

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)**

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**Past significant illnesses:** \_\_\_\_\_

**Any known allergies to medications?** \_\_\_\_\_

**List any CURRENT medications and dosages:**

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**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.**