Aleksandra Wirga, M.D.

at Aleksandra Wirga, M.D., Inc.

Dedicated secure fax line: 562 595 7703

New Patient History/Intake Information

Please complete all of the information on this form and send, fax or bring it to the first visit. The form is quite detailed but we want to be well informed to be able to provide the best help. Many of the questions require only a check, so it will go quickly. You may need to ask family members for some information. If there is something that you are still not certain how to answer or don't feel comfortable putting it on paper now, you may discuss it with us in person during your visit. Thank you very much!

Referred by _____ Phone/Address_____

□ Self □ Primary Care Physician □ Specialist □ Psychologist/Psychotherapist □ Family □ Friend

1. Patient Name: _____ Date: _____

Date of Birth: _____ Age: ____ Gender: M F SS# _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____

May we contact you at home? YES NO May we contact you on your cell? YES NO May we contact you at work? YES NO

E-Mail: _____

Race and Ethnicity – please forgive the format but our electronic medical record requires it this way

Ethnicity: [ ] Non-Hispanic [ ] Hispanic [ ] Not Specified

Race: [ ] African or African-American [ ] Asian or Asian-American [ ] Caucasian or European

[ ] Native American or Alaska Native [ ] Native Hawaiian [ ] Pacific Islander

[ ] Other: _____

How did you hear about us? _____

Person financially responsible, if not yourself? _____

Relation: _____ Phone: (____) _____

Address: _____

Emergency Contact Info

Name: _____

Relation: _____ Phone: (____) _____

Address: _____

Reason for your visit - what can we help you with?

_____

_____

2. Current Care Providers

Specialty	Name (with credentials)	Phone #
Primary Care Physician		
Psychotherapist		
Other		

3. Psychiatric History:

Regarding the current issue, when was the last time you were functioning at your usual emotional baseline? _____

Looking back at your life, at what age do you think you were emotionally different than your peers?

_____

What is the earliest age that you saw a psychotherapist, counselor or a psychiatrist?

What diagnosis, if any, was given? _____

Any history of suicidal attempts? [ ] Yes [ ] No

If yes, please provide approximate dates, means, and other details: _____

_____

_____

4. Previous Psychiatric Treatment *(may use separate page if necessary)*

Form of Treatment	Purpose of Treatment	Provider(s) Facility(ies)	Location(s)	Approximate Dates
Psychiatric Hospital	Number of admissions: - Voluntary: ____ - Involuntary: ____			
Electro-Convulsive				
Residential				
Partial Hospitalization or Intensive Outpatient (IOP)				
Outpatient Psychotherapy or Counseling				
Family/Couples Therapy				
Therapeutic Groups				
Other				

6. Psychotropic medications used (Please underline meds with "good" response and circle meds with "bad" reactions):_____

_____

_____

7. Medical History:

If you have never received a diagnosis of cancer, other malignancies or oncologic problems, please go to the next page.

Any history of Cancer, Oncologic Diagnosis or Other Malignancy:

_____

_____

_____

_____

Approximate date of the original diagnosis:

Location: _____ Pathology/Receptor Status _____

If cancer has recurred, please specify the approximate date(s) and location(s) of recurrence

_____

Forms of treatment to date:

Surgery (approximate dates, types): _____

Chemotherapy (who administered it?) _____

Radiation (approximate dates, area of the body irradiated, in what facility) _____

_____

Hormonal therapy _____

Other (including Complementary/Alternative): _____

_____

Forms of support:

[ ]Beat the Odds; [ ]Peer Mentorship; [ ]Oncology Coach; [ ]Support Group(s); [ ]Other:_____

Oncologist(s) names and phone numbers:

_____

_____

Do you have any questions to your doctors about your diagnosis or treatment? If yes, please list them here: _____

_____

_____

How would you like your doctors to communicate "bad news" to you?

_____

_____

Did you receive your Survivorship Care Plan? [ ] Yes [ ] No

- If yes, please bring a copy with you for your next appointment.

