

Registration

© 010211 Norton A. Roitman, MD
filled out by applicant, parent, guardian or completed by assistant

Applicant _____ age _____ sex _____ birth date _____

address _____ city, state, zip _____

phones: home _____ work _____ cell _____ email _____

best time to call at home _____ work _____ days off (circle) Su M T W Th F S

check your preferences: any contact is fine do not call at home; do not call at work; do not leave messages; do not fax

employer/school _____ job/grade _____

street address _____ city, state, zip _____

referred by _____ personal physician _____

Primary contact _____ relationship _____

address check if same as above: _____ city, state, zip _____

phones: home _____ work _____ cell _____ email _____

best time to call at home _____ work _____ days off (circle) Su M T W Th F S

check your preferences: any contact is fine do not call at home; do not call at work; do not leave messages; do not fax

employer/school _____ job/grade _____

street address _____ city, state, zip _____

Secondary contact _____ relationship _____

address check if same as above: _____ city, state, zip _____

phones: home _____ work _____ cell _____ email _____

best time to call at home _____ work _____ days off (circle) Su M T W Th F S

check your preferences: any contact is fine do not call at home; do not call at work; do not leave messages; do not fax

employer/school _____ job/grade _____

street address _____ city, state, zip _____

I request initial consultative services for myself, my family, my client and/or my dependent.

If applying for a minor, I certify that I have the legal right to obtain of consultation, evaluation and/or treatment.

Permission for services and release of information can be revoked at any time.

I understand that this initial consultation does not initiate a doctor/patient relationship and may result in a referral, report, discharge or consultation with a third party.

I understand that I am responsible for the charges incurred for these services unless a specific payor (person, third party or agency) arranged for payment in advance.

Please specify payor: myself _____.

Responsible party _____ date _____

Applicant _____ Age _____ Date of Evaluation _____

Filled out by applicant other _____ clinician _____

Use the lines below each section or the back of the page to explain your answers. Although some questions may be difficult to answer in the space provided, do your best to be brief and to the point. During the interview you can ask questions, explain your answers, discuss whatever you like.

1. What is the purpose of your interview? Do you, or other people, think you are having any problems?

Problem list: _____

2. When did these problems start? _____ How long do you think it will take to take care of them? _____

3. What do you think caused them? _____

Treatment

4. Did you have counseling for depression, addiction or emotional or behavioral problems? yes no

Age	Where	Who treated you	What for	How long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Did you take medication in the past? yes no (List current medications on page 4, past meds below)

If so	What kind	What for	How much/how often	Doctor	I took it for (how long)	How long ago
Example:	PROZAC	anxiety	20 mgs/ 2 times a day	Smith	2 years	4 yrs ago
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

6. Were you hospitalized for these or other problems? yes no If so, how many times? _____

Age	Where	Your doctor	What for (diagnosis, if any)	How long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7. Was any treatment helpful? yes no sort of Explain: _____

Did you have any BAD REACTIONS to medications? yes no _____

Growing up

8. Did you have any MEDICAL problems [] at birth [] birth to age 3 [] 3 to 5 [] 5 to 12 [] 12 to 18? [] no

Please explain: (put recent and current conditions on page 4) _____

9. Did you have DELAYS or problems with: [] don't know

- [] crawling/walking [] coordination [] eating
[] ear infections [] growing [] weaning
[] learning to talk [] toileting [] attention
[] staying alone [] playing [] learning

10. What words fit your early PERSONALITY best: [] social [] leader [] loner [] joiner [] fearful [] temperamental [] self-absorbed
[] shy [] careful [] serious [] scattered [] fighter [] withdrawn [] impulsive [] aggressive [] thoughtless [] gothic [] stoner
[] rigid [] fearless [] angry [] fun [] easy going [] defiant [] weird [] studious [] other _____

11. Did you have trouble GETTING ALONG _____ [] no
with [] other kids [] brothers/sisters [] parents _____
[] teachers [] other authority figures? _____
starting in [] preschool [] KG [] grade _____

Any past trouble with the law? [] no [] yes _____
[] vandalism/theft [] fires [] drugs [] truant _____
[] hurt animals [] gang activity [] violence _____

12. Did you have WORRIES about [] leaving home [] going to school [] safety/health [] being around people? [] no
When worried, did you have [] stomach pains [] trouble sleeping [] nightmares [] panic attacks? Other: _____ [] no

