

**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 \_\_\_\_\_ Current Therapist/Counselor \_\_\_\_\_

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

What are your treatment goals?

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

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

Depressed mood

Unable to enjoy activities

Loss of interest

Sleep pattern disturbances

Concentration/forgetfulness

Change in appetite

Excessive guilt

Fatigue

Decreased libido

Increased irritability

Crying spells

Racing thoughts

Impulsivity

Excessive energy

Increase risky behavior

Increased libido

Decrease need for sleep

Excessive worry

Anxiety attacks

Suspiciousness

Avoidance

Hallucinations

\_\_\_\_\_

\_\_\_\_\_

**Suicide Risk Screening:**

Have you ever wished that you were dead?  Yes  No

Have you ever thought of killing yourself?  Yes  No

Have you ever tried to kill yourself?  Yes  No

Do you currently have any thoughts of killing yourself?  Yes  No

**Medical History:** Please list if you have any medication allergies (if none state so) \_\_\_\_\_

Current Weight \_\_\_\_\_ Height \_\_\_\_\_

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

**For women only:** Are you using any contraception?  Yes  No; If Yes, what \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_ Are you currently pregnant or you think you might be pregnant? ( ) Yes ( ) No.

Are you planning to get pregnant in the near future? ( ) Yes ( ) No

**Please check mark any of the physical symptoms you have today:**

**General:** Fatigue  Fever or chills  Change in appetite  Weight loss  Weight gain  **Skin:** rash  itching  dryness

**Ears:** ringing in ears  earache  drainage  **Eyes:** blurry or double vision  **Nose:** stuffiness  discharge  itching

**Throat:** dry mouth  sore throat  hoarseness  **Respiratory:** cough  sputum  shortness of breath  wheezing

**Cardiovascular:** chest pain  palpitations  shortness of breath  **Gastrointestinal:** heartburn  nausea

difficulty swallowing  vomiting  diarrhea  constipation  rectal bleeding  **Genitourinary:** urinary urgency

burning while urinating  decreased sex drive  delayed ejaculation  **Musculoskeletal:** muscle or joint pain

stiffness  back pain  swelling of joints  **Neurologic:** dizziness  seizures  headaches  tingling  numbness

tremors  memory problems  **Hematologic:** bruising easily  bleeding easily  **Endocrine:** Heat or cold intolerance

sweating excessively  increase thirst  **Breast:** lump  discharge  pain

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
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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, write 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 (nortriptyline) _____	Tofranil (imipramine) _____
Elavil (amitriptyline) _____	Tegretol (carbamazepine) _____	Lithium _____
Depakote (valproate) _____	Lamictal (lamotrigine) _____	Topamax (topiramate) _____
Seroquel (quetiapine) _____	Zyprexa (olanzapine) _____	Geodon (ziprasidone) _____
Abilify (aripiprazole) _____	Latuda (Lurasidone) _____	Saphris (Asenapine) _____
Cariprazine (Vraylar) _____	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 ( ) \_\_\_\_\_  
 Xanax or similar drugs ( ) \_\_\_\_\_ 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? \_\_\_\_\_ Did you attend college? \_\_\_\_\_  
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? \_\_\_\_\_  
Have you ever served in the military? \_\_\_\_\_ Honorable discharge ( ) Yes ( ) No Other type discharge \_\_\_\_\_

Relationship History and Current Family: Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed  
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 ( ) 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: \_\_\_\_\_

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

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Telephone # \_\_\_\_\_