Please check all of the following which you now have or have had in the past:

[ ] Heart Disease	[ ] COPD	[ ] Head Injury
[ ] Diabetes	[ ] High Blood Pressure	[ ] Fainting/Dizziness
[ ] Stroke	[ ] Liver Disease	[ ] Back Problems
[ ] HIV/AIDS	[ ] Kidney Disease	[ ] Stomach Problems
[ ] Epilepsy/Seizures	[ ] Asthma	[ ] Frequent/Severe Headaches
[ ] Multiple Sclerosis	[ ] Chronic Fatigue	[ ] Fibromyalgia
[ ] Parkinson's disease	[ ] Lupus	[ ] Carpal Tunnel Syndrome

Other illnesses or **injuries** not specified above:

_____
_____
_____
_____

Please list **surgeries** that you have undergone and approximate dates (exclude oncology if listed above):

_____
_____
_____
_____

Please list **alternative or complementary** treatments that you have used or are using:

_____
_____
_____

Pain:

Do you have any pain associated with your disease? [ ] Yes [ ] No

If so, please indicate the level of your pain on the scale from 0 to 10, where 0 is no pain and 10 is the worst pain that you have ever experienced: 1 2 3 4 5 6 7 8 9 10

8. Substance Use

Alcohol [ ] Yes [ ] No Age when you began using: _____

Quantity/Frequency: _____ Most Recent Use: _____

Cigarettes [ ] Yes [ ] No Age when you began using: _____

Quantity/Frequency: _____ Most Recent Use: _____

Pipe, cigars, or chewing tobacco [ ] Yes [ ] No Age when you began using: _____

Quantity/Frequency: _____ Most Recent Use: _____

9. Illicit Drug Use History [ ] Yes [ ] No Age when you began using: _____

- Substance _____
  Quantity/Frequency: _____ Most Recent Use: _____
- Substance _____
  Quantity/Frequency: _____ Most Recent Use: _____
- Substance _____
  Quantity/Frequency: _____ Most Recent Use: _____
- Substance _____
  Quantity/Frequency: _____ Most Recent Use: _____

History of Substance Abuse Treatment [ ] Yes [ ] No

Detox [ ] Yes [ ] No

Residential [ ] Yes [ ] No

Explain: _____

_____

10. List Allergies To Foods Or Medications:

Medication or Food	Reaction	Affected Organs	Severity of Reaction
		□Skin □Nose □Lungs □GI □Generalized □Other_____	□Mild □Moderate □Severe □Anaphylactic Shock
		□Skin □Nose □Lungs □GI □Generalized □Other_____	□Mild □Moderate □Severe □Anaphylactic Shock
		□Skin □Nose □Lungs □GI □Generalized □Other_____	□Mild □Moderate □Severe □Anaphylactic Shock
		□Skin □Nose □Lungs □GI □Generalized □Other_____	□Mild □Moderate □Severe □Anaphylactic Shock
		□Skin □Nose □Lungs □GI □Generalized □Other_____	□Mild □Moderate □Severe □Anaphylactic Shock

11. Lifestyle and Health Behaviors:

I. Nutrition:

a. Any recent changes in weight or eating habits? [ ] Yes [ ] No
   If yes, please describe: _____
   _____
b. How many meals do you usually eat per day? ____
c. In the last week, how many times did you eat sitting in front of TV? _____
d. In the last week, how many servings of fruits and vegetables did you eat every day? _____
e. Are you engaging in any unhealthy food related behaviors like binging, purging, and restricting?
   [ ]Yes [ ]No
   If yes, please explain what behaviors and how many times per month_____
   _____
f. Did you notice any obstacles or challenges in healthy eating? [ ] Yes [ ] No What were they?
   _____

II. Physical Activity:

In the **past week** on average:

a. How many times were you physically active for more than 7 minutes at a time? _____

b. How many times did you break into sweat from physical activity? _____

c. How many times did you intentionally increase your normal activity (by for example taking stairs instead of the elevator/escalator or walking instead of driving)? _____

d. How many times did you need to talk yourself against resistance to engage in physical activity? _____

- How many times did you overcome this resistance? _____

e. Did you notice any obstacles or challenges to physical activity? What were they?

_____

_____

III. Sleep:

Do you have difficulty falling or staying asleep? [ ] Yes [ ] No

If yes, please describe your difficulties?

_____

_____

Do you wake up rested? [ ] Yes [ ] No

In the **past week** on average:

a. How many hours did you sleep per each 24 hours? _____

b. Did you have any nightmares? [ ] Yes [ ] No

c. On average, what was the quality of your sleep?

Very good	Good	Fair	Not so good	Bad	Very bad

d. What did you do, to assure good quality of your sleep?

_____

_____

e. Did you notice any obstacles or challenges in healthy sleeping? What were they?

_____

_____

IV. List below your own 2 behaviors, that you know are unhealthy but you keep engaging in them.

a. **Unhealthy Behavior 1: _____**

- In the past week, how many times did you engage in this behavior? _____
- What would be a healthier behavior?

