DR JILL ZECHOWY
Women's Mental Health, MD

Name _____ DOB _____ Date _____
Home # _____ Cell # _____
Work # _____ Which number is best to try? _____
OK for me to leave a message? ☐Yes ☐No Do you text? ☐Yes ☐No
Email: _____
Primary address: _____
Secondary residence: _____
* Please describe in one or two sentences your main reason/s for coming:

_____

_____

Have you ever seen a therapist (MFT, PhD, LCSW) or a psychiatrist (MD)? ☐Yes ☐No
Were you referred by a physician or a therapist? ☐Yes ☐No _____
Are you? ☐Single ☐Divorced ☐Separated ☐Married ☐Liv Together/Dom Part
Do you have children? ☐Yes ☐No How many? _____
Are you a caregiver? ☐Yes ☐No To whom? _____
Who lives at your home? (list below)

Name	Age	Sex	Relationship

Who are people of support to you? _____

_____

Emergency Contact (name, relationship & number): _____

Please flip page over.

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725 College Avenue Santa Rosa, CA 95404
707.515.6673
844.255.0408

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Your occupation: _____ Commute time: _____
Any hobbies? (please list) _____
_____
Do you have any pets? ☐Yes ☐No _____
_____
Do you exercise? ☐Yes ☐No If yes, describe: _____
_____
Describe your usual eating habits: _____
_____
Do you sleep well? ☐Yes ☐No ☐Sometimes
Usually go to bed at: _____ Usually wake up at: _____
Problems falling asleep? _____ Problems staying asleep? _____
What makes it hard for you to sleep? _____

	Do you currently use?	Have you ever used?
Caffeine	☐Yes ☐No	☐Yes ☐No
Tobacco	☐Yes ☐No	☐Yes ☐No
Alcohol	☐Yes ☐No	☐Yes ☐No
Marijuana	☐Yes ☐No	☐Yes ☐No
Prescription meds	☐Yes ☐No	☐Yes ☐No
Amphetamines or Meth	☐Yes ☐No	☐Yes ☐No
Cocaine	☐Yes ☐No	☐Yes ☐No
Heroine	☐Yes ☐No	☐Yes ☐No
Hallucinogens (Acid, LSD)	☐Yes ☐No	☐Yes ☐No
Other _____	☐Yes ☐No	☐Yes ☐No

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Name of primary care physician: _____ Number: _____

Medications:

Have you ever taken medication to improve your mood (antidepressants)? ☐Yes ☐No

Have you ever taken medication to help with anxiety or panic attacks? ☐Yes ☐No

What have you tried in the past? (please list below)

Name of medication How long you tried it Reason for stopping Did it help?

_____

_____

_____

_____

_____

_____

Do you take any medications now? ☐Yes, list below ☐No

Do you take any vitamins, natural treatments, or over-the-counter remedies? ☐Yes ☐No

List all medications / supplements Dosage & frequency Reason you take it

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any allergies to medications? ☐Yes ☐No known drug allergies

If yes, to what medication/s? Describe reaction:

_____

_____

_____

_____

_____

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Past Medical History:

Do you have any medical conditions? ☐Yes ☐No

If yes, describe _____

_____

_____

_____

_____

Have you ever had:

Thyroid problem?	☐Yes	☐No	Depression?	☐Yes	☐No
Recurrent headaches?	☐Yes	☐No	Weight changes?	☐Yes	☐No
High blood sugar?	☐Yes	☐No	Bipolar disorder?	☐Yes	☐No
High blood pressure?	☐Yes	☐No	Irregular heart beat?	☐Yes	☐No
Any surgeries?	☐Yes	☐No	Any hospitalizations?	☐Yes	☐No

If yes to any question above, describe: _____

_____

_____

_____

_____

Family History:

Do you have a *family* history of:

Thyroid disease?	☐Yes	☐No	Heart disease?	☐Yes	☐No
Addictions?	☐Yes	☐No	Depression?	☐Yes	☐No
Cancer?	☐Yes	☐No	Diabetes?	☐Yes	☐No
Mental illness?	☐Yes	☐No	Suicide?	☐Yes	☐No

Are there other medical or mental health problems in your family? _____

_____

_____

Is there anything you would like to add that you feel is important for me to know you? _____

_____

_____

_____

_____

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