NEW BEHAVIORAL/MENTAL HEALTH INTAKE

Today's Date: _____

Patient's Name: _____ **DOB:** _____

1. Who is filling out this form? □ Self □ Other _____

2. Please list reason for today's visit: _____

3. Do you have any allergies to medications? □ No □ Yes Please describe below if any

_____

4. CURRENT MEDICATIONS:
Please list your current medications:

Drug Name: _____	Dose: _____	Frequency: _____
Drug Name: _____	Dose: _____	Frequency: _____
Drug Name: _____	Dose: _____	Frequency: _____
Drug Name: _____	Dose: _____	Frequency: _____
Drug Name: _____	Dose: _____	Frequency: _____

5. Previous Psychiatrist/Therapist:

Name of Clinician	Address/Phone#:	Treatment Dates:
_____	_____	_____
_____	_____	_____

Describe the problems for which you have sought therapy in the past:
_____

Your experience with previous therapy**:** □ Positive □ Neutral □ Limited □ Negative

6. Have you ever been hospitalized for psychiatric or substance abuse problems?
□No □Yes

Facility:	**Dates:**	**Reason:**
_____	_____	_____
_____	_____	_____

7. Do you have a history of suicidal attempts or history of assault? □No □Yes
If yes, please describe: _____

8. <u>Social/Occupational/Family Functioning</u>

- Your social network: □ No close friends □ One close friend □ Few friends □ Many friends
- How often do you make contact with your friends? □ Regularly □ Occasionally □ Rarely □ Never
- Are you currently in a romantic relationship?
  □ No □ Yes it is: □ Generally positive □ Neutral □ Problematic

- Are you able to talk to others about the concerns that bring you into therapy?
  □ No □ Yes
- What is your current living situation?
  □ I live alone □ I live with others, with whom? _____
- How do you feel about work/school?
  □ Pleased □ Mostly satisfied □ Mixed □ Mostly dissatisfied □ Unhappy

Any major dissatisfaction with: □ Work □ School □ Other, please explain: _____
Please describe any hobbies or recreational activities that you enjoy: _____

9. Please circle if you had any of the following in the past 1 week:

Fever	Chills	Fatigue
Headaches	Ear problems	Hoarseness
Chest pain	Fainting	Irregular heartbeat
Heartburn	Vomiting	Abdominal pain
Wheezing	Cough	Difficulty breathing
Seizures	Dizziness	Stroke
Skin rash	Hives	Itchy skin
Joint pains	Joint swelling	Joint redness
Depression	Anxiety	Insomnia
Anemia	Low iron	Blood disorders

Other medical problems _____

10. Please list any previous medical problems: _____
_____

11. Please list any previous surgeries: _____
_____

12. FAMILY HISTORY: List family members who have any of the following:

- Obesity _____
- High Blood Pressure _____
- Sleep Apnea _____
- Diabetes_____
- Heart Disease _____
- Psychiatric Disease_____

13. SOCIAL HISTORY:

Please list if you consume any of the following along with amount:
□ Caffeine _____
□ Tobacco _____
□ Alcoholic Beverages _____
□ Recreational Drugs_____

FOR OFFICE USE ONLY
Vitals:
BP: _____/_____ Pulse: _____ O_2: _____. Ht: _____ Wt: _____

HPI:

Exam:

General Appearance	□ Normal	□ Abnormal	Describe _____
Mental Status	□ Normal	□ Abnormal	Describe _____
Head	□ Normal	□ Abnormal	Describe _____
Eyes	□ Normal	□ Abnormal	Describe _____
Ears	□ Normal	□ Abnormal	Describe _____
Nose	□ Normal	□ Abnormal	Describe _____
Oropharynx	□ Normal	□ Abnormal	Describe _____
Neck	□ Normal	□ Abnormal	Describe _____
Chest	□ Normal	□ Abnormal	Describe _____
CVS	□ Normal	□ Abnormal	Describe _____
Abdomen	□ Normal	□ Abnormal	Describe _____
Extremeties	□ Normal	□ Abnormal	Describe _____
Neuro	□ Normal	□ Abnormal	Describe _____

Diagnosis:

Plan:

Physician's Signature: _____(Anoop Karippot, MD) Date: _____