[] Did you ever try to harm yourself? Explain: _____ [] no

13. Did you undergo TRAUMA such as [] DEATHS, illness or losses [] parents DIVORCED [] witness ABUSE? [] no
Were you abused, mistreated or abandoned? [] yes [] no Explain this section below

How were you PUNISHED? [] not _____
[] timed out [] grounded [] points _____
[] natural consequences [] belted _____
[] lectured [] chores [] other _____

Were you [] poorly accepted or _____
[] rejected by your parents _____
[] raised by foster parents? _____

[] Did your parents lose control? _____
[] Did either use drugs or alcohol? _____
[] Were they in trouble with the law? _____

Your everyday life

14. Where do you work? _____ position _____ # mo/yr at this job _____

Longest employment at _____ position _____ how long? _____

Military experience yes no Branch _____ Discharge honorable other _____

Other notable work or experience _____

15. How much education do you have? _____ Spiritual practice? _____ devote occasional none

16. Problems and stress. Check all areas of concern. Other _____

- | | | | | | | | |
|--|---|--|--|---|---|---|--------------------------------|
| <input type="checkbox"/> PERSONAL | <input type="checkbox"/> self-control | <input type="checkbox"/> motivation | <input type="checkbox"/> concentration | <input type="checkbox"/> fatigue | <input type="checkbox"/> mood | <input type="checkbox"/> organization | <input type="checkbox"/> grief |
| | <input type="checkbox"/> family illness | <input type="checkbox"/> health | <input type="checkbox"/> accident | <input type="checkbox"/> adoption | <input type="checkbox"/> parenting | <input type="checkbox"/> home/household/move(s) | |
| <input type="checkbox"/> RELATIONSHIP | <input type="checkbox"/> friend(s) | <input type="checkbox"/> supervisor | <input type="checkbox"/> roommate | <input type="checkbox"/> coworker | <input type="checkbox"/> spouse | <input type="checkbox"/> girl/boyfriend | |
| <input type="checkbox"/> FAMILY | <input type="checkbox"/> fighting | <input type="checkbox"/> conflicts/divorce | <input type="checkbox"/> custody | <input type="checkbox"/> child problems | <input type="checkbox"/> parents | <input type="checkbox"/> other relatives | |
| <input type="checkbox"/> SCHOOL | <input type="checkbox"/> performance | <input type="checkbox"/> concentration | <input type="checkbox"/> behavioral | <input type="checkbox"/> disability | <input type="checkbox"/> accommodation | | |
| <input type="checkbox"/> WORK | <input type="checkbox"/> conflicts | <input type="checkbox"/> fitness for duty | <input type="checkbox"/> disability | <input type="checkbox"/> financial/loss | <input type="checkbox"/> vocational direction | | |
| <input type="checkbox"/> HABIT | <input type="checkbox"/> alcohol/drug | <input type="checkbox"/> gambling | <input type="checkbox"/> sexual | <input type="checkbox"/> obsession | <input type="checkbox"/> impulsivity | <input type="checkbox"/> other behavioral | |
| <input type="checkbox"/> LEGAL | <input type="checkbox"/> probation | <input type="checkbox"/> parental fitness | <input type="checkbox"/> competency | <input type="checkbox"/> drug/alcohol | <input type="checkbox"/> community safety | <input type="checkbox"/> criminal allegation | |
| | <input type="checkbox"/> personal injury/workman compensation | <input type="checkbox"/> other | _____ | | | | |

17. Explain how you cope with stress: _____

How well do you think you are doing? poorly could be better varies very well feel great

18. What are your strengths and interests? reading writing music (what kind) _____ play sports (which one) _____

faith/prayer community/church building/mechanics/computer work shopping collections video/computer games play instrument
 movies/TV art/photo travel friends/social blogs/chat/online gamble journal design /fashion coach/volunteer other: _____

You and your family

19. Did you go through divorce as an adult? yes no Was it difficult? yes no Is it still? yes no
 If you have children, do you have legal custody? physical custody? visitation? 50/50 I have more than 50% less than 50%
 Are there conflicts with these or other arrangements, such as alimony/child support parenting differences abuse allegations yes no

20. Were you raised by parents other than your birth parents? yes no

21. Have any of your blood relatives had EMOTIONAL, BEHAVIORAL or ADDICTION problems? yes no
 Check all that apply addiction (drugs alcohol) ADD/ADHD Manic depression/bipolar depression anxiety panic autism
 learning disability obsessive/compulsions psychosis/schizophrenia diagnosis unknown needed medication needed hospitalization

