Hope Said Psychiatry, LLC

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INTAKE FORM

Name
Last | First | Middle

Date of Birth | Age | Sex Male | Birthplace

Home Address
Street | City | State | Zip

Mailing Address
(if different)
Street | City | State | Zip

Phone Numbers

Cell

Home

Work

Emergency Contact Information

NAME

CONTACT NUMBER

RELATIONSHIP OTHER FAMILY

EMERGENCY EMAIL (We will only use this if we cannot reach you by phone)

Please select how you would like to receive appoint reminders: Text messsage

Automated reminders are provided as a courtesy. Please call 24 hours in advance to cancel or reschedule your appointments. A no-show fee will apply to missed appointments.

Who referred you to us?

Briefly, what is the primary reason for your consultation and/or evaluation?

PAST PSYCHIATRIC HISTORY

Hospitalizations for psychiatriac reasons (if applicable).
Please list all hospitalizations you have had, date, where, and what for:

Counseling or therapy services (if applicable).
Please indicte any current or past counseling or therapy sessions you have had, and if so, which whom, when, for how long, and what for?
Are you happy with the treatment?

Past psychiatric medications (if applicable).
Please list the name, dose, what it was prescribed for, if it was effective, and any side effects.

Please indicate any other mental health treatment outside the scope of a traditional medical practice: holistic treatments, church counseling, alternative treatments, dietary treatments, etc.

Have you been physically, sexually, or verbally abused? YES
Please describe, if applicable:

Have you ever attempted suicide or are spending time thinking about it? YES
Please describe, if applicable:

Have you ever engaged in cutting or other means of self harm? YES
Please describe, if applicable:

Have you ever had hallucinations? (hearing voices that others do not or seeing things that that others do not) YES
Please describe, if applicable:

MEDICAL INFORMATION

Primary Care Physician name:

City/State

Allergies

Please list all medical problems (including history of seizures, loss of conscious, heat trauma, etc.), medical hospitalizations and surgeries:

Please list your current medications: name, dose, what for, side effects

SOCIAL HISTORY

Marital Status Single

Eduation Doctorate

Current Occupation

Smoking **Nonsmoker**

Former smoker **Date of last smoked**

Smoker **How many packs a day?**

Alcohol **Non drinker**

Current drinks a week **Choice of drink** Beer/Wine

Have you ever tried to cut back? YES

Have you ever felt annoyed at someone for commenting on your drinking? YES

Do you feel guilty about anything you have done while drinking? YES

Do you ever have a drink to get you going in the morning? YES

Caffeine **Current caffeinated beverages a day** **What Type?**

Other substances

FAMILY MENTAL HEALTH HISTORY

Has anyone in your immediate or extended family ever been diagnosed with a psychiatric illness, had a psychiatric hospitalization, suicide attempt, or struggled with issues around drugs or alcohol? Please provide information on psychiatric medications taken if known. (Examples of conditions are depression, anxiety, PTSD, ADHD, autism, OCD, schizophrenia, bipolar, alcohol or other substance dependence.) Please indicate relation, condition, treatments, and medications taken, if known:

PSYCHIATRIC REVIEW OF SYSTEMS

- [ ] 1. Have you had periods of feeling sad, despondent, or hopeless?
- [ ] 2. Have you noticed a change in your interest in things you normally enjoy?
- [ ] 3. Have you been feeling down on yourself? Guilty about anything?
- [ ] 4. Have you tended to feel more tired than usual? As if all your energy is drained?
- [ ] 5. Have you had trouble concentrating? Making decisions?
- [ ] 6. Have you had any changes in your appetite? Lost or gained weight?
- [ ] 7. Have you felt restless or agitated? Have you been feeling slowed down?
- [ ] 8. Have you had trouble sleeping?
- [ ] 9. Have you ever felt that life isn't worth living? Thought about taking your own life?

- [ ] 1. Have you ever experienced a sudden attack of panic or fear?
- [ ] 2. Did you feel as if you were going to die or go crazy?
- [ ] 3. Ever been afraid of going outside, so that you tended to stay home all the time?
- [ ] 4. Are you ever bothered by persistent ideas that you can't get out of your head, such as being dirty or contaminated?
- [ ] 5. Is there anything you have to do over over and over, such as washing your hands or checking the stove/

- [ ] 1. Are you a moody person?
- [ ] 2. Do you often feel empty inside?
- [ ] 3. When something goes really wrong in your life, like getting rejected, do you ever do something to hurt yourself, like cutting yourself or overdosing?
- [ ] 4. When you're under stress, do you feel like you lose touch with your environment or with yourself?
- [ ] 5. During those times, do you feel like people are ganging up against you?
- [ ] 6. When someone abandons you or rejects you, do you feel terrified?
- [ ] 7. Do you ever get really impulsive and do crazy things, like going on spending sprees, having a lot of sex, driving like a maniac and so forth?
- [ ] 8. Do your relationships tend to be stormy with lots of ups and downs?
- [ ] 9. Do you make yourself sick (induce vomiting) because you feel uncomfortably full from eating?
- [ ] 10. Have you recently lost more than 15lbs in a three-month period?
- [ ] 11. Do you think you are too fat, even though others say you are too thin?
- [ ] 12. Would you say that food dominates your life?

- [ ] 1. Have you felt that people are against you? Trying to harm you in any way?
- [ ] 2. Do you have any special powers, talents, or abilities?
- [ ] 3. Have you heard your own thoughts out loud, as if they were a voice outside your head?
- [ ] 4. Have you felt that your thoughts were broadcast so that other people could hear them?