# New Client - Intake Form

Please complete all information on this form and submit at least 24 hours before your initial psychiatric evaluation.

1. **Last Name** *

2. **First Name** *

3. **DOB** *

*Example: December 15, 2012*

4. **Address**

5. **Phone Number**

6. **Email**

7. **Current Weight**

8. **Current Height**

9. **Identified Sex/Gender** *

*Mark only one oval.*

- ◯ Female
- ◯ Male
- ◯ Other: _____

10. **Reasons for seeking help?**
Check any/all that apply
*Check all that apply.*

- [ ] Bipolar Disorder
- [ ] Attention Deficit Hyperactive Disorder (ADHD)
- [ ] Post-Tramatic Stree Disorder (PTSD)
- [ ] Schizophrenia
- [ ] Schizoaffective Disorder
- [ ] Personality Disorder
- [ ] Other: _____

*Skip to question 11.*

## Anxiety

11. **Do you experience anxiety?**
*Mark only one oval.*

- ◯ Yes
- ◯ No

## Anxiety continued

12. **Over the LAST 2 WEEKS, how often have you been bothered by the following problems?**
*Mark only one oval per row.*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious or on edge | ◯ | ◯ | ◯ | ◯ |
| Not being able to stop or control worrying | ◯ | ◯ | ◯ | ◯ |
| Worrying too much about different things | ◯ | ◯ | ◯ | ◯ |
| Trouble relaxing | ◯ | ◯ | ◯ | ◯ |
| Being so restles | ◯ | ◯ | ◯ | ◯ |
| Becoming easily annoyed or irritable | ◯ | ◯ | ◯ | ◯ |
| Feeling afraid as if something awful might happen | ◯ | ◯ | ◯ | ◯ |

## Depression

13. **Do you experience depression?**
*Mark only one oval.*

- ◯ Yes
- ◯ No

## Depression continued

14. **Over the LAST 2 WEEKS, how often have you been bothered why any of the following problems?**
*Mark only one oval per row.*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Little interest or pleasure in doing things | ◯ | ◯ | ◯ | ◯ |
| Feeling down, depressed, or hopeless | ◯ | ◯ | ◯ | ◯ |
| Trouble falling or staying asleep, or sleeping too much | ◯ | ◯ | ◯ | ◯ |
| Feeling tired or having little energy | ◯ | ◯ | ◯ | ◯ |
| Poor appetite or overeating | ◯ | ◯ | ◯ | ◯ |
| Feeling bad about yourself, or that you are a failure or have let yourself - or your family down | ◯ | ◯ | ◯ | ◯ |
| Trouble concentrating on things, such as reading newspaper or watching television | ◯ | ◯ | ◯ | ◯ |
| Moving or speaking so slowly that other people could have noticed. Or the opposite- being so figety or restless that you have been moving around a lot more than usual | ◯ | ◯ | ◯ | ◯ |
| Though that you would be better off dead, or thoughts of hurting yourself | ◯ | ◯ | ◯ | ◯ |

15. **If you checked off ANY problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**
*Mark only one oval.*

- ◯ Not difficult at all
- ◯ Somewhat difficult
- ◯ Very difficult
- ◯ Extremely difficult

## Female

16. **Are you pregnant? Or think you may be pregnant?**
*Mark only one oval.*

- ◯ Yes
- ◯ No

17. **Are you planning to become pregnant?**
*Mark only one oval.*

- ◯ Yes
- ◯ No
- ◯ Maybe

18. **Birth Control:**

19. **Most recent mammogram**
    Leave blank if you have not had one

    *Example: December 15, 2012*

20. **Last menstrual cycle**
    Leave blank if you do not have one

    *Example: December 15, 2012*

## Provider Information & Treatment Goals

Please list provider name and contact number if possible

21. **Current Psychiatric Provider**
    List name and phone number

22. **Current Therapist/Counselor**
    List name and phone number

23. **Current Primary Care Provider**
    List name and phone number

24. **What are your treatment goals?**
    Describe in your own words

## Medical Information

25. **General Health** *

Check any/all that apply
*Check all that apply.*

- [ ] Recent changes in appetite
- [ ] Weight gain or weight loss
- [ ] Fevers
- [ ] Chills or sweats
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

26. **Head** *

Check any/all that apply
*Check all that apply.*

- [ ] Occasional mild headaches
- [ ] Migraines
- [ ] Recent trauma or concussion
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

27. **Eyes** *

Check any/all that apply
*Check all that apply.*

- [ ] Recent visual changes or double vision
- [ ] Presbyopia (need bifocals)
- [ ] Cataracts
- [ ] Glaucoma
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

28. **Ears** *

*Check all that apply.*

- [ ] Ringing
- [ ] Infection
- [ ] Drainage or pain
- [ ] Mild hearing loss
- [ ] Hearing impaired
- [ ] Hearing aid
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

