Medication Intake Form

Name:____**DOB:**______________ **Date:** ________________________

Primary Care Doctor:______________________________________**Pharmacy:**________________________________

What are the problem(s) for which you are seeking help?

1.____

2.____

3.____

What are your treatment goals?

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Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood	( ) Racing Thoughts	( ) Excessive worry
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety attacks
( ) Sleep pattern disturbance	( ) Increase risky behavior	( ) Avoidance
( ) Loss of interest	( ) Increased libido	( ) Hallucinations
( ) Concentration/forgetfulness	( ) Decrease need for sleep	( ) Suspiciousness
( ) Change in appetite	( ) Excessive energy	( ) Excessive guilt
( ) Increased irritability	( ) Fatigue	( ) Crying Spells
( ) Decreased libido		

Past Medical history:

Allergies:

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List all CURRENT prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated start date

Current medical problems:

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Past Medical Problems, Nonpsychiatric hospitalization, or surgeries:

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Personal & Family Medical History:

	You	Family	Which family member?
Thyroid Disease-----------------------	( )	( )	___________________________
Anemia ----------------------------------	( )	( )	___________________________
Liver Disease --------------------------	( )	( )	___________________________
Chronic Fatigue-----------------------	( )	( )	___________________________
Kidney Disease------------------------	( )	( )	___________________________
Diabetes--------------------------------	( )	( )	___________________________
Asthma/respiratory problems------	( )	( )	___________________________
Stomach or intestinal problems----	( )	( )	___________________________
Cancer (type)---------------------------	( )	( )	___________________________
Fibromyalgia----------------------------	( )	( )	___________________________
Heart Disease---------------------------	( )	( )	___________________________
Epilepsy or seizures-------------------	( )	( )	___________________________
Chronic Pain----------------------------	( )	( )	___________________________
High Cholesterol----------------------	( )	( )	___________________________
High Blood Pressure-------------------	( )	( )	___________________________
Head Trauma---------------------------	( )	( )	___________________________
Liver Problems-------------------------	( )	( )	___________________________

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol Abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem?

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Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, describe for what reason, when and where

Reason **Dates Treated** **By Whom**

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Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where

Reason **Dates Treated** **By Whom**

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Substance use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? ____

How many days per week do you drink any alcohol? ________________________________

What is the least number of drinks you will drink in a day? ___________________________

What is the most number of drinks you will drink in a day? ___________________________