Psychiatric Intake Form
(All information on this form is strictly confidential)

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!

Today's date_____
Name_____ Date of Birth_____
Home Phone_____ May I leave messages on this phone? ( ) y ( ) n
Work Phone_____ May I leave messages on this phone? ( ) y ( ) n
Cell phone _____ E-mail _____
Street address_____
City _____ Zip code _____
Emergency Contact:_____
Phone:_____ Relationship to you:_____
Marital status: S___ M___ D___ W___ Non-married committed relationship?_____
Name all the people with whom you live and their relationship to you:
_____
_____
Occupation:_____
Employer:_____
Highest level of education:_____Age:_____ Sex: M___ F___

Insurance _____
Policy number _____ Group number _____
Name of insured _____ Phone _____
Who will be responsible for payment for treatment? _____
Relationship to you _____What is your expected co-pay? _____
Social Security number (if you are requesting insurance coverage) _____
Social Security number of insured _____
Who referred you (if applicable) _____
Phone_____ Relationship_____

Secondary Insurance _____
Policy number _____ Group number _____
Name of insured _____
Relationship to you: _____

Do you wish me to contact your referral person regarding today's visit?( )y( )n
If yes, person's name, address and phone number _____
_____
_____

List the problems for which you wish to be seen today:

2
1._____
2._____
3._____

What are your three biggest stressors right now?
1. _____
2. _____
3. _____

What are your goals for treatment?
_____
_____

Psychiatric History
Do you have a history of mental health problems or hospitalizations? ( ) y ( ) n
If so, please complete the following:

Diagnosis Dates treated By whom
_____
_____
_____
_____
_____

Are you currently receiving professional counseling or any kind of psychotherapy?
( ) y ( ) n If yes, by whom? _____ Phone_____

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.)

	Dates	Dosage	Helpful?
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Desyrel (trazodone)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			

Dates Dosage Helpful?

Tofranil (imipramine)_____
Elavil (amitriptyline)_____
Tegretol (carbamazepine)_____
Lithium_____
Depakote (Valproate)_____
Lamictal (lamotrigine)_____
Seroquel (quetiapine)_____
Zyprexa (olanzepine)_____
Geodon (ziprasidone)_____
Abilify (aripiprazole) _____
Clozaril (clozapine)_____
Haldol (haloperidol)_____
Prolixin (fluphenazine)_____
Xanax (alprazolam)_____
Ativan (lorazepam)_____
Restoril (temazepam)_____
Klonopin (clonazepam)_____
Valium (diazepam)_____
Ambien (zolpidem)_____
Buspar (buspirone)_____
Adderall (amphetamine)_____
Concerta (methylphenidate)_____
Ritalin (methylphenidate)_____
Strattera (atomoxetine)_____
Other _____

Suicide Risk Assessment
Have you ever had feelings so bad that you have had thoughts that you didn't want to go on, or that you might want to kill yourself? ( ) y ( ) n
IF YES, please answer the following.. If no, please skip to family history.
Is this unhappy feeling so strong you ever wish you were dead? ( ) y ( ) n
How often have you had these thoughts?_____
Has anything happened recently to make you feel like this?_____
_____
On a scale of 1 to 10, how strong is your desire to kill yourself? _____
What would it take to move you one point down the scale? _____
_____
Have you ever thought about how you would kill yourself ? _____
Is the method you would use readily available? _____
Have you planned a time for this?_____
Have you ever tried to kill or harm yourself before?_____
Did things change as a result of these attempts?_____
Is there anything that would stop you from killing yourself?_____
_____
If you could look into the future, what do you feel you could look forward to? _____
_____

Are you bothered by problems with sleep? ( ) y ( ) n

Are you bothered by hearing or seeing things or by voices? ( ) y ( ) n If yes, please complete the DES questionnaire.
Do you have difficulty with focusing or following through on tasks? ( ) y ( ) n

Family Psychiatric History:
Has any one in your family been diagnosed with or treated for:

	Yes	No		Yes	No
Bipolar disorder	_____		Schizophrenia	_____	
Depression	_____		Post-traumatic stress	_____	
Anxiety	_____		Alcohol abuse	_____	
Anger	_____		Other substance abuse	_____	
Suicide	_____		Violence	_____	
ADHD	_____				

If yes, who had what problems?
_____
_____
Has any family member been treated with a psychiatric medication? ( ) y ( ) n If yes, what medications and how effective were they?_____
_____
_____

Medical Information: Allergies_____
Current prescription medications and how often you take them: (if none, write none)
_____
_____
Current over-the-counter medications or supplements: _____
_____
Current medical problems:_____
_____
Past medical problems, hospitalizations or surgeries: _____
_____
Do you have any concerns about your health you would like to discuss with me?( )y( ) n
On a 1 to 10 scale, with 10 being the most pain, what number would you rate your current physical pain now? _____ What number is it normally? _____
Name of your primary health care provider:_____
Phone:_____ Address _____
Date and place of last physical exam:_____
Have you ever had an EKG? ( ) y ( ) n Date _____

