Janet Lee Kemp, M.D., LLC
Adult Form

Name : _____ Date of Appointment : _____

Primary Care Doctor: _____

Name of Therapist (current)_____

Who Referred you: _____

Please briefly comment if any of the below are concerns (a few examples listed below) :

Mood (depressed, anxious, panic attacks, obsessions/compulsions, mood swings):

Energy level (fatigue, hyperactivity)

Concentration (difficulty focusing, staying on task, distractibility)

Appetite (excessive, loss of, picky eating, weight changes)

Sleep (onset, maintenance, snoring, daytime sleeping)

Behavioral (rages, impulse control)

Physical Symptoms

Work Related Stressors

Family/Social Stressors

Please list any family history of psychiatric conditions (include mood disorders, academic difficulties, struggles socially, substance use):

Please list any medical history , please see below for a list of general checklist of conditions but not limited to:

Cardiovascular (murmurs, blood pressure abnormalities) , Endocrine: (thyroid, hormonal)

Hematologic: (anemia, blood related, abnormal bleeding) , Musculoskeletal: (muscle, bones)

Neurological (ex. seizures, injuries, tremors, migraines, concussions) , Nutritional (Vitamin deficiencies)

When was your last physical exam : _____

ALLERGIES:

Please list prior treatments (psychiatrists, counselors, treatment centers, substance use treatment) and dates:

Please list prior medications, dates, benefits, side effects:

Current list of medications (including non psychiatric medications) and response / side effects:

Additional Information: