PsychNP Wellness Center, LLC.
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New Patient Intake Form

Patient Name: _____ Appointment Date: _____

Describe the Problems that concern you:

Presenting Problems and Concerns (History of Present Illness)

Please check all of the behaviors and symptoms that you consider problematic:

- o distractibility
- o racing thoughts
- o anxiety/worry
- o seasonal mood changes
- o eating problems
- o compulsive behavior
- o self-harm behaviors
- o sexual problems
- o flashbacks
- o fatigue
- o Change in appetite
- o impulsivity
- o wide mood swings
- o fear away from home
- o loss of pleasure/interest
- o computer addiction
- o frequent arguments
- o loneliness
- o work/school problems
- o visual hallucinations
- o Suspicion/paranoia
- o withdrawal from people
- o poor memory/confusion
- o nightmares
- o obsessive thoughts
- o thoughts of death
- o parenting problems
- o homicidal thoughts
- o guilt/shame
- o auditory hallucinations
- o hyperactivity
- o excessive energy
- o panic attacks
- o sadness/depression
- o gambling problems
- o problems with pornography
- o crying spells
- o relationship problems
- o hearing voices
- o suicidal thoughts
- o Lack of motivation
- o boredom
- o sleep problems
- o social discomfort
- o hopelessness
- o aggression/fights
- o irritability/anger
- o low self-worth
- o alcohol/drug

Are your problems affecting any of the following?

- o handling everyday tasks
- o housing
- o health
- o self-esteem
- o legal matters
- o relationships
- o finances
- o hygiene
- o recreational
- o activities
- o work/school
- o sexual activity

Have you ever had suicidal thoughts with or without a plan? Yes No Did you have a plan? Yes No
If yes to any of the above, please describe: _____
Have you ever had homicidal thoughts? Yes No Did you have a plan? Yes No
If yes to any of the above, please describe: _____
have you ever had thoughts, made statements, or attempted to hurt yourself? Yes No
If yes please describe: _____
have you ever had thoughts, made statements, or attempted to hurt someone else? Yes No
If yes please describe: _____
have you ever been physically hurt or threatened by someone else? Yes No
If yes please describe: _____

PMHNP Notes:

Past Medical History

Date of last physical exam: _____

Have you experienced any of the following during your lifetime?

- o allergies
- o surgery
- o seizures
- o chest pain/angina
- o pacemaker
- o stroke/CVI/TIA
- o liver disease
- o tuberculosis
- o asthma
- o serious accident
- o vision problems
- o high blood pressure
- o kidney stones
- o heart palpitations
- o depression
- o headaches
- o head injury
- o high fever
- o heart disease
- o kidney disease
- o HIV/AIDS
- o congestive heart failure
- o stomach aches
- o dizziness/fainting
- o diabetes
- o heart attack
- o cancer
- o hepatitis
- o heart surgery
- o thyroid disease
- o chronic pain
- o meningitis
- o hearing problems
- o high cholesterol
- o osteoporosis
- o stomach ulcer
- o blood clots
- o glaucoma

Review of Symptoms

ROS	(-)	Please check all current positive findings			
Constitutional		o weight loss o fatigue	o fevers o insomnia	o chills o weight gain	o poor appetite o night sweats
Eyes		o blurry vision o decrease in vision	o eye pain o dry eyes	o eye discharge o double vision	o eye redness o cataracts
ENT/Mouth		o sore throat o ear discharge	o hoarseness o nose bleeds	o ear pain o sinus problems	o hearing loss o oral surgery
Cardiovascular		o chest pain o poor circulation	o palpitations o swelling in legs or feet	o rapid heart rate o heart murmur	o
Respiratory		o shortness of breath chronic cough	o excess sputum production	o coughing up blood	o history of tuberculosis
Gastrointestinal		o nausea o blood in stool	o vomiting o frequent heartburn	o diarrhea o trouble swallowing	o constipation o IBS
Genitourinary		o frequent urination o urinary retention	o blood in urine o abortion	o incontinence	o painful urination
Skin		o rash o itching	o hives o skin thickening	o hair loss o nail changes	o skin sores o mole changes
Musculoskeletal		o joint pain o joint swelling	o muscle aches o back pain	o frequent leg cramps o fibromyalgia	o muscle weakness o motor vehicle accident
Psychiatric		o Anxiety o ADHD	o Depression o Bipolar Disorder	o insomnia o panic attacks	o alcohol/drug dependence
Endocrine		o goiter o increased thirst	o heat intolerance o excess sweating	o cold intolerance o hypothyroidism	o change in skin pigment
Neurological		o seizures o dizziness/vertigo	o tremors o loss of balance	o migraines o stroke	o numbness
Hemo/Lymph		o low blood count o prolonged bleeding	o easy bruising o blood clots	o swollen lymph nodes transfusions	o
Allergy/Immune		o allergic reactions o HIV positive	o hay fever o STD	o frequent infections o hepatitis	o positive skin test

PHMNP Notes

Past Mental Health Treatment

Yes	No	Type of Treatment	Date or Age	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (Mental Health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			

Substance Abuse History

Substance type	Current Use			Past Use		
	Yes	No	Frequency/Amount	Yes	No	Frequency/Amount
Tobacco						
Caffeine						
Alcohol						
Marijuana						
Cocaine/Crack						
Ecstasy						
Heroine/Methadone						
Amphetamines						
Pain Killers						
PCP/LSD/Mushrooms						
Steroids						
Tranquilizers						

Have you had withdrawal symptoms when trying to stop using any substances? Yes No
If yes, please describe: _____
Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? Yes No
If yes please describe: _____

PHMNP Notes:

Family Medical History

Please list known medical problems

Father:	Mother:
Siblings:	
Your Children:	

Family Mental Health Problems

Type of Problem	Who?	Type of Problem	Who?
Hyperactivity		Panic Attacks	
Sexually abused		Obsessive compulsive	
Depression		Anger/abusive	
Manic Depression		Schizophrenia	
Suicide		Eating Disorder	
Anxiety		Alcohol/Drug abuse	

PHMNP Notes:

Family Relationships

Relationship	Name	Age	Quality of Relationship

Family, Marital, and Developmental History

- parents legally married or living together
- parents temporarily separated
- parents divorced or permanently separated
- Mother remarried (number of times _____)
- Father remarried (number of times _____)

Interpersonal/Social/Cultural Information

Please describe your social support network

- Family
- Neighbors
- Friends
- Students
- Co-workers
- Support/self-help group
- Community group
- Religious/Spiritual center (which one) _____

To which cultural/ethnic group do you belong: _____

If you are experiencing any difficulties due to cultural or ethnic issues? _____

_____

How important are spiritual matters to you? Not at all Little Somewhat Very Much

Please describe your strengths skills and talents: _____

PMHNP Notes: _____

Miscellaneous Information

Employment

Current Employer _____ Position: _____

Length of Time in this position: _____ Stress level of this position: Low Medium High

Previous Employer _____ Position: _____

Length of Time in this position: _____ Stress level of this position: Low Medium High

Previous Employer _____ Position: _____

Length of Time in this position: _____ Stress level of this position: Low Medium High

Previous Employer _____ Position: _____

Length of Time in this position: _____ Stress level of this position: Low Medium High

Education

Are you currently attending school? Yes No

- High School Graduate GED____ Year: _____
- Associate degree Year ____ Major/area of study: _____
- Undergraduate degree Year ____ Major/area of study: _____
- Graduate degree Year ____ Major/area of study: _____

Military Service

Yes No (If no, skip this section)

Branch _____ Date of Discharge _____ Type of discharge: _____ Rank _____

Were you in combat? Yes No

Legal

Have you ever been convicted of a misdemeanor or felony (including DUI)? Yes No

If yes please explain: _____

Are you currently involved in any divorce or child custody proceedings? Yes No

If yes please explain: _____

PMHNP Notes: _____

Current Medications

- None

Are you allergic to any medications Yes No

If yes, please list: _____

Medication	Dosage	Date First Prescribed	Prescribed by

Current over the counter medications (including vitamins, herbal remedies, etc.) None

_____

Allergies and/or adverse reactions to medications None

_____

Women

Date of Last Menstruation: _____

Birth Control Method: _____