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ( ) y ( ) n Are you planning to get pregnant in the near future? ( ) y ( ) n Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have a history of:

	Yes	No		Yes	No
Thyroid Disease			Depression		
Anemia			Bipolar Disorder		
Liver Disease			Psychosis		
Fibromyalgia			Anxiety		
Chronic Fatigue			Panic Attacks		
Heart Disease			Epilepsy or seizures		
Kidney Disease			Chronic Pain		
Diabetes			High Cholesterol		
Asthma/respiratory problems			High blood pressure		
Stomach or intestinal problems			Head trauma		
Cancer			High Cholesterol		

Family history: If there a family history of any of the illnesses listed above, **please put an "F" next to that illness.** Is there a family history of anything NOT listed here? (Please explain):

_____
_____

When your mother was pregnant with you, were there any complications around the pregnancy or birth? _____

How many days a week do you get exercise?____ How many minutes a week do you exercise? _____ What kind of exercise do you get? _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) y ( ) n
If yes, for which substances?_____
If yes, where were you treated and when? _____
_____
How many alcoholic drinks do you consume each week? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you used any street drugs in the past 3 months? ( ) y ( ) n
If yes, which ones? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) y ( ) n
Have people annoyed you by criticizing your drinking or drug use? ( ) y ( ) n
Have you ever felt bad or guilty about your drinking or drug use? ( ) y ( ) n
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) y ( ) n
Do you think you may have a problem with alcohol or drug use? ( ) y ( ) n

Check if you have ever tried the following:

	Yes	No	If yes, when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____

	Yes	No	If yes, when did you last use?
Marijuana	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Ecstasy	( )	( )	_____
Alcohol	( )	( )	_____

Other _____ _____
How many caffeinated beverages do you drink a day? _____

Tobacco History
Cigarettes: Now? **( )** N **( )** Y In the past? **( )** N **( )** Y When did you quit? _____
How many per day on average? _____ For how many years? _____
Pipe, cigars, or chewing tobacco: Now? **( )** N **( )** Y In the past? **( )** N **( )** Y What kind?
_____How often per day on average? _____ For how many years? _____

Social History:
Family Background and Childhood History:
Were you adopted? ( ) y ( ) n Where were you raised? _____
Please list your brothers and sisters and their ages:_____
_____
What was your father's occupation? _____
Your mother's occupation? _____
Did your parents divorce? ( ) y ( ) n If so, how old were you when they divorced?____
If your parents divorced, who raised you? _____
Describe your father and your relationship with him:
_____
Describe your mother and your relationship with her:
_____
_____
How old were you when you left home? _____
Where you ever physically or sexually abused? _____
If so, at what age(s)? _____
Has anyone in your immediate family died? _____
Who and when? _____

II. Educational History:
Did you attend college? _____ Where? _____
What was your major? _____
What is your highest educational level or degree attained?_____

Occupational History:
Are you currently: ( )□Working ( )□Not working
How long in present position? _____
What is your occupation? _____
Where do you work? _____

Have you ever served in the military ?_____ If so, what branch and when? _____
_____
Have you ever been arrested? _____ Do you have any pending legal problems?_____

Marital History and Current Family:
Are you currently dating, sexually active, or in a relationship(s)? ( ) y ( ) n
How would you identify your sexual orientation:
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer
Do you have concerns related to your sexual orientation? ( ) y ( ) n
Are you currently: ( ) Married ( ) Divorced ( ) Single ( ) Widowed
( ) Non-married committed For how long? _____
What is your significant other's occupation? _____
Describe your relationship with your spouse or significant other:
_____
Have you had any prior marriages? ( ) y ( ) n If so, how many? _____
For how long? _____
Do you have children? ( ) y ( ) n Ages: _____
Describe your relationship with your children: _____
List everyone who currently lives at home: _____
_____

Trauma History: Do you have a history of trauma from childhood abuse, military combat, workplace trauma, domestic violence, rape, or medical trauma? _____
If you have a history of trauma, please complete the PTSD questionnaire.
Spiritual Assessment:
Do you belong to a particular religion or spiritual group? ( ) y ( ) n
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
If you do not belong to a particular group, do you have any particular religious, spiritual beliefs or a philosophy of life that are particularly important to you?
( ) y ( ) n _____
Do your beliefs or philosophy of life affect how you to think or feel a about your illness?
( ) y ( ) n If so, how? _____
Are there parts of your belief which you are calling into question because of your illness and current situation? ( ) y ( ) n
As you face this illness, what activities do you use to help you cope, feel better, and heal?
_____
What would you like your health care team and me, as your provider, to know about your spiritual needs as we care for you during this illness?_____
_____
What can I, as your provider, do to support you in your spiritual coping with this illness?
_____

24 Hour Diet Recall

In the last 24 hours, what did you eat and drink for:

Breakfast_____
_____
Between breakfast and lunch _____
Lunch _____
_____
Between lunch and dinner _____
_____
Dinner_____
_____
After dinner _____
_____
Did you eat or drink anything other than the above (for example, glasses of water, alcoholic beverages, middle of the night) _____
_____