Shadid Integrative Psychiatry
Nicole Shadid, MD, ABIHM
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Denver, Colorado 80246
Phone (303) 656-9215 - Fax (303) 459-7827

PATIENT INFORMATION

First Name:	**Last Name:**	**Middle Initial:**
Address:		**Apt/Suite:**
City:	**State:**	**Zip Code:**

Home Phone: **May we leave confidential voice message at this #?** □ **Yes** □ **No**	**Work Phone:** **May we leave confidential voice message at this #?** □ **Yes** □ **No**	**Cell Phone:** **May we leave confidential voice message at this #?** □ **Yes** □ **No**
Date of Birth:	**Age:**	**Referred By:**

Email Address:	**Social Security Number:**

Occupation:	**Employment Status:** □ **Employed** □ **Unemployed**	**Insurance Type:** □ **Private** □ **None** □ **Medicaid** □ **Medicare**

Marital Status: □ **Single** □ **Married/Partner** □ **Divorced/Widowed** □ **Other (please specify):**	**Gender:** □ **Male** □ **Female** □ **Transgender** □ **Additional (please specify):**

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	**Relationship to Patient:**
Address:	**Phone Number:**

Financial Policy

The following is a statement of our Financial Policy, which we ask that you read and sign prior to being seen. **Please note that Dr. Shadid does not accept any insurance plans, including Medicaid or Medicare insurance. Dr. Shadid is considered an out-of-network provider with all insurance companies and will not directly bill your insurance company for payment of services.** SIP will provide a receipt or invoice for you to submit directly for reimbursement from your insurance company, if applicable. Please be aware that some of the services provided may be "non-covered" services and not considered medically necessary under your insurance plan. Insurance reimbursement depends on individual patients' policy terms, and Dr. Shadid is not responsible for ensuring insurance reimbursements.

You are responsible for payment in full, regardless of your insurance company's final determination of coverage. For new patients, 50% of the new patient appointment fee will be charged when the new patient appointment is scheduled and the remaining balance will be charged on the date of service. The prepayment will not be refunded to new patients for late-cancelled appointments (less than 72 hours notice) or missed and no-show appointments. A credit card is required to keep on file for collection of payment for services rendered, such as appointments or additional paperwork requested by patients.

□ I have read and understand Shadid Integrative Psychiatry's financial policy and agree to all its provisions.

Patient Signature: _____ Date: _____

Credit Card Authorization

Name on Card: _____ Credit/Debit Card: □ Mastercard □ Visa

Card Number: _____ Expiration Date: _____

Security Code: _____

Billing Address: _____ City, State, Zip Code: _____

□ I hereby authorize Shadid Integrative Psychiatry to charge the credit card listed for payment of appointments (including late-cancelled, missed/no-show appointments), and/or additional paperwork requested. I certify that I am a person who is authorized to use this credit card.

□ If the name on the credit card is different from my own and belongs to someone else (such as a parent, spouse, family member), I do hereby grant permission for SIP to disclose information regarding appointment dates kept or missed to the credit card holder as necessary in order to collect payment.

Patient Signature: _____ Date: _____

SHADID INTEGRATIVE PSYCHIATRY

At Shadid Integrative Psychiatry, we want to provide you with the best level of care and would appreciate you taking the time to complete the following intake or consultation paperwork to the best of your ability. It is recommended that if you have or can obtain any past psychiatric records or medical labwork, you bring them to your appointment with you to review. Please bring any bottles of psychiatric medications or supplements you are currently taking to your appointment. Thank you.

Name: _____ Age: _____ Date: _____

Reason for this appointment: What is your goal in scheduling an appointment with Dr. Shadid?

☐ Seeking on-going treatment ☐ One-time consultation ☐ Diagnostic Evaluation
☐ Pharmacological Evaluation/Medication Management ☐ Psychotherapy/Counseling Services
☐ Nutritional/Supplemental Evaluation ☐ Integrative and Holistic Approaches
☐ Other: (please specify:) ☐ Hormone Evaluation

_____
_____
_____

Please list the symptoms that you would like to have Dr. Shadid evaluate (may also see page 2):

_____
_____
_____

How long have you had these symptoms? Are there any particular patterns to these symptoms that you have identified? (seasonal pattern, monthly hormonal pattern, cyclical pattern, after exposure to particular triggers, etc):

_____
_____
_____

What treatments have you tried in the past for these symptoms (medications, therapy, supplements, alternative approaches, etc)? What was the result of this treatment on your symptoms?