_____

- Did you notice any obstacles or challenges in engaging in a healthier instead of unhealthy behavior? What were they?

_____

_____

b. **Unhealthy Behavior 2: _____**

- In the past week, how many times did you engage in this behavior? _____
- What would be a healthier behavior?

_____

- Did you notice any obstacles or challenges in engaging in a healthier instead of unhealthy behavior? What were they?

_____

_____

12. Family History:

	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Anxiety	[ ]	[ ]	[ ]	[ ]	[ ]
Insomnia/Sleep problems	[ ]	[ ]	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	[ ]	[ ]
Suicide Attempts/Thoughts	[ ]	[ ]	[ ]	[ ]	[ ]
Current Suicidal Thoughts/Plans	[ ]	[ ]	[ ]	[ ]	[ ]
Alcoholism	[ ]	[ ]	[ ]	[ ]	[ ]
Drug Problems	[ ]	[ ]	[ ]	[ ]	[ ]
Mental/Emotional Problems	[ ]	[ ]	[ ]	[ ]	[ ]
Eating Problems	[ ]	[ ]	[ ]	[ ]	[ ]
Psychiatric Hospitalizations	[ ]	[ ]	[ ]	[ ]	[ ]
Extreme Mood Swings	[ ]	[ ]	[ ]	[ ]	[ ]
Dementia/Alzheimer Disease	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	[ ]	[ ]
Other: _____	[ ]	[ ]	[ ]	[ ]	[ ]

13. Current Medications: Instead of copying them to this form, you can give us the list of these medications on a separate sheet *(including prescriptions, over-the-counter medicine, vitamins and herbal supplements)*

Medication	Dosage	Frequency	Began Taking	Prescribed By

Social History:

14. Family Background and Childhood History:
Were you adopted? [ ] Yes [ ] No
Where were you born? _____
Where did you grow up? _____

Please list the ages of your brothers and sisters:

_____

_____

_____

What was your father's occupation?

_____

What was your mother's occupation?

_____

Did your parents divorce? [ ]Yes; [ ]No; If yes, how old were you when they divorced? _____
If your parents divorced, who did you live with afterwards?_____
Describe your relationship with your father:

_____

Describe your relationship with your mother:

_____

How old were you when you left home?

_____

Has anyone in your immediate family died? [ ]Yes; [ ]No;
Who and when?

_____

_____

15. Relationship Status

[ ]Single [ ]Dating [ ]Partnered/Common Law [ ]Married [ ]Divorced [ ]Separated [ ]Widowed

Duration of Current Relationship: _____
Level of satisfaction with the relationship: 1 2 3 4 5 6 7 8 9 10
Not Satisfied Very Satisfied

What is/was the occupation of your spouse/partner?

_____

If married before, list number of your marriages and how long they lasted:

_____

Names, Sex, and Ages of Children: _____
#1 M F Age___Name_____ #2 M F Age___Name_____ #3 M F Age___Name_____
#4 M F Age___Name_____ #5 M F Age___Name_____

Children still residing with you: _____

16. Educational History:

Highest grade level completed: _____ Degree: _____ Field of Study: _____

History of Learning Disability? [ ]Yes [ ]No If yes, explain: _____

_____

17. Vocational History/Economical:

Are you currently: [ ] Working [ ] Student [ ] Unemployed [ ] Disabled [ ] Retired

Current job: _____

Level of satisfaction with job: 1 2 3 4 5 6 7 8 9 10
Not Satisfied Very Satisfied

Previous jobs:

_____

How many people depend on your income? _____

Level of stress related to financial situation: 1 2 3 4 5 6 7 8 9 10
No Stress Very High Stress

18. Military History:

Have you ever served in the military? [ ] Yes [ ] No

If yes, what branch and when? _____

Have you ever been in combat? _____

If yes, where and when? _____

Honorable discharge [ ] Yes [ ] No

Other type discharge _____

19. Legal History:

Have you ever been arrested/incarcerated [ ] Yes [ ] No

If yes, when and how many times? _____

Do you have any pending legal problems? _____

20. Religion/Spirituality:

In what, if any, religion or spiritual tradition were you raised?

_____

Are you practicing any form of spirituality or religion? [ ] Yes [ ] No

If yes, please say more about it:

_____

21. Social Support System:

List people you can count on for practical help and/or emotional support in the time of need:

_____

_____

_____

22. List 5 or more activities that bring you joy:

_____

_____

_____

_____

Is there any more information that you want to share with us?

_____

_____

_____ _____

Patient Signature Date

Thank you very much for completing this form!