Adult Psychiatry Clinic Intake Form

Date_____ Name_____ Age_____
Address_____
Home phone_____ Work phone_____ Cell phone_____
What issue(s) bring(s) you to the Psychiatry Clinic?

_____
_____
_____

What has been stressing you of late (e.g. Family, job, recent loss of loved ones, financial issues)?

_____
_____
_____

Are you currently having any of the following problems (please circle)?

Depression Loss of interest in activities Feeling hopeless, worthless Poor energy Poor self-esteem Change in appetite Increased or decreased energy, Fatigue Poor focus Problems going to sleep Thoughts of not being alive Periods of euphoria or unusually good mood Having very high energy for no reason Going days without needing to sleep Thoughts racing	Talking too fast Acting impulsively (spending, speeding) Worrying excessively Having tense muscles So anxious you feel you cannot rest Having panic attacks Traumatic events that come back in nightmares, flashbacks Feeling awkward in public Thoughts that replay Repetitive or compulsive behaviors Phobias or fears Grunts, tics, or jerks	Hyperactive or fidgety Inattentiveness at work or school? If so, since what age Hearing voices Seeing things Feelings people were trying to watch or harm you Concerns about alcohol use Drug use Concerns about eating too Much, Eating too little Memory problems Getting lost easily Forgetting how to do tasks Problems finding words Problems caring for yourself (cooking, dressing)

Are you currently having or have you recently had any of these physical symptoms?

Fevers	Decreased sex drive	Night sweats	Sore throat
Problems reaching orgasm	Unexplained weight loss/gain	Easy bruising or bleeding	Pain or difficulty urinating
Constipation	Shortness of breath	Weakness in arms/legs	Episodes of passing out
Hot/cold flashes	Joint pains	Cough	Nausea or vomiting
Chills	Headache	Dental problems	Changes in vision
Chest pain	Heart palpitations	Rashes	Problems walking
Acid reflux	Muscle pains or tension	Numbness in arms/legs	Diarrhea
Changes in hearing	Memory problems		

Past Psychiatric Care Have you been ever diagnosed with a mental health condition by a medical provider (e.g. Depression, bipolar, schizophrenia, ADHD)? If so, please list.

_____

_____

_____

Have you ever been seen by a psychiatrist or therapist/counselor? Please list and describe.

Date(s) seen? By whom? What	For what problem?	What treatment (meds, ECT, therapy)?

Have you ever been hospitalized for psychiatric care? Please list and describe.

Date(s) seen? By whom? What	For what problem?	What treatment (meds, ECT, therapy)?

<u>Past Medical Care</u>

Do you have a primary care doctor? Name_____

Last Seen?_____

What medical illnesses do you have?

_____

_____

_____

What surgeries have you had?

_____

_____

_____

Have you or are you on any psychiatric medication? YES NO

Please list all medications you are currently taking, including over-the-counter medications, herbals, and supplements.

Medication	Dosage	# times per day	For What condition	Who Prescribes it

LIST any **allergies** you have (e.g. to medications, foods).

_____

_____

For women:

Last menstrual period? _____ Usually regular? YES NO

Do you use any birth control? YES NO If yes, please list. _____

Have you been pregnant before? YES NO If yes, how many times? _____

Miscarriages? YES NO Elective abortions? YES NO

Any depression or unreal thoughts around pregnancies? YES NO

Substance Use History : How often have you used the following substances? NA if no use

	Last Time Used?	Approximately how often (# of times per week, month or year)?	How much do you use in a sitting if/when you do use
Tobacco			
Alcohol			
Marijuana or K2/"spice"			
Cocaine			
Opiates (e.g. Heroin, morphine, Percocet, oxycodone, Tylenol #3, Dilaudid/hydromorphone)			
Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)			
PCP or LSD Mushrooms Microdosing			
Others			

Family History

Please list blood relatives who have been diagnosed with the following conditions.

Alcoholism _____

Anxiety disorders _____

Bipolar disorder _____

Cancer _____

Depression _____

Diabetes _____

Drug abuse _____

Heart disease/high blood pressure/arrhythmias _____

Osteoporosis _____

Seizures _____

Schizophrenia _____

Strokes _____

Suicides _____

Thyroid disease _____

Social History

Where do you live? _____

Who lives with you? _____

How far did you go in school/highest level of education? _____

What is your current job/occupation? _____

What Jobs have you had in the Past? _____

_____

_____

Are you **married**? YES NO If so, for how long? _____

Have you been married in the past? YES NO # of times? ____ Do you have children? YES NO

If so, how many, what are their birth year?_____

_____

What do you do in you free time to relax? _____

_____

Do you have any religious beliefs? Yes/ No How important are your religious/spiritual beliefs to your life?_____

Have you had any legal issues (arrests, charges, time in jail)? YES NO If so, please describe.

_____

_____

_____

Have you ever been the victim of a violent crime? YES NO Have you ever been a victim of physical abuse? Emotional? Sexual abuse or rape? YES NO If so, please explain.

_____
_____
_____
_____

Safety

Do currently have thoughts of hurting yourself? YES NO Please explain.

_____

Have you tried to hurt yourself in the past? YES NO If so, please explain.

_____
_____
_____

Do you currently have thoughts of hurting anyone else? YES NO Please explain.

_____

Have you tried to hurt anyone in the past? YES NO If so, please explain.

_____
_____
_____

Do you own any guns? YES NO _____

Do you own any knives? YES NO _____

Attached: Adult or Child Routine Intake form
Psychiatric Mental Health Medications
PHQ
GAD
Insomnia Severity Scale