_____
_____
_____

Current Psychiatric Diagnosis/Diagnoses (if known):

_____
_____
_____

What are your thoughts and feelings and/or concerns about taking psychiatric medications for your symptoms?

_____
_____
_____

Please check all of the emotional symptoms or moods that you would like to speak to Dr. Shadid about and have evaluated.

	Depression or Intense Sadness		Anxiety or Nervous		Irritability or Frustration
	Emotionally Numbness or Feeling Flat		Feeling Tense/Tension		Anger or Agitation
	Tearful, Crying, Weepiness		Panic Sensations/Panic Attacks		Furious or Rage
	Helpless or Hopeless		Feeling Keyed Up or On Edge.		Mood Swings (high to low, low to high)
	Diminished Interest or Pleasure in Activities		Sense of Being Out of Control		Elevated, Expansive Mood
	Feeling Worthless		Feeling Overwhelmed or In Distress		Jealous or Envious
	Excessive Shame and Guilt		Excessive Worrying/Worried		Suspicious or Paranoid
	Feelings of Loss or Grief/Grieving		Traumatized or Terrified		Defensive or Overly-Sensitive
	Feelings of Emptiness		Feeling Hurt or Harmed		Restless or Impulsive
	Pervasive Unhappiness		Fearful/Scared		Inadequate or Insecure

Please check all of the behavioral symptoms that you would like to speak to Dr. Shadid about and have evaluated.

	Alcohol Misuse/Abuse		Drug Use/Abuse		Nicotine Use/Abuse
	Prescription Medication Misuse/Abuse		Caffeine Misuse/Abuse		Acting Impulsively/Rashly
	Attacking Others Verbally/ Verbal Rages		Physical Aggression Towards People or Property		Temper Outbursts
	Stealing or Lying		Risky, Dangerous, Impulsive Behaviors		Reckless Driving
	Preoccupation with Gambling		Detach from Social Relationships		Inappropriate Spending/ Overspending of Funds
	Isolation/Withdrawal/Alienation		Avoiding/Avoidant Behaviors		Hoarding Behaviors
	Hair Pulling/Trichotillomania		Picking Skin Excessively/ Excoriation		Compulsive/Repetitive Behaviors (checking, counting excessively, etc)
	Overeating/Binge Eating		Restriction of Eating and Calories		Inducing Vomiting After Eating
	Promiscuity		Preoccupation with Sexual Urges or Fantasies		Preoccupation with Pornography
	Failing to Meet Obligations or Responsibilities		Lack of Grooming (not showering, brushing teeth)		Nervous Tics or Habits/ Repetitive Movements
	Cutting Self/Self-Mutilation		Disconnection from Oneself/ Dissociation		Illegal Acts/Actions Against the Law
	Suspiciousness or Paranoid Ideations or Gestures		Suicidal Ideations or Gestures		Homicidal Ideations or Gestures

Please check all of the mental or cognitive symptoms that you would like to speak to Dr. Shadid about and have evaluated.

	Thoughts Disorganized/ Poor Organization of Thoughts		Foggy Thinking/ Poor Mental Clarity		Increased Forgetfulness
	Poor Memory/Recall		Memory Lapses/Blacking Out or Losing Time		Poor Attention/Concentration
	Distractibility in Thought Process		Racing/Faster Thoughts		Slowed Thought Process
	Obsessional Thinking/ Rumination		Poor Work Performance due to Decreased Mental Sharpness		Difficulty Learning New Information
	Procrastination or Avoiding Mental Acts that Require Effort		Difficulty Making Decisions		Disorientation/Confusion

Past Psychiatric History and Treatment

Have you had any past psychiatric or mental health treatment? ☐ Yes ☐ No

☐ Medication Management ☐ Individual Therapy ☐ Group Therapy
☐ Intensive Outpatient ☐ Acute Inpatient ☐ Extended Stay Inpatient
☐ Self Help Group Attendence (12 Step Program, etc) ☐ Other Therapy (Family, etc)
☐ Other (please specify):

_____

_____

If yes, please list type of treatments that have been helpful for you:

_____

_____

Please list why you were seen, when and for how long you were treated.