29. **Nose/Throat/Mouth** *

Check any/all that apply
*Check all that apply.*

- [ ] Frequent nose bleeds
- [ ] Bleeding gums
- [ ] Sores in mouth or lips
- [ ] Difficulty swallowing
- [ ] Hoarseness
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

30. **Lungs** *

Check any/all that apply
*Check all that apply.*

- [ ] Wheezing
- [ ] Chronic cough
- [ ] Emphysema
- [ ] COPD
- [ ] Coughing up blood
- [ ] TB
- [ ] Positive skin test
- [ ] Sleep apnea
- [ ] Use of CPAP
- [ ] Pulmonary embolism
- [ ] Asthma
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

31. **Heart** *

Check any/all that apply
*Check all that apply.*

- [ ] Chest pain or angina
- [ ] Heart skips
- [ ] Rapid heart rate
- [ ] Exertional or nocturnal shortness of breath
- [ ] Cardia testing within the last year (EKG, stress test, cardia catheterization or echo)
- [ ] Heart attack
- [ ] Atrial fibrilation
- [ ] Pacemaker
- [ ] Mitral valve prolapse
- [ ] Hypertension
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

32. **Breast** *

Check any/all that apply
*Check all that apply.*

- [ ] Current breast mass
- [ ] Nipple discharge
- [ ] Personal history of breast cancer
- [ ] Breast augmentation
- [ ] Current abnormal mammogram or sonogram
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

33. **Digestive** *

Check any/all that apply
*Check all that apply.*

- [ ] Abdominal pain
- [ ] Nausea
- [ ] Vomiting
- [ ] Bloating
- [ ] Heartburn
- [ ] GERD
- [ ] Diarrhea
- [ ] Constipation
- [ ] Cirrhosis
- [ ] Jaundice
- [ ] Gallstones
- [ ] Black stools or blood in stool
- [ ] Hemorrhoid problems
- [ ] History of cancer
- [ ] Crohn's disease ulcerative colitis
- [ ] Diverticulitis
- [ ] Irritable bowel disease
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

34. **Gento-urinary** *

Check any/all that apply
*Check all that apply.*

- [ ] Difficulty urinating
- [ ] Difficulty holding urine
- [ ] Frequent urination at night
- [ ] Blood in urine
- [ ] Kidney stones
- [ ] Herpes
- [ ] Prostate cancer (MEN only)
- [ ] Discharge from penis (MEN only)
- [ ] Menopause (WOMEN only)
- [ ] Hysterectomy (WOMEN only)
- [ ] Ovaries removed (WOMEN only)
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

35. **Musculoskeletal** *

Check any/all that apply
*Check all that apply.*

- [ ] Pain in joints
- [ ] Pain in muscles
- [ ] Muscle weakness
- [ ] Fibromyalgia
- [ ] Arthritis under treatment
- [ ] Chronic back problems
- [ ] Swollen ankles
- [ ] Varicose veins
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

36. **Neurological** *

Check any/all that apply
*Check all that apply.*

- [ ] Dizziness
- [ ] Loss of conciousness
- [ ] Transient loss of function
- [ ] Stroke
- [ ] Seizures
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

37. **Skin** *

Check any/all that apply
*Check all that apply.*

- [ ] Rash
- [ ] Psoriasis
- [ ] Non-healing lesions
- [ ] History of skin cancers or melanoma
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

38. **Endocrine** *

Check any/all that apply
*Check all that apply.*

- [ ] Thyroid disorder
- [ ] Masses
- [ ] Heat or cold intolerance
- [ ] Taking thyroid medication
- [ ] Diabetes under treatment
- [ ] Excessive thirst, hunger or urination
- [ ] Adrenal or pituitary disorder
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

39. **Hematologic** *

Check any/all that apply
*Check all that apply.*

- [ ] Anemia
- [ ] Bruise easily
- [ ] Excessive bleeding
- [ ] Swollen glands
- [ ] Leukemia
- [ ] Lymphoma
- [ ] Transfusions
- [ ] Blood clots
- [ ] Phlebitis
- [ ] Deep venous thrombosis
- [ ] Anticoagulated with Coumadin
- [ ] Sickle cell
- [ ] NONE OF THE ABOVE
- [ ] Other: _____

# Medical History

40. **Past medical problems, non-psychiatric hospitalization, or surgeries:**

_____

_____

_____

_____

_____

41. **Have you ever had an EKG?**
If yes, when?
*Check all that apply.*

- [ ] Yes
- [ ] No

42. **Date and place of last physical exam:**

_____

43. **Personal and Family Medical History**
*Check all that apply.*

| | Self | Mother | Father | Maternal Grandmother | Paternal Grandmother | Maternal Grandfather | Paternal Grandfather |
|---|---|---|---|---|---|---|---|
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Liver Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma/Respiratory disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease Pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Chronic Pain | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Liver problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

