

PASS Program Intake Packet
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Welcome to the PASS (Psychiatry and Student Support Service) Program! I look forward to meeting with you. Please complete the following questionnaire and bring to your first appointment. Don't worry about any questions that don't apply.

Name: _____ **Date of birth:** _____

Local address: _____

Phone: _____

Year of medical school: _____

How were you referred to the PASS program? _____

What primary concerns bring you for treatment? _____

PSYCHIATRIC TREATMENT HISTORY

Are you currently seeing anyone for psychotherapy or counseling? If so:

Name

Phone and/or fax number

Have you previously taken any psychiatric medications? If so, please list:

MEDICAL HISTORY

Primary care physician (if you have one)

Name

Practice

Phone

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Chronic medical problems (e.g., asthma, diabetes, high blood pressure, seizures)

Past significant illnesses: _____

Any known allergies to medications? _____

List any CURRENT medications and dosages:

FAMILY HISTORY

Please indicate if any immediate family members have been diagnosed or treated for any psychiatric conditions of which you are aware:

Mother: _____

Father: _____

Sibling(s): _____

Additional (if significant): _____

Please describe any other concerns not elsewhere addressed in the space below.