_____

_____

Do you have a history of mood symptoms that occurred at an intensity or frequency that affected your functioning and well-being:

☐ Depression ☐ Anxiety ☐ Panic attacks ☐ Mood Swings
☐ Anger or Rage ☐ Irritability or Agitation ☐ Emotional Numbing/Flattening

If yes, please describe when you experienced any of these and for how long did these symptoms last:

_____

_____

Has a doctor, therapist, or psychiatrist ever diagnosed you with (check all that apply):

☐ Major Depressive Disorder
☐ Anxiety Disorder or Panic Disorder
☐ Bipolar Disorder, type 1 or 2
☐ Attention Deficit/Hyperactivity Disorder
☐ Alcohol Abuse/Dependence
☐ Schizophrenia or Schizoaffective Disorder
☐ Obsessive Compulsive Disorder
☐ Personality Disorder
☐ Post Traumatic Stress Disorder
☐ Drug Abuse/Dependence

Have you had any hospitalizations for a psychiatric or mental health condition? ☐ Yes ☐ No
If yes, please explain why you were hospitalized? Where and when you were hospitalized?

_____

_____

Are you currently in psychotherapy/counseling? ☐ Yes ☐ No
If yes, who is your therapist, how long have you seen him/her, and what type of therapy?

_____

_____

Have you had one or more severely stressful events that have affected your well-being? ☐ Yes ☐ No
If yes, please specify the event, including how long you felt stressed or your well-being was negatively affected:

_____

_____

Have you experienced any assaults or traumas, including physical, emotional, verbal or sexual abuse or assaults: ☐ Yes ☐ No

Please specify all that apply: ☐ Physical ☐ Sexual ☐ Emotional ☐ Verbal

Please list the ages which the traumas/assaults occurred:

_____

_____

_____

Do you believe these traumas are related to the symptoms you are presenting with today? ☐ Yes ☐ No

Has there been any past history of suicidal ideations or attempts? ☐ Yes ☐ No

Has there been any past history of self-harming or self-mutilation behaviors? ☐ Yes ☐ No

Has there been any past history or risky/dangerous/impulsive behaviors? ☐ Yes ☐ No

If yes, please specify about the attempts or behaviors:

_____

_____

_____

Family Psychiatric History

Is there any family genetic psychiatric history? ☐ Yes ☐ No

If yes, please be specific (who has what type of psychiatric problem? on mother's or father's side?)

Please consider psychiatric hospitalizations, psychiatric treatment, depression, bipolar disorder (manic-depressive illness), anxiety/panic attacks, suicide attempts, "nervous breakdowns", or schizophrenia:

_____

_____

_____

Are any relatives on psychiatric medications? ☐ Yes ☐ No

If yes, which medications? Were they helpful?

_____

_____

Do any relatives have a history of problems with alcohol or drug abuse? ☐ Yes ☐ No

If yes, which relative(s) and which substances?

_____

_____

Family/Childhood History

While being raised, my parental figures were: ☐ Married ☐ Never Married ☐ Divorced

☐ Living as Married/Cohabitating ☐ Separated/No Longer Living as Married ☐ Widowed

Number of brothers: _____ Ages of brothers: _____

Number of sisters: _____ Ages of sisters: _____

Were you adopted? ☐ Yes ☐ No

What was your overall experience of being raised in your family? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

(Please describe):

_____

_____

_____

Medical History

In general, would you say that your overall health is: ☐ Good ☐ Average ☐ Fair ☐ Poor

Are you experiencing any body sensations or physical symptoms that concern you? : ☐ Yes ☐ No
If yes, please specify:

_____

_____

Do you have any of the following medical conditions? (check all that apply)

