Intake Paperwork

Please complete paperwork at least 24 hours prior to scheduled appointment. This will save time and allow us to use our meeting more efficiently.

Patient Name (First and Last, given name) Date of Birth:
Phone number:
Emergency Contact (name, address and telephone):
SSN:
Branch of Military and Job:
Dates of Service and Deployments:

Psychiatric History:

- Psychiatric Hospitalizations (circle one) Yes or No (If yes, when)
  - _____
- Outpatient services (other outpatient psychiatric care including prescription medications)
  - _____
  - _____
- Therapy (circle one) Yes or No (If yes, when)
  - _____

Occupational History (please list any significant employments since Highschool)

- _____
- _____
- _____
- _____
- _____

Educational History (list highest level of education)

- _____

Social and Marital History (please describe friends, marriages/relationship and kids)

- _____
- _____
- _____
- _____

Substance Use/ Alcohol Use (including alcohol):

- _____
- _____

Legal Issues/ Arrests (circle one): Yes or No (If yes, when)

➢ _____

PLEASE COMPLETE THE FOLLOWING SCREENERS and Consent Form

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:**_____

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 figety 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	0	1	2	3

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Please see next document for Informed Consent