IglePsych, Inc.

14 Racetrack Rd. NW, Fort Walton Beach, FL 32547
Phone: (850) 374-3990
Fax: (850) 374 – 8133

ADULT CLIENT INTAKE FORM

Name: _____

(Last) (First) (Preferred) (Middle Initial)

Birth Date: ____/____/____

Marital status: Never Married Partnered Married Separated Divorced Widowed

Number of children: _____ Ages: _____

Current Address: _____

(city) (state) (zip)

Home Phone: _____ May we leave a Message? Yes No

Cell Phone: _____ May we leave a Message? Yes No

Email: _____ May we email you? * Yes No

*NOTE: Emails may not be confidential

Who may we contact in case of an emergency: _____ Telephone number: _____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other Mental health services? Yes No

Reason for change: _____

Are you currently taking any psychiatric prescription medication'? Yes No

If yes, please list on back page

Have you been prescribed psychiatric prescription medications in the past? Yes No

If yes, please list on back page

Have you been psychiatrically hospitalized in the past? Yes No

Medications Tracker

Name:		Date:	

Medicine name/strength	Purpose	Dosage/frequency/time	Doctor	Notes	Refill Date

Medicines allergic to:

Any other notes / comments:

Date:_____ Provider:_____

Name:_____ DOB:_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

CENTER FOR NEUROLOGIC STUDY-LABILITY SCALE (CNS-LS)

NAME **DATE OF ASSESSMENT** ____/___/____

FOR PSEUDOWLBAR AFFECT (PBA)

The CNS-LS is a short (seven-item), self-administered questionnaire, designed to be completed by the patient, that provides a quantitative measure of the perceived frequency of P BA episodes. The CNS*LS can assist in evaluating patients who may be experiencing symptoms of PBA. A CNS-LS score of 13 or higher may suggest PBA.[1] This score does not diagnose P BAI and lower or higher scores can occur in persons with and without

Using the scale below, please write the number that describes the degree to which each item applies to you DURING THE PAST WEEK. Write only 1 number for each item.

1	2	3	4	5
never	rarely	occasionally	frequently	Most of the time

ASSESSMENT OUESTIONS	ANSWER (1-5)
There are times when I feel fine one minute, and then I'll become tearful the next over something small or for no reason at all.	☐
Others have told me that I seem to become amused very easily or that I seem to become amused about things that really aren't funny,	☐
I find myself crying very easily.	☐
I find that even when I try to control my laughter, I am often unable to do so.	☐
There are times when I won't be thinking of anything happy or funny at all, but then I'll suddenly be overcome by funny or happy thoughts.	☐
I find that even when I try to control my crying, I am often unable to do so.	☐
I find that I am easily overcome by laughter.	☐

Total Score:

General Health Information

Please provide the name, address and telephone number for your primary care provider: _____

_____

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.)

_____

_____

_____

Are you having any problems with your sleep habits? Yes No
If yes, circle those that apply:

Sleep too much Sleep too little Poor quality Disturbing dreams Other: _____

Are there any changes or difficulties with your eating habits? Yes No
If yes, circle those that apply:

Eating less Eating more Bingeing Restricting Other: _____

Have you experienced a weight change in the last two months? Yes No

Do you exercise regularly? Yes No
If yes, how many days per week do you exercise? _____

Do you consume alcohol regularly? Yes No
How many drinks do you consume per week? _____

Do you smoke tobacco? Yes No

If yes, what form and how frequently? _____

Do you engage in recreational drug use? Yes No
If yes, what kinds of recreational drugs do you use: _____

Are you currently in a romantic relationship'? Yes No

If yes, how long have you been in this relationship? _____

On a scale from I-1 0 (10 being great), how would you rate the quality of your relationship? _____

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

Quick Check

Check the issues below that apply to you.

Depressed Mood	Panic Attacks	Memory Lapse	Relationship Problems
Mood Swings	Phobias	Trouble planning	Hallucinations
Rapid Speech	Repetitive Behaviors	Sleep Disturbance	Eating difficulties
Suicidal Thoughts	Anxiety	Time loss	Body Complaints
Homicidal thoughts	Excessive Worry	Alcohol/Drug abuse	Traumatic Event

Have you felt depressed recently? Yes No

If yes, for how long?

Have you had any suicidal thoughts recently? Yes No

If yes, how often? Frequently Sometimes Rarely

Have you ever had suicidal thoughts in your past? Yes No

If yes, how long ago? _____

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Depression	Yes	No	_____
Suicide	Yes	No	_____
Anxiety Disorders	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Sexual Abuse	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____
			_____

Religious/ Spiritual Information

Do you practice religion? Yes No

If yes, what is your faith? _____

Occupational Information

Are you currently employed? Yes No

If yes, who is your employer? _____

Are you happy in your current position? Yes No

Does your work make you stressed? Yes No

Other Information

List your strengths and what you like most about yourself: _____

_____

_____

List areas you feel you need to develop: _____

_____

_____

What are some ways you cope with life obstacles and stress? _____

_____

What are your goals for therapy/what would you like to accomplish? _____

_____

By signing below, I acknowledge that I have chosen to receive mental health services in the form of evaluation and treatment from Dr. James Igleburger at IglePSYCH, Inc. My decision is voluntary, and I understand that I may terminate these services at any time.

Printed Name

_____

Signature **Date**

_____ _____

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