Psychiatric Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name____Date of Birth________________Date___________________

Primary Care Physician________________________Do you give permission for ongoing regular updates to be provided to your primary care physician? ____ Current Therapist/Counselor______________________________________

What are the problem(s) for which you are seeking help?

1.____
2.____
3.____

What are your treatment goals?

____
____
____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

[ ][ ]Depressed mood
[ ][ ]Sleep pattern disturbances
[ ][ ]Excessive guilt
[ ][ ] Increased irritability
[ ][ ]Impulsivity
[ ][ ]Increased libido
[ ][ ]Anxiety attacks
[ ][ ]Hallucinations
[ ][ ] Unable to enjoy activities
[ ][ ]Concentration/forgetfulness
[ ][ ]Fatigue
[ ][ ]Crying spells
[ ][ ]Excessive energy
[ ][ ]Decrease need for sleep
[ ][ ]Suspiciousness
[ ][ ] ________________
[ ][ ]Loss of interest
[ ][ ] Change in appetite
[ ][ ]Decreased libido
[ ][ ]Racing thoughts
[ ][ ]Increase risky behavior
[ ][ ]Excessive worry
[ ][ ]Avoidance
[ ][ ] ________________

Suicide Risk Assessment:
Have you ever had thoughts that you didn't want to live? **[ ] Yes [ ] No**
If Yes, do you currently have any thoughts of not wanting to live? **[ ] Yes [ ] No**

Medical History:
Allergies_____________________ Current Weight ____________ Height ____________

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _________ . Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only: Date of last menstrual period ________
Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.
Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method ____________
How many times have you been pregnant? ______ How many live births? ________

For Office Use Only:
1.Const- neg ___ pos ___
2.Eyes -neg ___ pos ___
3.ENT- neg ___ pos ___
4.Cardio-neg ___ pos ___
5.Resp.-neg ___ pos ___
6.GI-neg ___ pos ___
7.GU-neg ___ pos ___
8.Musc.-neg ___ pos ___
9.Skin-neg ___ pos ___
10. Neuro-neg ___ pos ___
11.Endo-neg ___ pos ___
12. Hem- neg ___ pos ___
13. Allerg.- neg ___ pos ___
14. Immu.- neg ___ pos ___

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam: __________List your physical complaints, if any: ______________________

Please list all your current and past medical disorders.

____
____
____

List ALL current prescription medications and how often you take them: (if none, write none)
Medication Name Total Daily Dosage Estimated Start Date

____
____
____
____
____
____
____
____

Past Psychiatric History: Outpatient treatment ( ) Yes ( ) No
If yes, Please describe when, by whom, and nature of treatment. Reason Dates Treated By Whom

____
____
____

Psychiatric Hospitalization ( ) Yes ( ) No: If yes, describe for what reason, when and where.

____
____
____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Prozac (fluoxetine) _______________Zoloft (sertraline)__________________Luvox (fluvoxamine)_________________
Paxil (paroxetine) ________________Celexa (citalopram)_________________Lexapro (escitalopram)_______________
Effexor (venlafaxine) ______________Cymbalta (duloxetine)______________Wellbutrin (bupropion) ______________
Remeron (mirtazapine) ____________Viibryd (Vilazodone)_______________ Desryl (trazodone) ________________
Anafranil (clomipramine)___________Pamelor (nortrptyline)______________Tofranil (imipramine) _______________
Elavil (amitriptyline) ______________ Tegretol (carbamazepine)___________Lithium____________________
Depakote (valproate) _____________ Lamictal (lamotrigine) ______________Topamax (topiramate)______________
Seroquel (quetiapine) _____________Zyprexa (olanzepine)_______________Geodon (ziprasidone) ______________
Abilify (aripiprazole) ______________Latuda (Lurasidone)_______________ Saphris (Asenapine)_____________
Cariprazine (Vryalar)______________Clozaril (clozapine) _______________ Haldol (haloperidol) _______________
Prolixin (fluphenazine) _____________Risperdal (risperidone)______________Ambien (zolpidem) ______________
Sonata (zaleplon) ________________ Rozerem (ramelteon)_______________Restoril(temazepam)_____________
Adderall (Dextroamphetamine) _____Concerta___________________________Ritalin (methylphenidate) _____________
Strattera (atomoxetine) _______________Vyvance_______________ Xanax (alprazolam) ______________
Ativan (lorazepam) _________ Klonopin (clonazepam) _____________ Valium (diazepam) _____________
Tranxene (clorazepate) ______ Buspar (buspirone) _______

Your **Exercise Level**: Do you exercise regularly? ( ) Yes ( ) No How many days a week do you get exercise? _________
How much time each day do you exercise? ____
What kind of exercise do you do? ____

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for If yes, who had each problem?

	Mother	Father	Sibling	Children	Grand Parent	Other relative
Bipolar disorder						
Schizophrenia						
Depression						
Post-traumatic stress						
Anxiety						
Alcohol abuse						
substance abuse						
Suicide						
Violence						

Substance Use: Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? ____
If Yes, where were you treated and when? ____

Alcohol:
How many days per week do you drink any alcohol? ____________
What is the average number of drinks you will drink each time? _______
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? ______
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs in the morning to steady your nerves/get rid of a hangover? ( ) Yes ( ) No Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No If yes, which ones?
____

Methamphetamine ( ) ___________________________________Cocaine ( ) ____
Stimulants (pills) ( ) ______________________________________Heroin ( ) ____
LSD or Hallucinogens ( ) _________________________________Marijuana ( ) ______________________________________
Pain killers (not as prescribed) ( )_________________________ Methadone ( ) ____________________________________
Tranquilizer/sleeping pills ( ) ______________________________Ecstasy ( ) ___________________________________
Other ____

Have you ever abused prescription medication? ( ) Yes ( ) No; If yes, which ones and for how long?_________________

How many caffeinated beverages do you drink a day? Coffee _______ Sodas ________ Tea ________

Tobacco History: How you ever smoked cigarettes? ( ) Yes ( ) No; Currently? ( ) Yes ( ) No
How many packs per day on average? ___________ How many years? _________

In the past? ( ) Yes ( ) No How many years did you smoke? ________ When did you quit? _____________
Do you use any other tobacco products?( ) Yes ( ) No; If Yes, what do you use____________________________________

Family Background and Childhood History:

Trauma History: Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No. Please describe when, where and by whom: ____
____

Educational History: Highest Grade Completed? __________ Where? ____ Did you attend college? ________ Where? ________________________Major? ________________________ What is your highest educational level or degree attained? ____

Occupational History: Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired How long in present position? ____ What is/was your occupation? ____ Where do you work? ____ Have you ever served in the military? _______ If so, what branch and when? ___________________________ Honorable discharge ( ) Yes ( ) No Other type discharge ____

Relationship History and Current Family: Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed How long? _____ If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? ___________________ Are you sexually active? ( ) Yes ( ) No How would you identify your sexual orientation? ( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual ( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer What is your spouse or significant other's occupation? ____ Describe your relationship with your spouse or significant other: ____ Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? ________________ How long? ____ Do you have children? ( ) Yes ( ) No If yes, list ages and gender: ___________________________________ ____ Describe your relationship with your children: ____ List everyone who currently lives with you: ____ ____ Page 6

Legal History: Have you ever been arrested? _______ Do you have any pending legal problems? _______________

Spiritual Life: Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No If yes, what is the level of your involvement? _____________________________ Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful Is there anything else that you would like us to know? ____
____

Signature______________________________Date_____________________________ ___________________________
Emergency Contact ____ Telephone # _______________________