22. Please list your family members living in your home and elsewhere. Use an "[s]" in the box to indicate stepchild.
 Example SUSAN SAMPLER . age 23 . spouse daughter son other--> Lives at home Step-home elsewhere Apartment

Name _____ . age ____ . spouse daughter son other--> Lives at home Step-home elsewhere _____

Name _____ . age ____ . spouse daughter son other--> Lives at home Step-home elsewhere _____

Name _____ . age ____ . spouse daughter son other--> Lives at home Step-home elsewhere _____

Name _____ . age ____ . spouse daughter son other--> Lives at home Step-home elsewhere _____

Name _____ . age ____ . spouse daughter son other--> Lives at home Step-home elsewhere _____

Name _____ . age ____ . spouse daughter son other--> Lives at home Step-home elsewhere _____

Name _____ . age ____ . spouse daughter son other--> Lives at home Step-home elsewhere _____

Your health

23. Past and current MEDICAL PROBLEMS. Write in your age (approximate) when you were first diagnosed.

Medical condition(s) and/or check below _____

_____ asthma/emphysema/lung disease _____ uterus/ovaries/breast/cancer _____ polycystic ovaries _____ Tourette's/tics

_____ serious injury to arms, legs, back _____ thyroid/pituitary/hormone _____ chronic fatigue _____ genital

_____ blood pressure/anemia/valve _____ urinary/bladder/prostate _____ skin cancer/disease _____ other cancer

_____ ulcers/colitis/rectal/colon/esophagus _____ prostate cancer/disease _____ shaking/Parkinson's _____ AIDS/HIV/STD

_____ jaundice/hepatitis/liver disease _____ heart attack/heart disease _____ paralysis/sensory _____ kidney/renal

_____ black-outs/epilepsy/seizures _____ head injury/stroke/migraine _____ infectious disease _____ diabetes

_____ eyes/ears/nose/throat _____ lymphoma/leukemia/blood _____ arthritis/ lupus _____ menopause

Other _____

24. Check any persistent or bothersome symptoms:

back problems headaches allergies gastrointestinal symptoms stomach aches nausea vomiting diarrhea

bloody/black stools unusual weight gain or loss bladder control leg swelling excessive coughing or coughing blood

chest pain wheezing fatigue joint pain muscular pain visual problems changes in sexual functioning sleeping

rash/abnormal itching persistent fever shortness of breath drug problems Other _____

Last physical exam by doctor _____ Month/year _____

25. For women: Are you having monthly periods? yes no Using birth control? yes no Could you be pregnant? yes no

26. List below accidents or work injuries involving workman's compensation or insurance claims.

Date	Type of Injury	Location of accident	case pending?
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no

27. Have you had an EKG (heart monitor)? yes no Was it abnormal? yes no

28. Ever have a head injury, an EEG (brain wave test) or seen a neurologist (brain specialist)? yes no

29. List the medications you are allergic to: penicillin sulfa others _____

30. Do you have a poor DIET? yes In what way? _____ no

31. CAFFEINATED beverages (energy drinks, colas, tea, coffee) each day? _____ Tobacco chew smoke _____

32. On average, how many cigarette packs have you smoked for how many years? none quit __packs/day __years

33. **CURRENT MEDICATIONS** and TREATMENTS you are taking still. Also list herbal remedies and supplements.

What kind	What for	How much/how often	Prescribing doctor	How long
Example: <u>LiPITOR</u>	<u>high cholesterol</u>	<u>10 mgs/ 1 in am</u>	<u>Dr. Smith</u>	<u>2 years</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Drug and Alcohol Profile

Check here if this section is Not Applicable

Has anyone told you they were concerned about your drug or alcohol use? yes no
 Does it annoy you when others tell you how they feel about your drinking or use? yes no
 Have you ever felt guilty about drinking? yes no
 Did you ever drink to get the day started when you first woke up (had an eye-opener)? yes no

Did you ever: have a seizure while withdrawing from alcohol or drugs? yes no
 hallucinate, shake, be anxious, agitated or have physical craving after stopping? yes no
 go to two or more, or switch doctors to get more prescriptions? yes no

Did you ever lose your memory due to alcohol or drugs? temporarily permanently Ever blacked out?
 Ever overdose on purpose? by accident? go to the hospital? stomach pumped? admitted overnight?
 If you no longer drink or use drugs, why did you stop? _____

Ever go to AA NA CA ACOA Al-anon Ever have a sponsor? Are you familiar with the 12 steps?

Check all the substances you have tried and circle your favorites.

