Adult Psychiatric Intake Form

Patient Name: ____________________ DOB: __________ Date: ____________

PCP: ____________________________ Home Phone#: ______________________

Cell phone #: ________________ Email address: ___________________________

Current therapist/Counselor: ____

Pharmacy (Name and cross streets): ____

Who referred you to our clinic today?

____

What are the issues/symptoms that brings you into the clinic today?

1. ____
2. ____
3. ____

What are your treatment goals? ____

Circle Current Symptoms:

Depressed or sad mood	Sleep pattern disturbance	Racing thoughts
Weight or appetite change	Fatigue or loss of energy	Excessive worry
Poor concentration	Irritability	Excessive energy
Decreased libido	Low self-esteem	Risky behaviors
Hallucinations	Suspiciousness	Panic attacks
Decreased interest in activities	Worthlessness	Crying spells

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you did not want to live? YES or NO

Do you currently feel that you do not want to live? YES or NO

How often do you have these thoughts? _________________________________

When was the last time you had thoughts of dying? ________________________

Has anything happened recently to make you feel this way? __________________

On a scale of 1 to 10, (ten being the strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? ____

Have you ever thought about how you would kill yourself? _____________________________

Is the method you would use readily available? _______________________________________

Have you planned a time for this? ____

Is there anything that would stop you from killing yourself? ____________________________

Have you ever tried to kill or harm yourself before? __________________________________

Medical History: (please list all the past and present medical conditions that you have been diagnosed and treated for? ____

____

Allergies *(medication, food or environmental):*

____

List Current Medications (Prescription and non-prescription):

Medication Name	Dose	How often do you take it?	Estimated Start Date

Past Psychiatric Medications: (Please circle the medication if taken in the past):

Antidepressants

Prozac (fluoxetine)	Celexa (citalopram)	Effexor (venlafaxine)
Luvox (fluvoxamine)	Lexapro (escitalopram)	Viibryd (vilazodone)
Paxil (paroxetine)	Wellbutrin (bupropion)	Anafranil (clomipramine)
Cymbalta (duloxetine)	Remeron (mirtazapine)	Pamelor (nortriptyline)
Tofranil (imipramine)	Elavil (amitriptyline)	Pristiq (desvenlafaxine)
Brintellix/Trintellix (vortioxetine)		

Mood Stabilizers

Tegretol (carbamazepine)	Lithium	Depakote (valproate)
Trileptal (oxcarbazepine)	Keppra (levetiracetam)	Neurontin (gabapentin)
Topamax (topiramate)		

Antipsychotic Medications

Haldol (haloperidol)	Navane (thiothixene)	Prolixin (fluphenazine)
Thorazine (chlorpromazine)	Abilify (aripiprazole)	Seroquel (quetiapine)
Clozaril (clozapine)	Zyprexa (olanzapine)	Geodon (ziprasidone)
Risperdal (risperidone)	Inapsine (droperidol)	Fanapt (iloperidone)
Latuda (lurasidone)	Invega (paliperidone)	Saphris (asenapine)

ADHD Medications

Adderall (amphetamine)	Concerta (methylphenidate)	Ritalin (methylphenidate)
Strattera (atomoxetine)	Vyvanse (lisdexamfetamine)	Dexedrine (amphetamine)
Intuniv/ Tenex (guanfacine)		

Anti-anxiety Medications

Xanax (alprazolam)	Ativan (lorazepam)	Klonopin (clonazepam)
Valium (diazepam)	Tranxene (clorazepate)	Buspar (buspirone)
Neurontin (gabapentin)	Vistaril (hydroxyzine)	

Sleep Medications

Ambien (zolpidem)	Restoril (temazepam)	Seroquel (quetiapine)
Sonata (zaleplon)	Desyrel (trazadone)	Vistaril (hydroxyzine)
Rozerem (ramelteon)	Lunesta (eszopiclone)	Neurontin (gabapentin)

Other Psychiatric Medications:

____

<u>Child's Medical and Family Medical History</u> *(Have you or a family member ever had any of the following? If family, specify which family member)*

