatry

Beth J. Makar, PMHNP-BC, MSN, RN | Telehealth Psychiatric Care for Utah | 385-452-9122 | IntegrativeMindBodyPsychiatry.com

*This form collects protected health information (PHI). All information is kept confidential in accordance with HIPAA regulations.*

## SECTION 1 — ADMINISTRATIVE & DEMOGRAPHICS

### Personal Information

Full Legal Name | Preferred Name / Nickname | Date of Birth

Legal Sex (at birth) | Gender Identity | Pronouns | Primary Language

### Contact Information

Street Address | City | State | ZIP

Primary Phone | Secondary Phone | Email Address

Preferred Contact Method | Best Time to Contact | May we leave a voicemail? Yes No

### Billing & Insurance

Insurance Carrier | Member ID / Policy # | Group #

Policy Holder Name | Policy Holder DOB | Relationship to Patient

Secondary Insurance (if any) | Member ID | Group #

### Emergency Contact

Emergency Contact Name | Relationship | Phone Number

## SECTION 2 — CHIEF COMPLAINT & PRESENTING CONCERNS

### Reason for Visit

In your own words, why are you seeking psychiatric care today?

How long have you been experiencing these symptoms? | When did symptoms first begin?

### Current Symptoms (check all that apply)

| | | | |
|---|---|---|---|
| Depressed mood | Anxiety / worry | Panic attacks | Racing thoughts |
| Mood swings | Irritability / anger | Difficulty concentrating | ADHD / inattention |
| Hyperactivity | Impulsivity | Memory problems | Psychosis / hallucinations |
| Paranoia | Sleep problems | Fatigue / low energy | Appetite changes |
| Weight changes | Low motivation | Social withdrawal | Hopelessness |
| Self-harm thoughts | Suicidal thoughts | Substance use concerns | Trauma symptoms |
| OCD symptoms | Grief / loss | Relationship problems | School / work problems |

Other symptoms:

### Treatment Goals

What do you hope to achieve through treatment?

Seeking: Medication Management Therapy Both Previous therapy? Yes No

## SECTION 3 — COMPREHENSIVE MEDICAL & PSYCHIATRIC HISTORY

### Past Psychiatric History

Previous psychiatric diagnoses (list all)

Year first diagnosed

Previous psychiatric providers / therapists

Dates of treatment

Hospitalized for psychiatric reasons? Yes No If yes — how many times / when?

### Current Medications

| Medication Name | Dose | Frequency | Prescribing Provider | Condition Treating |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

### Past Medication Trials

| Medication Name | Approx. Duration | Reason Discontinued | Helpful? |
|---|---|---|---|
| | | | Y N |
| | | | Y N |
| | | | Y N |
| | | | Y N |
| | | | Y N |

### General Medical History

Current chronic medical conditions:

Known drug allergies / reactions

Past major surgeries (with dates)

History of head trauma / TBI? Yes No Details:

Seizure history? Yes No

## SECTION 4 — LIFESTYLE & BIOPSYCHOSOCIAL CONTEXT

### Substance Use History

| Substance | Current Use? | | Frequency / Amount | Past Use? | | History of Rehab? | |
|---|---|---|---|---|---|---|---|
| Alcohol | Y | N | | Y | N | Y | N |
| Tobacco / Nicotine | Y | N | | Y | N | Y | N |
| Caffeine | Y | N | | Y | N | Y | N |
| Cannabis / Marijuana | Y | N | | Y | N | Y | N |
| [redacted]ed) | Y | N | | Y | N | Y | N |
| Opioids | Y | N | | Y | N | Y | N |
| Other | Y | N | | Y | N | Y | N |

### Sleep & Biological Habits

Average hours of sleep/night: Trouble falling/staying asleep? Yes No Exercise days/week:

Typical diet / food sensitivities / dietary restrictions:

### Family Mental Health History (first-degree relatives)

| | | | |
|---|---|---|---|
| Depression | Anxiety | Bipolar Disorder | ADHD |
| Schizophrenia / Psychosis | PTSD / Trauma | Substance Use Disorder | Suicide attempt/death |
| Autism Spectrum | Learning Disabilities | Dementia / Memory Loss | Other mental illness |

Family history notes:

### Social & Legal History

Current Living Situation Marital / Relationship Status Number of Children

Highest Education Completed Employment Status Employer / School

Current or past legal issues? Yes No Details:

## SECTION 5 — SAFETY SCREENING

*The following questions help ensure your safety. Please answer honestly. All responses are confidential.*

| | | |
|---|---|---|
| Do you currently have thoughts of harming yourself? | Yes | No |
| Do you currently have thoughts of suicide? | Yes | No |
| Have you ever attempted suicide? | Yes | No |
| Do you have thoughts of harming others? | Yes | No |
| Do you have access to firearms or weapons at home? | Yes | No |

If YES to any above, please describe:

[redacted]

## SECTION 6 — INTEGRATIVE & HOLISTIC HEALTH

### Mind-Body-Gut Assessment

The following questions support our integrative approach to your care.

| | | | |
|---|---|---|---|
| Do you experience digestive issues (bloating, IBS, constipation, etc.)? | Yes | No | |
| Do you take any supplements, vitamins, or herbal remedies? | Yes | No | If yes, describe: |
| Do you practice mindfulness, meditation, or yoga? | Yes | No | |
| Do you follow a specific diet (gluten-free, dairy-free, vegetarian, etc.)? | Yes | No | If yes, describe: |
| Do you have a history of food sensitivities or intolerances? | Yes | No | |
| Are you interested in integrating nutrition and lifestyle into your treatment? | Yes | No | |

Stress level: Low Moderate High Severe

Activities that support your wellbeing (nature, faith, exercise, creative outlets, etc.):

[redacted]

## SECTION 7 — CONSENT & ACKNOWLEDGMENT

By signing below, I confirm that the information provided on this form is accurate and complete to the best of my knowledge. I consent to the collection and use of this information for psychiatric evaluation and treatment. I understand this information is protected under HIPAA and will not be shared without my written consent except as required by law.

Patient Signature: [redacted] Date: [redacted]

Printed Name: [redacted] If signing for minor — Relationship: [redacted]