When did you start?

	Age	How much and how often do/did you use? Cost per week.	Did you stop?	When
<input checked="" type="checkbox"/> EXAMPLE (weed)	10	One or two blunts every day. \$50 to \$300 per week	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	2 months ago
<input type="checkbox"/> alcohol	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> weed/marijuana	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> crystal meth/speed	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> cocaine/ crack	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> XTC/ecstasy/MDMA/X	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> heroin	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> mushrooms/peyote	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> LSD/ PCP	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> GHB/ DXM/ K	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> sherm	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> Xanax/Valium/Ativan	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> barbiturates	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> other prescriptions	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> huffing paint, glue, etc.	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> other _____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> I mixed them as follows _____				

Did you get into legal or other trouble in any way due to your substance use? Please explain:

List any other addiction you think you might have. _____

Adult Psych Symptoms Checklist

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Name _____

Date _____

Filled out by _____

Relationship _____

This questionnaire defines your problem areas. Many of these questions may not apply. Some may sound strange or be inappropriate but please do your best. You can ask questions and explain your answers during the interview.

Check NOW, PAST, or N/A (Not Applicable/appropriate) for each line as it applies to you NOW, in the past only, both or neither.

For example:

NOW PAST N/A

Do you like to watch television?

Do you play baseball?

Do you have allergies?

Do you wet your bed?

If you have DEPRESSION, please describe what it is like for you: (If not, check here, and move on to page 2)

NOW PAST N/A

Does your depression or sadness COME AND GO frequently?

Do your moods come OUT of the BLUE?

Is your depression triggered by things that HAPPEN?

Do you stay depressed for 2 WEEKS or more with little if any relief?

When you are depressed, do you:

NOW PAST N/A

... lose your ENERGY?

... have a "WHATEVER" attitude *only* when you are depressed?

... lose INTEREST in everything? ... slow down ... become RESTLESS?

... lose your APPETITE? ... LOSE weight ... GAIN weight?

Do you have trouble FALLING ASLEEP?

... wake up in the MIDDLE of the night, or EARLY in the morning? wake up IN A PANIC?

... need a lot of NAP TIME?

Do you wake GASPING for breath? SNORE?

During periods of depression, do you:

NOW PAST N/A

... get very ANGRY AT yourself? ... all the time? ... only when very depressed?

... feel GUILTY for things that are not your fault?

... STAY ALONE ... MOPE around?

... have trouble THINKING or CONCENTRATING?

... CRY easily ... feel DESPERATE?

If you have thoughts about hurting yourself:

NOW PAST N/A

Have you INJURED yourself on purpose?

Do you have THOUGHTS about taking your life?

Do you have PLANS to do it?

Have you ever TRIED to end your life?

Do you have any such thoughts or plans NOW?

Adult Psych Symptoms Checklist

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Are you ever ON EDGE (anxiety or panic) to an extreme? (If not, check [] here, and move on to the next section.)

NOW PAST N/A

- Do your nerves effect EVERY PART of your life?
- Do you have sudden ATTACKS ...[] MINUTES or ... [] HOURS that go away quickly?
- ...do you stay nervous for a ...[] FEW DAYS, or ... is it [] ALWAYS THERE?
- Do you have FEELINGS IN YOUR BODY when you get upset, such as...
- PAINS in your ...[] CHEST, ...[] HEAD or ...[] STOMACH?
- When nervous, do you have trouble BREATHING?
- ... your ...[] HEART POUNDS? ...[] LOSES FEELING in your hands, head or feet?
- Do you feel SHAKY, SWEATY, FLUSHED or DIZZY when you get nervous?
- Do you AVOID PEOPLE or ...[] THINGS? _____
- Do you have extreme NIGHTMARES? For instance
- Do you have memories that are so real, it's like you are actually LIVING them?
- Do you ever feel OUT OF TOUCH like you are OUTSIDE OF YOUR BODY as though you are watching a movie of your life instead of living it?

Do you have abnormal MOVEMENTS of your face or other parts of your body?

(If not, check [] here, and move on to the next section below.)

NOW PAST N/A

- Do you get movements or irritations in your THROAT or MOUTH such as throat clearing or sniffing?
- Do your hands SHAKE a lot of the time?
- Do other parts of your body JERK uncontrollably?
- Does this happen only when you are nervous?
- Does it happen at BEDTIME when you are trying to fall asleep?
- Do you call out FOUL LANGUAGE out of the blue as though you have no control?
- Do you have severe HEADACHES?
- ... have you ever ...[] BLACKED-OUT ... [] have FITS ... [] FAINTED ... [] SEIZURE(S)?
- Have you WET or SOILED your clothes? ... [] DURING BLACKOUTS?