☐ Allergies	☐ Cardiac/Heart Disease	☐ Liver Disorder/Hepatitis
☐ Asthma	☐ High/Low Blood Pressure	☐ Kidney Disorder/Infections
☐ Headaches/Migraines	☐ Blood Disorder	☐ Fibromyalgia
☐ Seizures	☐ Cancer	☐ Nervous System Disorder
☐ Head Injury/Concussion	☐ Adrenal Fatigue/Insufficiency	☐ Respiratory Disorder
☐ Stroke	☐ Diabetes	☐ Skin Disorder
☐ Pain Disorder	☐ Multiple Sclerosis/Lupus	☐ Peptic Ulcer Disease/GERD
☐ Sleep Disorder	☐ Osteoarthritis	☐ Thyroid Disorder
☐ Gastrointestinal Disorder	☐ Autoimmune Disorder	☐ Other: _____

Have you been hospitalized for any medical reasons (not psychiatric)? ☐ Yes ☐ No
If yes, please specify why and when

_____

_____

Have you had any surgeries? ☐ Yes ☐ No
If yes, please specify why and when

_____

_____

When was your most recent physical exam and labwork/bloodwork? Was anything abnormal?

_____

_____

Allergies to Medications: ☐ No known allergies or adverse reactions

_____ ☐ Allergy ☐ Adverse Reaction Please Describe: _____

_____ ☐ Allergy ☐ Adverse Reaction Please Describe: _____

CURRENT MEDICATIONS (Please list any prescription & non-prescription medications, vitamins, supplements or herbs; include name, dose & how often taken)

Medicine/Supplement	Dose	Frequency of Med
1.		
2.		
3.		
4.		
5.		
6.		

Who has been prescribing your meds?

_____

Female Patients:

Menses: ☐ Regular ☐ Irregular ☐ Amenorrhea ☐ Menopausal ☐ Postmenopausal

Are you taking contraceptives or hormone supplement? ☐ Yes ☐ No ☐ N/A
Do you have any perimenopausal/menopausal symptoms? ☐ Yes ☐ No ☐ N/A
Do you have any PMS/PMDD symptoms? ☐ Yes ☐ No ☐ N/A

Do you believe your moods have been negatively affected by: ☐ Puberty ☐ Menstrual Cycles ☐ Pregnancy(s) ☐ Menopause

If yes, how disruptive to your mood have these been: ☐ Mildly ☐ Moderately ☐ Severely
If yes, please describe:

_____

_____

Have you ever been evaluated for any hormonal dysfunctions, such as thyroid or adrenal gland dysfunctions?
If yes, please describe which ones, and what treatment occurred? ☐ Yes ☐ No

_____

_____

Male Patients:

Have you ever been evaluated for any hormonal dysfunctions, such as testosterone deficiencies or thyroid gland dysfunctions? If yes, please describe which ones, and what treatment occurred? ☐ Yes ☐ No

_____

_____

Diet/Nutrition History

How would you describe your diet/nutrition? What do you typically eat? How many times a day do you eat?

_____

_____

Are you currently on a restricted diet? (vegan, high protein only, etc) ☐ Yes ☐ No
If yes, please describe:

_____

_____

Do you take any diet/vitamin supplements? ☐ Yes ☐ No
If yes, what types, for how long?

_____

_____

Do you have any Food Allergies/Sensitivities? ☐ Yes ☐ No
If yes, please describe:

_____

_____

Do you suffer or have your suffered from anorexia, bulimia or any other eating disorder? ☐ Yes ☐ No
If yes, which type, for how long, any treatment received?

_____

_____

Do you regularly have caffeine intake? ☐ Yes ☐ No
If so, how much consumption daily, what types? (energy drinks, coffee, tea):

_____

_____

Sleep Pattern History

Do you have any sleep disturbances (difficulty falling asleep or staying asleep)? ☐ Yes ☐ No
If yes, how long does it take you to fall asleep or fall back asleep? How often does this occur?

_____

_____

If yes, how long have you suffered with sleep problems? What treatments have you tried in the past for sleep?

_____

_____

On average, how many hours do you sleep per night? _____

Have you ever had a sleep study or have been given a Sleep Disorder diagnosis? ☐ Yes ☐ No
If yes, when and what were the results?

_____

_____

Do you have history of: ☐ Heavy Snoring ☐ Sleep Apnea ☐ Grinding Teeth ☐ Sleepwalking

Do you take medications, herbals, OTC treatments for sleep disturbances? ☐ Yes ☐ No
If yes, which types and for how long?

