**Adult Psychiatric Intake Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current therapist/Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy (Name and cross streets): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to our clinic today?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the issues/symptoms that brings you into the clinic today?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your treatment goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle Current Symptoms:**

Depressed or sad mood Sleep pattern disturbance Racing thoughts

Weight or appetite change Fatigue or loss of energy Excessive worry

Poor concentration Irritability Excessive energy

Decreased libido Low self-esteem Risky behaviors

Hallucinations Suspiciousness Panic attacks

Decreased interest in activities Worthlessness Crying spells

**Suicide Risk Assessment:**

Have you ever had feelings or thoughts that you did not want to live? YES or NO

Do you currently feel that you do not want to live? YES or 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 the 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever tried to kill or harm yourself before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**: (please list all the past and present medical conditions that you have been diagnosed and treated for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies** *(medication, food or environmental):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List Current Medications (Prescription and non-prescription):**

|  |  |  |  |
| --- | --- | --- | --- |
|  Medication Name |  Dose | How often do you take it? |  Estimated Start Date |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Past Psychiatric Medications: (Please circle the medication if taken in the past):**

**Antidepressants**

|  |  |  |
| --- | --- | --- |
| Prozac (fluoxetine) | Celexa (citalopram) | Effexor (venlafaxine) |
| Luvox (fluvoxamine) | Lexapro (escitalopram) | Viibryd (vilazodone) |
| Paxil (paroxetine) | Wellbutrin (bupropion) | Anafranil (clomipramine) |
| Cymbalta (duloxetine)  | Remeron (mirtazapine) | Pamelor (nortriptyline) |
| Tofranil (imipramine) | Elavil (amitriptyline) | Pristiq (desvenlafaxine) |
| Brintellix/Trintellix (vortioxetine) |  |  |

**Mood Stabilizers**

|  |  |  |
| --- | --- | --- |
| Tegretol (carbamazepine) | Lithium  | Depakote (valproate) |
| Trileptal (oxcarbazepine) | Keppra (levetiracetam) | Neurontin (gabapentin) |
| Topamax (topiramate) |  |  |

**Antipsychotic Medications**

|  |  |  |
| --- | --- | --- |
| Haldol (haloperidol) | Navane (thiothixene) | Prolixin (fluphenazine) |
| Thorazine (chlorpromazine) | Abilify (aripiprazole) | Seroquel (quetiapine) |
| Clozaril (clozapine) | Zyprexa (olanzapine) | Geodon (ziprasidone) |
| Risperdal (risperidone) | Inapsine (droperidol) | Fanapt (iloperidone) |
| Latuda (lurasidone) | Invega (paliperidone) | Saphris (asenapine) |

**ADHD Medications**

|  |  |  |
| --- | --- | --- |
| Adderall (amphetamine) | Concerta (methylphenidate) | Ritalin (methylphenidate) |
| Strattera (atomoxetine)  | Vyvanse (lisdexamfetamine) | Dexedrine (amphetamine) |
| Intuniv/ Tenex (guanfacine) |  |  |

**Anti-anxiety Medications**

|  |  |  |
| --- | --- | --- |
| Xanax (alprazolam) | Ativan (lorazepam) | Klonopin (clonazepam) |
| Valium (diazepam) | Tranxene (clorazepate) | Buspar (buspirone) |
| Neurontin (gabapentin) | Vistaril (hydroxyzine) |  |

**Sleep Medications**

|  |  |  |
| --- | --- | --- |
| Ambien (zolpidem) | Restoril (temazepam) | Seroquel (quetiapine) |
| Sonata (zaleplon) | Desyrel (trazadone) | Vistaril (hydroxyzine) |
| Rozerem (ramelteon) | Lunesta (eszopiclone) | Neurontin (gabapentin) |

Other Psychiatric Medications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Medical and Family Medical History** *(Have you or a family member ever had any of the following? If family, specify which family member)*

|  |  |  |  |
| --- | --- | --- | --- |
|  |  You |  Family  | Which family member? |
| Thyroid disease |  |  |  |
| Anemia |  |  |  |
| Liver problems/hepatitis |  |  |  |
| Kidney problems |  |  |  |
| Diabetes |  |  |  |
| Asthma |  |  |  |
| Stomach or intestinal problems |  |  |  |
| Cancer |  |  |  |
| Chronic pain |  |  |  |
| Heart disease |  |  |  |
| Epilepsy/seizures |  |  |  |
| High cholesterol |  |  |  |
| High blood pressure |  |  |  |
| Head injury |  |  |  |
| Lung disease |  |  |  |
| Sleep apnea |  |  |  |
| Stroke |  |  |  |
| Neurological Problems |  |  |  |
| Skin problems |  |  |  |
| Other:  |  |  |  |