	You	Family	Which family member?
Thyroid disease			
Anemia			
Liver problems/hepatitis			
Kidney problems			
Diabetes			
Asthma			
Stomach or intestinal problems			
Cancer			
Chronic pain			
Heart disease			
Epilepsy/seizures			
High cholesterol			
High blood pressure			
Head injury			
Lung disease			
Sleep apnea			
Stroke			
Neurological Problems			
Skin problems			
Other:			

<u>List Past Surgical History:</u>

Type of Surgery	Year

<u>For Females Only:</u>

Date of last menstrual period? __________________

Are you currently pregnant or do you think you might be pregnant? YES or NO

Current birth control method: _______________

How many times have you been pregnant? _____________

How many live births? _______

Any miscarriages/ ectopic pregnancy/still births? ________

Developmental History

Any problems during your mother's pregnancy with you? (please circle)

❑ None ❑High blood pressure ❑Kidney infection ❑ Emotional stress

❑Bleeding ❑Alcohol use ❑ Drug abuse ❑ Cigarette use

Other: _________________

Birth: ❑ Normal ❑C-section ❑Other

Did you have any developmental delays? (such as rolling over, sitting, crawling, speaking, standing, walking, toileting, controlling bladder or bowels etc): ____________________________________

____

Past Psychiatric History

	You	Family	Which family member?
Depression			
Anxiety			
Bipolar I/ Bipolar II			
ADHD			
Suicide			
Schizophrenia			
PTSD			
Alcohol problems			
Drug problems			
Other			

Have you had prior psychiatric **outpatient** treatment?

Reason	Dates Treated	By whom and where?

Have you had prior **inpatient** treatment? (hospitalization, intensive outpatient treatment, substance abuse treatment?

Reason	Dates Admitted	Where?

Substance Use History

❑ No history of substance use

	YES	NO	If YES, how long and when did you last use?
Alcohol			
Tobacco			
Vape			
Methamphetamines			
Cocaine			
Stimulants			
Heroine			
LSD or Hallucinogens			
Marijuana			
Pain killers/Narcotics			
Methadone			
Chronic pain			
Tranquilizers/ sleeping pills			
Ecstasy			
Other:			

How many cups caffeinated beverages do you drink a day?

Coffee: __________ Sodas: _________ Tea: ________ Other: ______________

Tobacco History

Have you ever smoked cigarettes? ❑ YES ❑ NO

Currently? ❑ YES ❑ NO Hoe many packs per day on average? ______.

How many years? _______

In the past? ❑ YES ❑ NO. How many years did you smoke? ________. When did you quit? ________

Pipe, cigars, or chewing tobacco? Currently? ❑ YES ❑ NO In the past? ❑ YES ❑ NO

Social History

Current living situation (home, apartment): _____________

Who do you live with? ________________________________

What are your hobbies? ______________________________

Who is your support system? _____________________________

Do you currently work? ______________________________

Have you served in the military? ____________________________

Family Background

Were you adopted? ❑ YES ❑ NO

Where did you grew up? ____

Who raised you? ____

List your siblings and their ages? ____

Are your parents alive or deceased? ____

Father's occupation? _______________________ Mother's occupation: _____________

Did your parents' divorce? ❑ YES ❑ NO. If yes, how old were you when they divorced? ______

Whom did you live with after your parents divorced? __________________________________

How is your relationship with your father? ____

How is your relationship with your mother? ____

Your Exercise Level

Do you exercise regularly? ❑ YES ❑ NO

How often do you exercise? ___________
What type of exercise do you do? ______________

Educational History

What is your highest level of education or degree attained? _________________________

Trauma History

Do you have a history of being abused emotionally, sexually, physically or by neglect? ❑ YES ❑ NO

Please describe when, where and by whom? ____

Relationship/ Family History

Are you currently in a relationship or married? ❑ Yes ❑ No

Do you have any children? (List their ages and gender): ____________________________

Do you feel safe in your relationship? ❑ Yes ❑ No

How you do you identify your sexual orientation? ❑ Heterosexual ❑ Homosexual ❑ Bisexual

❑ Transsexual ❑ Other

Legal History

Have you ever gotten into any trouble with the law? ❑ YES ❑ NO

Hobbies

Do you have any hobbies? If yes, what are they?

____

Is there anything else that you would like your psychiatric provider to know?

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