_____

_____

Substance Use History

Do you use alcohol? If yes, how many drinks per night, and how many nights per week? ☐ Yes ☐ No

_____

_____

In the last 12 months, have you drank more than you meant to or felt your drinking patterns were excessive or out of control for you? Have you wanted to cut down on your drinking patterns? ☐ Yes ☐ No

Do you use nicotine? If yes, how much and how often? ☐ Yes ☐ No

_____

Do you use any recreational drugs? If yes, which ones and how often? ☐ Yes ☐ No

_____

_____

Do you have a history of drug use and/or prescription medication misuse? If yes, which substances and for how long did you use them? ☐ Yes ☐ No

_____

_____

Does your use of any of these substances play a part in the reason for your appointment today? ☐ Yes ☐ No
If yes, please explain: _____

_____

Have you ever been treated for substance abuse in the past and/or attended detox or rehab program?
If yes, when and what type of treatment did you receive? ☐ Yes ☐ No

_____

_____

Social/Background History

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ In a Relationship
Do you consider yourself: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other: _____

Are you currently involved in a significant relationship? ☐ Yes ☐ No
If yes, are you satisfied with this relationship? ☐ Yes ☐ No

Current living situation (relationship of person(s) with whom patient resides)?
☐ Self ☐ Spouse/family ☐ Roommate(s) ☐ Group Home or Assisted Living Facility
☐ Other (please specify)
_____
_____

How many dependents do you have excluding yourself?
☐ Number or sons: _____ ☐ Age of sons: _____
☐ Number or daughters: _____ ☐ Age of daughters: _____

What is highest level of education/degree you have received?
☐ None ☐ High School Diploma ☐ GED (General Equivalency Degree for HS) ☐ Some College
☐ Associate Degree/Technical Degree ☐ College Degree (Bachelors Degree) ☐ Masters Degree
☐ Doctorate or Professional Degree (MD, JD, PhD)

Are you currently employed?
☐ Yes, full time ☐ Yes, part time ☐ Retired ☐ Student ☐ Disabled ☐ Homemaker
If working, current occupation: _____
If not working, former occupation: _____

Have you ever had any legal problems including jail, prison, lawsuits, probation, etc.? ☐ Yes ☐ No
If yes, please explain:
_____
_____

Have you ever served in the military? ☐ Yes ☐ No
If yes, what branch of the military? When did you serve? What type of discharge did you receive?
_____
_____

Do you have any spiritual or religious or affiliation that you identify with?
☐ Christian ☐ Muslim ☐ Jewish ☐ Buddhist ☐ Spiritual but not religious
☐ Seeking/Undecided ☐ None ☐ Other (please specify): _____

How important is spirituality/religious practice in your life?
☐ Very Important ☐ Important ☐ Not Very Important

Stress Management

What current stressors do you have in your life? Please explain what type of stressors, for how long they have occurred, and how much distress do these stressors cause you?

_____

_____

_____

_____

Do you experience constant stress in your life or work? ☐ Yes ☐ No
Are any of your relationships at work and/or home unhappy? ☐ Yes ☐ No
Has your ability to handle stress and pressure decreased? ☐ Yes ☐ No
Do you feel overwhelmed and have little control over your life? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No
If so, what type of exercise and how many days a week?

_____

_____

Do you feel that you have a support system? ☐ Yes ☐ No

If you were to need help with your current difficulties, who are the people you could rely on the most to help and/or support you?

☐ Family ☐ Friends ☐ Coworkers ☐ Therapist/Counselor ☐ Other: _____

If so, who? _____

_____

Are there any cultural or spiritual or religious beliefs that are important to you, that you would like to tell us?

_____

_____

How do you typically cope with stressors in your life? ☐ Very Well ☐ Fair ☐ Not Very Well
Please specify techniques/skills that are helpful for you:

_____

_____

What hobbies or activities do you enjoy? How often do you get to do these activities?