**List Past Surgical History:**

|  |  |
| --- | --- |
|  Type of Surgery | Year |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**For Females Only:**

Date of last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently pregnant or do you think you might be pregnant? YES or NO

Current birth control method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_\_\_\_\_\_\_\_

How many live births? \_\_\_\_\_\_\_

Any miscarriages/ ectopic pregnancy/still births? \_\_\_\_\_\_\_\_

**Developmental History**

Any problems during your mother’s pregnancy with you? (please circle)

❑ None ❑High blood pressure ❑Kidney infection ❑ Emotional stress

❑Bleeding ❑Alcohol use ❑ Drug abuse ❑ Cigarette use

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth:** ❑ Normal ❑C-section ❑Other

Did you have any developmental delays? (such as rolling over, sitting, crawling, speaking, standing, walking, toileting, controlling bladder or bowels etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Psychiatric History**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  You |  Family  | Which family member? |
|  |  |  |  |
| Depression |  |  |  |
| Anxiety |  |  |  |
| Bipolar I/ Bipolar II |  |  |  |
| ADHD |  |  |  |
| Suicide |  |  |  |
| Schizophrenia |  |  |  |
| PTSD |  |  |  |
| Alcohol problems |  |  |  |
| Drug problems |  |  |  |
| Other |  |  |  |

Have you had prior psychiatric **outpatient** treatment?

|  |  |  |
| --- | --- | --- |
| Reason | Dates Treated  | By whom and where? |
|  |  |  |
|  |  |  |
|  |  |  |

Have you had prior **inpatient** treatment?(hospitalization, intensive outpatient treatment, substance abuse treatment?

|  |  |  |
| --- | --- | --- |
| Reason | Dates Admitted | Where? |
|  |  |  |
|  |  |  |
|  |  |  |

**Substance Use History**

❑ No history of substance use

|  |  |  |  |
| --- | --- | --- | --- |
|  |  YES |  NO | If YES, how long and when did you last use? |
| Alcohol |  |  |  |
| Tobacco |  |  |  |
| Vape |  |  |  |
| Methamphetamines |  |  |  |
| Cocaine |  |  |  |
| Stimulants |  |  |  |
| Heroine |  |  |  |
| LSD or Hallucinogens |  |  |  |
| Marijuana |  |  |  |
| Pain killers/Narcotics |  |  |  |
| Methadone |  |  |  |
| Chronic pain |  |  |  |
| Tranquilizers/ sleeping pills |  |  |  |
| Ecstasy |  |  |  |
| Other:  |  |  |  |

How many cups caffeinated beverages do you drink a day?

Coffee: \_\_\_\_\_\_\_\_\_ Sodas: \_\_\_\_\_\_\_\_ Tea: \_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco History**

Have you ever smoked cigarettes? ❑ YES ❑ NO

Currently? ❑ YES ❑ NO Hoe 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

**Social History**

Current living situation (home, apartment): \_\_\_\_\_\_\_\_\_\_\_\_\_

Who do you live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your support system? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you served in the military? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Background**

Were you adopted? ❑ YES ❑ NO

Where did you grew up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who raised you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List your siblings and their ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your parents alive or deceased? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_

Did your parents’ divorce? ❑ YES ❑ NO. If yes, how old were you when they divorced? \_\_\_\_\_\_

Whom did you live with after your parents divorced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your relationship with your father? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your relationship with your mother? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Exercise Level**

Do you exercise regularly? ❑ YES ❑ NO

How often do you exercise? \_\_\_\_\_\_\_\_\_\_\_
What type of exercise do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Educational History**

What is your highest level of education or degree attained? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship/ Family History**

Are you currently in a relationship or married? ❑ Yes ❑ No

Do you have any children? (List their ages and gender): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel safe in your relationship? ❑ Yes ❑ No

How you do you identify your sexual orientation? ❑ Heterosexual ❑ Homosexual ❑ Bisexual

❑ Transsexual ❑ Other

**Legal History**

Have you ever gotten into any trouble with the law? ❑ YES ❑ NO

**Hobbies**

Do you have any hobbies? If yes, what are they?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else that you would like your psychiatric provider to know?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_