44. **Personal and Family Medical History (continued)**
*Check all that apply.*

| | Self | Mother | Father | Maternal Grandmother | Paternal Grandmother | Maternal Grandfather | Paternal Grandfather |
|---|---|---|---|---|---|---|---|
| Anemia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stomach or intestinal issues | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy or seizures | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Head Trauma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Past Psychiatric History

45. **Have you ever had feelings or thoughts that you did NOT want to live?**
*Mark only one oval.*

- ◯ Yes, currently
- ◯ Yes, in the past
- ◯ No

46. **How often do you have these thoughts?**

_____

47. **Have you ever tried to kill or harm yourself before?**
*Mark only one oval.*

- ◯ Yes
- ◯ No

48. **Do you have access to guns?**
*Mark only one oval.*

- ◯ Yes
- ◯ No

49. **Outpatient Psychiatric Treatments**
i.e. Age when first saw therapist/psychiatrist/psychiatric provider

_____

_____

_____

_____

_____

50. **Psychiatric Hospitalizations**
Years, Reason for hospitalization

_____

_____

_____

_____

_____

51. **Past Psychiatric Medications**
If you have ever taken any psychiatric medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you remember)

_____

_____

_____

_____

_____

52. **Past Psychiatric Medications Continued**

_____

_____

_____

_____

_____

53. **Has anyone in your family been diagnosed with or treated for a psychiatric illness?**
Please list:

54. **Has any family member been treated with a psychiatric medication?**
Please list who was treated, what medications did they take, and how effective was the treatment (If none, please leave blank):

## Substance Use

55. **Have you ever been treated for alcohol or drug use or abuse?**
*Check all that apply.*

- [ ] Yes
- [ ] No

56. **If yes, for which substances?**

57. **If yes, where were you treated and when?**

58. **How many days per week do you drink alcohol?**

59. **Do you think you may have a problem with alcohol or drug use?**
*Mark only one oval.*

- ◯ Yes
- ◯ No

60. **Have you used any street drugs in the past 3 months?**
*Mark only one oval.*

- ◯ Yes
- ◯ No

61. **If yes, which ones?**

_____

_____

_____

_____

_____

62. **Have you ever abused prescription medication?**
*Mark only one oval.*

- ◯ Yes
- ◯ No

63. **If yes, which ones and for how long?**

_____

_____

_____

_____

_____

## Tobacco History

64. **Describe tobacco use**
Check any/all that apply:
*Check all that apply.*

| | Yes, currently | Yes, but not currently | No |
|---|---|---|---|
| Cigarettes | ☐ | ☐ | ☐ |
| Pipe | ☐ | ☐ | ☐ |
| Cigars | ☐ | ☐ | ☐ |
| Chewing tobaco | ☐ | ☐ | ☐ |

65. **If yes to any, how ofter per day on average?**

_____

66. **If yes to any, how many years?**

_____

## Family Background and Childhood History

67. **Developmental History:**
Check any that apply
*Check all that apply.*

- [ ] Known developmental delays
- [ ] Pregnancy complication
- [ ] Birth complications

68. **Were you adopted?**
*Mark only one oval.*

- ◯ Yes
- ◯ No

69. **Where were you born? Where were you raised?**

_____

70. **List your siblings and their ages:**

_____

_____

_____

_____

_____

71. **Did your parents divorce?**
*Mark only one oval.*

- ◯ Yes
- ◯ No

72. **If yes, who did you live with?**
*Check all that apply.*

| | Full time | Mostly | Half & half |
|---|---|---|---|
| Mother | ☐ | ☐ | ☐ |
| Father | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ |

73. **Are your parents living?**
*Check all that apply.*

| | Yes | No |
|---|---|---|
| Mother | ☐ | ☐ |
| Father | ☐ | ☐ |

74. **Legal History**
Briefly describe any past or current legal troubles

_____

_____

_____

_____

_____

75. **Education**
Select highest degree COMPLETED
*Mark only one oval.*

- ◯ Some high school
- ◯ High School graduate or GED
- ◯ Some college
- ◯ Associates Degree
- ◯ Bachelors Degree
- ◯ Masters Degree
- ◯ Doctorate, PHD, MD,

76. **Occupation**
List job title

_____

77. **Military History**
*Mark only one oval.*

- ◯ Yes, currently
- ◯ Yes, inactive or discharged
- ◯ No

78. **Religion**
Please type "yes" or "no". If yes, please list religion.

_____

79. **Marital Status**

*Mark only one oval.*

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Widowed
- ◯ Seperated

80. **Living Situation (own, rent, roommates, etc.)**

81. **Support System**

List anyone who you feel supports you in your life (list relationship)

82. **Abuse or Trauma History**

*Check all that apply.*

- ☐ History of Physical Abuse
- ☐ History of Sexual Abuse
- ☐ History of Emotional Abuse
- ☐ Other

83. Children (biological, adopted, step, etc.)
Do you have children? If so, how many, ages, & names