_____

_____

Additional notes that you would like Dr. Shadid to know:

_____

_____

_____

_____

MEDICATION REFERENCE SHEET

Please circle all of the medications you have tried in the past and provide more information about these medication trials on page 2. Please be as specific as you can about the doses, how long you took the medication, and the responses to your symptoms, or any positive/negative effects of medications.

ANTIDEPRESSANTS

Celexa (citalopram)	Lexapro (escitalpram)	Prozac (fluoxetine)	Zoloft (sertraline)	Paxil (paroxetine)
Luvox (fluvoxamine)	Cymbalta (duloxetine)	Effexor (venlafaxine)	Pristiq (desvenlafaxine)	Fetzima (levomilnacipran)
Trintillex (vortioxetine)	Wellbutrin (buprobion)	Viibryd (vilazodone)	Desyral (trazodone)	Remeron (mirtazapine)

TRICYCLIC ANTIDEPRESSANTS (TCAs) / MONOAMINE OXIDASE INHIBITORS (MAOIs)

Anafranil (clomipramine)	Elavil (amitriptyline)	Sinequan/Adapin (doxepin)	Tofranil (imipramine)	Pamelor/Aventyl (nortriptyline)
Norpramin (desipramine)	EMSAM (selegiline)	Marplan (isocarboxazid)	Nardil (phenelzine)	Parnate (tranylcypromine)

STIMULANTS / NONSTIMULANTS FOR ADHD

Adderall IR/XR (amphetamine mixture)	Ritalin IR/SR/LA (methylphenidate)	Focalin IR/XR (dexmethylphenidate)	Daytrana (methylphenidate transdermal)	Concerta (methylphenidate ER)
Dexedrine (dextroamphetamine)	Metadate IR/CR (methylphenidate ER)	Vyvanse (lisdexamfetamine)	Strattera (atomoxetine)	Provigil (modafinil)
Nuvigil (armodafanil)	Dexedrine Spansules /DetroStat (dextroamphetamine)	Intuniv / Tenex (guanfacine)	Cylert (premoline)	Catapres (clonidine)

MOOD STABILIZERS

Depakote IR/ER (divalproex sodium)	Depakene (valproic acid)	Lithium Eskalith/Lithobid (lithium carbonate)	Lamictal IR/XR (lamotrigine)	Neurontin (gabapentin)
Lyrica (pregabalin)	Tegretol IR/XR (carbamazepine)	Trileptal (oxcarbazepine)	Topamax (topiramate)	Keppra (levetiracetam)

ANTI-ANXIETY MEDICATIONS / SEDATIVE-HYPNOTICS/ SLEEP MEDICATIONS

Ativan (lorazepam)	**Klonopin (clonazepam)**	**Xanax (alprazolam)**	**Valium (diazepam)**	**Serax (oxazepam)**
Restoril (temazepam)	**Halcion (triazolam)**	**Librium (chlordiazepoxinde)**	**Vistaril / Atarax (hydroxyzine)**	**Benadryl (diphenhydramine)**
Ambien (zolpidem)	**Sonata (zaleplon)**	**Lunesta (eszopiclone)**	**Rozerem (ramalteon)**	**Prosom (estazolam)**
Tranxene (clorazepate)	**Buspar (buspirone)**	**Desyral (trazodone)**	**Unisom (doxylamine**	**Dalmane (flurazepam)**

ATYPICALS / ANTI-PSYCHOTIC / STABILIZING MEDICATIONS

Abilify (aripiprazole)	**Geodon (ziprazodone)**	**Risperdal (risperidone)**	**Invega (paliperidone)**	**Seroquel (quetiapine)**
Zyprexa (olanzapine)	**Saphris (asenapine)**	**Latuda (lurasidone)**	**Haldol (haloperidol)**	**Clozaril (clozapine)**
Loxitane (loxapine)	**Mellaril (thioridazine)**	**Navane (thiothixene)**	**Prolixin (fluphenazine)**	**Sonazine / Thorazine (chlorpromazine)**

Please be as specific as you can about the doses, how long you took the medication, and the responses to your symptoms, or any positive/negative effects of medications.

Medication 1: _____

Medication 2: _____

Medication 3: _____

Medication 4: _____

Medication 5: _____

Medication 6: _____

Medication 7: _____

Medication 8: _____

Medication 9: _____

Medication 10:_____