



Young Minds Psychiatry

Name: _____ Age: _____ Date: _____

A. Place an **X** next to the problems that you are having.

_____ Sleep changes (Increase, decrease) _____ Stress _____ Violence/ Assaultive _____ Tics
 _____ Hopeless _____ Paranoia _____ Anxiety _____ Hyperactive _____ Behavior Problems
 _____ Eating Disorders _____ Work /School Problems _____ Appetite Changes _____ Mania
 _____ Memory Problem _____ Substance Abuse _____ Parenting Issues _____ Abuse Issues
 _____ Delusions _____ Poor Concentration/Attention Problems _____ Depression
 _____ Relationship Problems _____ Mood Swing _____ Panic Attack _____ Marital Issues
 _____ Decrease/Increase Energy _____ Dissociative Behaviors

Concerns: _____

B. Place an **X** next to the following (if you have used them in the past 30 days)

_____ Tobacco _____ Alcohol _____ Marijuana _____ Sleeping/pain killers _____ Heroin
 _____ Cocaine _____ Methadone
 Other _____

C. List all medical problems (heart disease, diabetes, seizures, etc.) list of medications..

For Office Use Only

90792 (new)	99215 (L5)	90833 (30)	96103 (test)	Dx Code
99205 (new L5)	99214 (L4)	90836 (45)	90875	_____
99204 (new L4)	99213 (L3)	90838 (60)		
	90847			_____