**West Bay Psychiatric Intake Screening Form**

**Please include a clear copy of your photo ID and the front and back of your insurance card. Intakes without this information cannot be reviewed.**

**Date of Submission:**
**Full Name:**
**Date of Birth:**
**Phone Number(s):**
**Email Address:**
**Gender Identity:**
**Preferred Pronouns (optional):**
**Marital Status:**
**Occupation:**
**Home Address:**

**Insurance Information**

**Insurance Provider Name:**
**Member ID:**
**Subscriber Name:**
**Subscriber Date of Birth:**

**Reason for Seeking Treatment**

What are the main concerns or symptoms that led you to seek psychiatric care?
How are these concerns affecting your daily life, work, or relationships?

**Mental Health History**

* Past psychiatric diagnoses (if known):
* Previous or current therapy or psychiatric treatment (including providers):
* History of psychiatric hospitalizations:
* Past or current psychiatric medications (name, dose, response, side effects):

**Safety & Risk Assessment**

* Have you ever had thoughts of harming yourself or others?
* Any history of suicide attempts or self-injury?
* Do you currently have any thoughts of self-harm or suicide?
* Do you feel safe at home?

**Medical Information**

* Current medications (psychiatric, medical, over-the-counter, supplements – include name and dosage):
* Past medical history (e.g., diabetes, high blood pressure, thyroid problems, seizures, migraines, liver/kidney conditions, heart issues):
* Past surgical history:
* Allergies (medications, food, environmental):
* Height and weight (approximate if unsure):

**Substance Use History**

* Current or past use of alcohol, marijuana, or other substances:
* Any history of substance use disorder or addiction treatment?
* History of medication-assisted treatment (e.g., Suboxone, Methadone, Vivitrol)?

**Trauma History**

* Any history of emotional, physical, or sexual abuse?
* Any history of neglect or other significant trauma?

**Legal History**

* Any current or past legal issues (e.g., arrests, probation, custody disputes)?

**Current Treatment Team**

* Primary Care Provider (name and contact):
* Current Therapist or Psychiatric Prescriber (name and contact):
* Do you authorize us to contact your providers for coordination of care? ☐ Yes ☐ No

**Family Psychiatric History**

* Any family history of mental health conditions (e.g., depression, anxiety, bipolar disorder, schizophrenia, substance use disorders, suicide)?

**Social & Developmental History**

* Education level:
* Employment status and history:
* Relationship status and family support:
* Any significant developmental issues in childhood (delays, diagnoses, trauma)?

**Additional Notes (Optional)**

Please include anything else you'd like us to know or feel is important for us to consider in evaluating your care.