New Patient Referral Form

This document is strictly private and confidential

Information is required for your safety and to benefit your health and welfare. The following details will be treated with the strictest confidence.

Questions, for which you do not wish to reply, leave blank and they will be discussed during initial consultation, please.

A **£30** – 1-hour pre-screening - will be conducted prior to scheduling the initial assessment/consultation session in order to determine the appropriateness of the referral, question the likelihood of fit for my services, and to answer your questions. All Q&A are on line at www.mpsym.co.uk

To get started, complete this Form, please.

PLEASE PRINT and bring it with you at first consultation or email it to: ap@mpsym.co.uk

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GENDER: Male / Female / Other (specify)_____ **DOB**: ___/___/____

NATIONALITY AT BIRTH: _____

PARENTS: Married / Divorced / Separated **Mother**: Alive **Father**: Alive

SIBLINGS: Sex + Age (1)_____ (2)_____ (3)_____ (4)_____

OCCUPATION: _____ **MARITAL STATUS**:_____

IF MARRIED, since_____/_____/_____ **CHILDREN**:_____

QUALIFICATIONS:_____

GP – NAME AND ADDRESS_____

_____ **TELEPHONE NUMBER**:_____

NEXT OF KIN:_____

REASONS FOR APPOINTMENT:_____

_____

_____

HOW WOULD YOU DESCRIBE YOUR CURRENT PRESENTING ISSUES/SYMPTOMS?

_____

_____

_____

_____

GOALS / AIMS / EXPECTATIONS / OUTCOMES

_____

_____

_____

_____

HAVE YOU BEEN IN ANY FORM OF THERAPY BEFORE? IF SO, PLEASE DESCRIBE!

_____

_____

_____

_____

ANY OTHER COMMENTS?

_____

_____

_____

_____

The Generalised Anxiety Disorder Assessment (GAD-7) is a seven-item instrument that is used to measure or assess the severity of generalised anxiety disorder (GAD). Each item asks the individual to rate the severity of his or her symptoms **over the past two weeks**. Response options include “not at all”, “several days”, “more than half the days” and “nearly every day”

GAD-7 Anxiety

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use “✔” to indicate your answer”*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

The PHQ-9 is the nine item depression scale of the patient health questionnaire.* It is one of the most validated tools in mental health and can be a powerful tool to assist clinicians with diagnosing depression and monitoring treatment response. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV.

PHQ-9 Depression

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "O" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.....	0	1	2	3
2. Feeling down, depressed, or hopeless.....	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....	0	1	2	3
4. Feeling tired or having little energy.....	0	1	2	3
5. Poor appetite or overeating.....	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual.....	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

ARE YOU TAKING ANY SUPPLEMENTS OR VITAMINS?

Name of Supplement or Vitamin	Dosage	How Often

HAVE YOU EVER HAD ANY SURGICAL INTERVENTION?

Type of intervention/operation	When

ARE YOU AWARE OF ANY, OUT OF THE ORDINARY, BLOOD RESULTS? (i.e. Creatinine, Uric acid, White blood cells, PSA, Cholesterol etc.) IF YES, please provide details (should you have latest blood test results, please bring them with you).

DO YOU SUFFER FROM ALLERGIES YES / NO

If YES, please give short descriptions to which one(s) and how often (when)

MEDICATIONS

Please list all medications that you are currently taking (**or within the last 8 years**)

	Name of medication	Dosage	How often
1			
2			
3			
4			
5			
6			
7			
8			

WHAT DO YOU FEEL THERAPY WILL DO FOR YOU?

ARE YOU CURRENTLY TAKING ANY NON PRESCRIPTION DRUGS, MEDICATIONS OR SUBSTANCES? (If taken any in the past, please enter year)

SOLVENTS	YES	**NO**	When last taken?
OPIATES	YES	**NO**	When last taken?
STIMULANTS	YES	**NO**	When last taken?
HALLUCINOGENS	YES	**NO**	When last taken?
CANNABIS	YES	**NO**	When last taken?
AMPHETAMINS	YES	**NO**	When last taken?

