Name _____ Phone Number_____

D.O.B._____ Email _____Referred by_____

1. Have you been psychiatrically hospitalized in the past? Yes ☐ No ☐

   If yes, how many times? _____ When was the most recent time? _____

2. Do you have thoughts of wanting to die or kill yourself? Yes ☐ No ☐

   If yes, have you tried to kill yourself in the past? Yes ☐ No ☐

   If yes, please provide details including when and how._____

Do you have thoughts of hurting or killing others? Yes ☐ No ☐

3. Do you use alcohol, marijuana or other drugs daily or weekly? Yes ☐ No ☐

4. Do you restrict your eating, vomit after eating, exercise excessively or use diuretics or

   laxatives? Yes ☐ No ☐

   If yes please give more details_____

5. If the doctor recommends medication for you or your child, are you open and willing to

   take medicine? Yes ☐ No ☐

6. Are you hearing voices? Do you think people are against you or watching you?

   Yes ☐ No ☐

7. Do you take any of the following medications?

   Buprenorphine ☐ Clozapine ☐ Naltrexone ☐ Methadone ☐ Spravato ☐

   Any injectable psychiatric medication? ☐

8. Is there any other relevant information that you feel would be helpful in determining if

   Dr. Rothbort will be able to adequately address your concerns?