Initial Intake Form

Please complete all information on this form.

Name_____Date_____

Primary Care Provider_____ Primary Care Provider Phone_____

Can we contact your primary care provider to discuss your care? Y N

PREFERRED PHARMACY NAME _____ PHONE _____

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

1._____

2._____

3._____

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

( ) Depressed Mood
( ) Unable to Enjoy Activities
( ) Sleep Pattern Disturbances
( ) Loss of Interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive Guilt
( ) Fatigue
( ) Avoidance
( ) Hallucinations
( ) Excessive worry
( ) Crying spells
( ) Increased Irritability
( ) Decrease need for sleep
( ) Excessive energy
( ) Increase risky behavior
( ) Impulsivity
( ) Racing thoughts
( ) Decreased libido
( ) Increased libido
( ) Suspiciousness
( ) Anxiety attacks

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

If YES, please answer the following. If NO, please skip to next section.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) 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 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?_____

Do you feel hopeless and/or worthless?_____

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

Do you have access to guns? If yes, please explain._____

Past Medical History:

Allergies_____

Current weight_____

Height_____

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

_____
_____
_____
_____

Current over-the-counter medications or supplements:

_____
_____

Current medical problems:

_____
_____

Past medical problems, non-psychiatric hospitalization, or surgeries:

_____

For women only: Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Birth control method_____

Past Psychiatric History:

Outpatient treatment: ( ) Yes ( ) No If yes, please describe when, by whom, and the nature of the treatment. _____
_____
_____

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

_____
_____
_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please check:

Antidepressants

Prozac (fluoxetine)	Lexapro (escitalopram)	Serzone (nefazadone)
Zoloft (sertraline)	Effexor (venlafaxine)	Anafranil (clomipramine)
Luvox (fluvoxamine)	Cymbalta (duloxetine)	Pamelor (nortriptyline)
Paxil (paroxetine)	Wellbutrin (bupropion)	Tofranil (imipramine)
Celexa (citalopram)	Remeron (mirtazapine)	Elavil (amitriptyline)
Other:		

Mood Stabilizers

Tegretol (carbamazepine)	Depakote (valproate)	Tegretol (carbamazepine)
Lithium	Lamictal (lamotrigine)	Topamax (topiramate)
Other:		

Antipsychotics/Mood Stabilizers

Seroquel (quetiapine)	Abilify (aripiprazole)	Prolixin (fluphenazine)
Zyprexa (olanzapine)	Clozaril (clozapine)	Risperdal (risperidone)
Geodon (ziprasidone)	Haldol (haloperidol)	Other:

Sedative/Hypnotics

Ambien (zolpidem)	Restoril (temazepam)	Rozerem (ramelteon)
Sonata (zaleplon)	Desyrel (trazodone)	Other

ADHD medications

Adderall (amphetamine)	Ritalin (methylphenidate)	Strattera (atomoxetine)
Concerta (methylphenidate)	Other	

Antianxiety medications

Xanax (alprazolam)	Klonopin (clonazepam)	Tranxene (clorazepate)
Ativan (lorazepam)	Valium (diazepam)	Buspar (buspirone)
Other		

Substance Use:

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

If yes, for which substances? _____

If yes, where were you treated and when? _____

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 greatest number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or dug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Check if you have ever tried the following:

Methamphetamine	Stimulants	LSD or Hallucinogens
Cocaine	Heroine	Marijuana
Pain Killers (not as prescribed)	Methadone	Tranquilizers/sleeping pills
Ecstasy	Alcohol	

If yes, how long and when did you last use? _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

Have you smoked cigarettes? ( ) Yes ( ) No

Currently? ( ) Yes ( ) No How 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

What kind? _____ How often per day on average? _____ How many years? _____

Your Exercise Level:

Do you exercise regularly ( ) Yes ( ) No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

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: _____

_____

_____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend College? _____ Where? _____ Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed

How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

How would you identify your gender orientation? _____

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

_____

Have you had any prior marriages? ( ) Yes ( ) No If yes, how many and for how long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

Legal History:

Have you ever been arrested? ( ) Yes ( ) No

Do you have any pending legal problems? ( ) Yes ( ) No

_____

Family Medical History:

Please list all medical history for your family: _____

_____

_____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No

Where did you grow up? _____

List your siblings and their ages: _____

_____

What is or was your father's occupation? _____

What is or was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced?_____

If your parents divorced, who did you live with? _____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for any of the following (check):

Bipolar Disorder	Anger	Alcohol Abuse
Depression	Schizophrenia	Other Substance Abuse
Anxiety	Post-Traumatic Stress	Violence
Suicide	Trauma	

If yes, who had each problem?

_____

_____

Has any family member been treated with a psychiatric mediation? ( ) Yes ( ) No

If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

When your mother was pregnant with you, were there any complications during pregnancy or birth?

_____

Emergency Contact Information:

Do you give permission for your emergency contact to be called in the case you might be a harm to yourself or others? ( ) Yes ( ) No

Emergency Contact _____ *Telephone #* _____

Signature _____ Date _____

Guardian Signature (if under age 18) _____