Do you have:

NOW PAST N/A

- THOUGHTS that just WON'T GO AWAY?
- ... the need to DO THINGS OVER AND OVER almost unable to stop?
- ... uncontrollable urges such as CHECKING your body, locking the door over and over again, washing, counting, or having to have everything ... [] "JUST SO"?
- If you try to control these, is it extremely UNCOMFORTABLE?

Do you take things very SERIOUSLY to the point that you performs:

- RITUALS, ROUTINES or HABITS that don't make sense?
- Would you or others describe you as RIGID?
- Do you ever think that "trying to be PERFECT" gets out of hand?

Do you:

NOW PAST N/A

- BINGE eat or PURGE food?
- Use LAXATIVES or make himself VOMIT?
- Do you think you or you are over-weight while others see you as just fine?

Adult Psych Symptoms Checklist

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Have you done things OUT OF CHARACTER such as:

NOWPAST N/A

- Gone SEVERAL NIGHTS WITH LITTLE IF ANY SLEEP?
- SPENT a lot? ... GAVE away THINGS you treasured?
- Shown a lot of ... ENERGY? Acted exceptionally ... STRONG or... SMART?
- Treated OTHERS POORLY, acted RUDE, HOSTILE or ARGUMENTATIVE out of character?
- Did you feel SHAME or regret LATER about unusual things you did?
- Has your SEXUAL DRIVE or behavior ever been a concern to you?
- Do you get very, very focused on HORROR films, PAIN or REVENGE?
- Do you suffer from EXTREME JEALOUSY?
- Do these characteristics come and go together in episodes?
- Are they part of your EVERYDAY behavior?
- Do you think these out of character reactions are due only to drug use?
- Are you in one of these episodes right now?

Did you ever feel like BIZARRE things were happening, such as:

NOW PAST N/A

- VOICES whispering, talking, calling your name or swearing at you?
- SMELLING things no one else does?
- ... heard or saw THINGS or PEOPLE that no one else does?
- ... lost your sense of DIRECTION ... MEMORY?
- Have you ever seen things breathing, shrinking or growing?

Have you:

NOWPAST N/A

- stopped TAKING CARE of yourself?
- become ill at ease WITH PEOPLE?
- ... lost your SENSE OF HUMOR?
- ... thought the RADIO or TV was TALKING to you?
- ... thought that your THOUGHTS WERE BEING READ or CONTROLLED?
- Do you have thoughts or beliefs that are IRRATIONAL or hard for others to follow, understand or believe?
- Do you think ALCOHOL or DRUGS were responsible for these reactions?

Would you use any of the following terms to describe your USUAL behavior when you were young?

- Selfish Steals Inattentive Stubborn Hurts animals
- Fidgety Sets fires Destructive Anti-authority Lacks conscience
- Lies Fights Restless Distractible Insensitive to pain
- Willful Argues Irresponsible Calls out in class Can't wait turn
- Bullies Cheats Disrespectful Short attention Acts without thinking
- Hateful Whines Demanding Takes risks Uncaring about others
- Abusive Defiant Out of control Manipulative Other:

Describe any illegal or other activities not covered elsewhere that you are concerned about below or on the back.

Release of information

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Filled out by applicant, parent or guardian, completed by assistant.

Today's date _____

Applicant _____ Age ____ Sex ____ Date of Birth: _____

I hereby authorize Dr. Roitman and his staff to (check all that are applicable):

- exchange information with:
 - only request information from:
 - only release information to:

Name _____ Title _____
 Street _____
 City, State and Zip Code _____
 Phone _____ fax _____ cell _____ **Initial** _____

Name _____ Title _____
 Street _____
 City, State and Zip Code _____
 Phone _____ fax _____ cell _____ **Initial** _____

Name _____ Title _____
 Street _____
 City, State and Zip Code _____
 Phone _____ fax _____ cell _____ **Initial** _____

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The purpose of this release of information is to

- Coordinate treatment with other providers
- Verify attendance
- Evaluate status
- Obtain assistance
- Other _____

I release Norton A. Roitman, MD and his staff from any legal liability resulting from the release of this information with the understanding that reasonable professional safeguards will be taken. Unless otherwise specified, release authorization will expire in one year. Release of information is subject to revocation at any time.

Responsible party _____ Staff _____