Do you smoke?	YES	NO
If Yes, **how many**?	Cigars	Cigarettes
Do you drink alcohol?	YES	NO
Do you know how many units?	Wine	
	Spirit	
	Beer	
	Other	
Do you drink socially?	YES	NO
Binge drinking	YES	NO

Ability to relax?	Poor
	Average
	High

Do you take exercise?	None
	Occasional
	Irregular
	Regular

WOMEN ONLY

Are you pregnant?	YES	NO
Have you recently experienced a		
miscarriage	YES	NO
termination	YES	NO
Do you experience irregular periods?	YES	NO
PMT?	YES	NO
MENOPAUSE?	YES	NO
Contraception Patch	YES	Since
IUS	YES	Since
IUD	YES	Since
LARC	YES	Since
Diaphragm/caps	YES	Since
Other	YES	Since

Your Height cm or feet

Your Weight kg/or Lbs

BMI (Office use) < 18.5 / 24.9 / 29.9 / > 30

Blood Pressure

Religion

Are you strict believer/follower YES NO

Sleep Patterns?	GOOD	POOR
On average, how many hours?		
Do you have daylight in your workplace?	YES	NO

On a scale of 1-100 (100 being the most stressful), how stressed are you at the moment

HOME	WORK

FOOD

Do you eat regular meals?	YES	NO
Do you eat in a hurry?	YES	NO
Do you have a healthy balance diet?	YES	NO

- Do you eat outside meals? **YES** **NO**

What? 

- Do you tend to suffer from indigestion? **YES** **NO**

How often do you eat the following?	Per Week
McDonalds	
KFC	
Pub	
Kebab	
Fish and Chips	
Pizza	
Other (specify)	

HOW MUCH OF EACH ITEM DO YOU CONSUME (PER WEEK - UNITS)

Beer	
Biscuits/Cakes	
Canned Fruit	
Cheese	
Chocolate	
Coffee	
Crisps	
Eggs	
Fat (oils - lard - butter)	
Fresh Fish	
Fresh Fruit	
Fresh Meat	
Fresh Vegetables	
Frozen Fish	
Frozen Meat	
Frozen Vegetables	
Grain(s)	
Ice-cream	
Milk	
Nuts	
Pizza	
Ready made meals	
Rice/Pasta	
Soft Drinks	
Sweets	
Tea	
Water	
Wine	

DO YOU SUFFER FROM ANY OF THE FOLLOWING

Acne		Gall bladder Problems	
ADHD		Headaches	
Anorexia		Hearth Problems	
Anxiety		High Blood pressure	
Arthritis		Hoarding	
Asperger's syndrome		Insomnia	
Back Problems		Kidney Problems	
Bipolar		Liver Problems	
Bloating		Loss of appetite	
Bulimia		Low blood pressure	
Cancer		Menopause	
Cellulite		Migraine	
Colds		Neck Problems	
Constipation		Obsessive-compulsive disorder	
Cystitis		Panic disorder	
Depression		Paranoia	
Diabetes		Phobias	
Diarrhoea		Poor blood circulation	
Digestive Problems		Post-traumatic stress disorder	
Dizziness		Rheumatism	
Ear Problems		Low Self-esteem	
Eating Disorder		Sickness	
Epilepsy		Sinuses	
Erectile Dysfunction		Stiff Joints	
Eye Problems		Stomach Problems	
Fluid retention		Stress	
		Varicose Veins	

ARE YOU AWARE OF ANY, OUT OF THE ORDINARY, BLOOD RESULTS? (i.e. Creatinine, Uric acid, White blood cells, PSA, Cholesterol etc.) IF YES, please provide details (should you have latest blood test results, please bring them with you).

Hobbies? _____

_____

_____

Interests? _____

_____

_____

CONSENT FORM

This form should be used for clients, over 16, who can consent to engage in Therapy. I declare that the information given is correct and, as far as I am aware, I can undertake Therapy and I am willing and happy to proceed.

I have read Terms and Conditions – www.mpsym.co.uk ☐

I have read Charges and Payments – www.mpsym.co.uk ☐

I (please, print full name) _____
consent to receiving therapy

Client Signature _____

Practitioner's name Alfredo Procaccini

Date _____/_____/_____