Queensland Specialist Centre

Unit 3 / 63 Annerley Road, Woolloongabba, QLD, 4102
Phone: 07 3217 3690
Fax: 07 3036 6011
www.qldspecialist.com E: admin@qldspecialist.com

Psychiatric Intake Form

(All information on this form is strictly confidential)

Name _____ Date: _____

Date Of Birth _____ Age_____ Sex M / F

Primary Care Physician _____ Phone:

Current Psychologist/Counsellor _____ Phone:

Medicare Card Number: _____ Exp: _____

What brings you to seek mental health treatment or consultation?

_____

_____

_____

What are your treatment goals?

_____

_____

_____

Please describe any recent life changes or challenges that have led you to seek treatment:

_____

_____

_____

Current Stressors

Please rank the following stressors in your life from 0 to 5 (0 = not a source of stress, 5 = extremely stress-provoking).

	No stress	A little bit	Sometimes	Usually	Always	Relentlessly
Family	0	1	2	3	4	5
Friends	0	1	2	3	4	5
Finances	0	1	2	3	4	5
House	0	1	2	3	4	5
School	0	1	2	3	4	5
Work	0	1	2	3	4	5
Social media	0	1	2	3	4	5

Symptom Checklist

Please circle the symptoms below that you have been experiencing over the past few weeks. Please indicate with * symptoms that are most distressing to you.

Emotional concerns	**Physical concerns**	**Behavioral concerns**	**Cognitive concerns**
Sadness	Fatigue	Panic attacks	Distractibility
Irritability	Muscle tension	Binging	Forgetfulness
Jealousy	Restlessness	Purging	Racing thoughts
Guilt	Insomnia	Crying	Flashbacks
Worry	Avoidance	Impulsivity	Desire to hurt others
Anger	Excessive energy	Nightmares	Paranoia
Hopelessness	Racing heart	Changes in appetite	Difficulty concentrating
Feeling on edge	Decreased need for sleep	Cutting/self-harm	Thoughts of self-harm
Numbness	Changes in libido	Restricting meals	Hallucinations

Psychiatric History

Have you ever attempted suicide? YES NO

Have you ever received inpatient psychiatric treatment? YES NO
Dates:_____-_____ Facility: _____ Reason:_____

Have you ever received mental health treatment (counselling or medication management)? YES NO
Dates:_____-_____ Provider: _____ Reason:_____

Dates:_____-_____ Provider: _____ Reason:_____

Dates:_____-_____ Provider: _____ Reason:_____

Please list ALL past psychiatric medications

Medication Name Dose(s) Date(s) Response(s) & or Side-effects Provider/Facility

_____

_____

_____

_____

Family Psychiatric History

Has anyone in your family been diagnosed or treated for:

Bipolar disorder	YES	NO	Depression	YES	NO
Schizophrenia	YES	NO	Anxiety	YES	NO
Alcohol abuse	YES	NO	Drug use/abuse	YES	NO
Anger issues	YES	NO	Suicide	YES	NO

If yes, who?_____

What medications were used? _____

Substance Use

Have you ever been treated for drug or alcohol abuse? YES NO

If yes which substance, when and where? _____
How many drinks do you drink per day on average? (please circle) 0 1-2 2-3 3-4 4-5 5-6 6+

Have you ever felt like you should drink less? YES NO

Have people ever criticized your drinking use or annoyed you about drinking? YES NO

Do you ever feel guilty about drinking? YES NO

Do you ever take a drink in the morning to calm your nerves? YES NO

Do you think you might have a problem with alcohol or drugs? YES NO
Have you used any street drugs in the last 3 months? YES NO
If yes, which?_____

Have you used any prescription medication in a way not prescribed? YES NO

If yes, which?_____

Please check if you have ever tried any of the following:

	YES	NO	If yes, how long and when was last use (how old were you)?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants(pills)	( )	( )	_____
Heroine/opium	( )	( )	_____
LSD or hallucin.	( )	( )	_____
Marijuana/THC	( )	( )	_____
Pain medication	( )	( )	_____
Methadone	( )	( )	_____
Sleeping aids	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Bath salts	( )	( )	_____
Flaka	( )	( )	_____

Medical History

Allergies _____ Weight_____ Height_____

Blood pressure (most recent) _____ Last EKG _____

Last Menstrual Period? _____ Was last EKG normal? Yes No

Last physical _____ Last Labs _____

List ALL medications & doses that you are *currently* taking, including supplements, vitamins and over the counter medications.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list ALL **medical conditions** you are or have been treated for:

1._____

2._____

3._____

4._____

Please list ALL **surgeries** you have had:

1._____

2._____

3._____

List NON-Psychiatric **hospitalizations**:

1._____

2._____

3._____

Have you ever had a **traumatic brain injury**? YES NO

Date(s):_____ Treatment(s):_____

Have you ever had **seizures**? YES NO

Dates(s):_____ Treatments(s):_____

Family History

Does your family have a history of any of the following?

	Yes	No	Family member		Yes	No	Family member
High blood pressure	( )	( )	_____	High Cholesterol	( )	( )	_____
Diabetes/sugar	( )	( )	_____	Anemia	( )	( )	_____
Sudden death	( )	( )	_____	Seizures	( )	( )	_____
Thyroid	( )	( )	_____	Liver problems	( )	( )	_____
Kidney problems	( )	( )	_____	Irritable bowel	( )	( )	_____
Crohns disease	( )	( )	_____	Multiple miscarriages	( )	( )	_____
Blood clots	( )	( )	_____	Cancer	( )	( )	_____

Are there any other family medical problems that run in your family? YES NO

If yes, what disease and who did/does it effect? _____

_____

_____

Any family history of mental illness / Self-harm / Suicide / Substance misuse

Social History

Employment: Employed - Unemployed - Retired - Disabled - Homemaker - Student

If employed, which company? _____ Position_____

If student, which school? _____ If retired, from which profession? _____

Sexual orientation: Heterosexual - Homosexual - Bisexual - Other/ Prefer not to disclose

Status: Married - Single - Divorced - Widowed (since _____) - Dating - Prefer not to disclose

Do you have children? YES NO If yes, how many? _____

List ages and genders_____

Living situation- please list everyone that lives with you by relationship

Have you served in the military? YES NO

Branch? _____ Dates served_____

Have you ever been arrested/charged? YES NO

Have you suffered from any major traumatic events in your life? YES NO

If yes please explain if you feel comfortable doing so,_____

_____

Is there anything else we should know about you?

_____

_____

Emergency Contact _____ Relationship _____

Phone Number _____

By signing below, I certify all information is true and correct to the best of my knowledge

Signature _____ Date_____