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?

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

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: r**ash[ ] 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: h**eartburn[ ] 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

_____
_____
_____
_____
_____
_____
_____
_____

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 (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 ( ) _____
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 # _____