Bartlett Regional Hospital
Bartlett Outpatient Psychiatric Services
3240 Hospital Drive
Juneau, AK 99801
Phone: (907) 796-8498
Fax: (907) 796-8497

Date: _____

Patient Information

Patient: _____
Last Name First Name Middle Initial

Preferred Name: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Social Security #: _____-_____-_____ Primary Care Physician: _____

Employer: _____Occupation: _____

Veteran Status: ☐ Active Duty ☐ Non Veteran ☐ Veteran ☐ N/A

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Provide

Race: ☐Alaska Native or Native American ☐Black or African American ☐Caucasian
☐ Hispanic ☐ Decline to Provide ☐ Other_____
Organ Donor: ☐Yes ☐No

Contact Information

Mailing Address: _____

Phone: _____ Email: _____

Parent or Legal Guardian Name (if applicable): _____

Preferred method of contact for appointment ***reminder calls***: ☐ Call ☐ Text ☐ Email

Emergency Contact Name: _____ Phone: _____

Relationship: _____

Insurance Information

Please provide all insurance policies.

Primary Policy: _____Policy #: _____Group #:_____
Subscriber: _____ Subscriber Date of Birth: _____
Subscriber Social Security #: _____-_____-_____

Secondary Policy: _____Policy #: _____ Group #:_____
Subscriber: _____ Subscriber Date of Birth: _____
Subscriber Social Security #:_____-_____-_____

Tertiary Policy: _____Policy #:_____Group #:_____
Subscriber: _____ Subscriber Date of Birth: _____
Subscriber Social Security #:_____-_____-_____

Please present insurance cards to front office staff.

Date:_____/_____/_____

NAME: _____ Birthdate: _____/_____/_____

Last First M. I.

Age:_____Gender:_____ Phone (Home):_____

Address:_____ Phone (Cell):_____

Emergency Contact:_____ Emergency Phone:_____

Insurance Carrier:_____ Policy Number:_____

Are you mandated to participate in mental health services? ❑Yes ❑No

What is your main reason for coming here?_____

_____

Please list the names of other practitioners you have seen for this problem:_____

_____

Psychiatric Hospitalizations (include where, when, & for what reason):_____

PSYCHIATRIC HISTORY

Do you now or have you ever had any of the following:

❑Depression	❑Schizophrenia	❑Borderline personality disorder
❑Bipolar disorder	❑Schizoaffective disorder	❑Substance use disorder
❑Anxiety disorder	❑Posttraumatic stress disorder	❑Other:_____

MEDICAL HISTORY

Do you now or have you ever had any of the following:

❑Diabetes	❑Heart murmur	❑Crohn's disease
❑High blood pressure	❑Pneumonia	❑Colitis
❑High cholesterol	❑Pulmonary embolism	❑Anemia
❑Hypothyroidism	❑Asthma	❑Jaundice
❑Goiter	❑Emphysema	❑Hepatitis
❑Cancer (type)_____	❑Stroke	❑Stomach or peptic ulcer
❑Leukemia	❑Epilepsy (seizures)	❑Rheumatic fever
❑Psoriasis	❑Cataracts	❑Tuberculosis
❑Angina	❑Kidney disease	❑HIV/AIDS
❑Heart problems	❑Kidney stones	

Have you ever had a seizure? ❑Yes ❑No

Have you ever had an accident or injury that caused you to lose consciousness for more than five minutes? ❑Yes ❑No

Have you ever had surgery? ❑Yes ❑No

If yes, what and when? _____

Other medical conditions (please list):_____

CURRENT MEDICATIONS

Pharmacy:_____

Drug allergies: ❑No ❑Yes If yes, to what?_____

Please list any medications that you are now taking. Include non-prescription medications, vitamins & supplements.

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SOCIAL HISTORY

Where were you born and raised?_____

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status:❑ Never married ❑Married ❑Divorced ❑Separated ❑Widowed ❑Partnered/significant other

What is your current or past occupation?_____

Are you currently working? ❑Yes❑No Hours/week_____ If no, are you: ❑Retired ❑Disabled ❑Sick leave?

Do you receive disability or SSI? ❑Yes ❑No If yes, for what & how long?_____

If no, do you have a pending disability claim? ❑Yes ❑No

Have you ever had legal problems? (specify)_____

Have you ever physically harmed another person on purpose? ❑Yes ❑No

Are there any firearms in your home or vehicle? _____

Religion:

FAMILY HISTORY

	IF LIVING							IF DECEASED
	Age(s)	Health & Psychiatric	Diabetes	High Blood Pressure	High Cholesterol	Heart Disease	Completed Suicide	Cause
Father								
Mother								
Siblings								
Children								

EXTENDED FAMILY PSYCHIATRIC PROMBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____

WOMENS REPRODUCTIVE HISTORY:

Are you pregnant? ❑Yes ❑No

Have you reached menopause? ❑Yes ❑No At what age?_____

Do you have regular periods? ❑Yes ❑No

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					❑Yes ❑No
CANNABIS: Marijuana, hashish, hash oil					❑Yes ❑No
STIMULANTS: Cocaine, crack					❑Yes ❑No
STIMULANTS: Methamphetamine—speed, ice, crank					❑Yes ❑No
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					❑Yes ❑No
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					❑Yes ❑No
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					❑Yes ❑No
HEROIN					❑Yes ❑No
STREET OR ILLICIT METHADONE					❑Yes ❑No
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					❑Yes ❑No
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					❑Yes ❑No
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					❑Yes ❑No
OTHER: specify)_____					❑Yes ❑No