Psychiatric Intake Form
Psychiatric Intake Form
(All information on this form is strictly confidential)

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_________________________________________Date___________________

Date of Birth ____________________ Primary Care Physician_______________________________________

Current Therapist/Counselor___________________________ Therapist’s Phone_________________________

What are the problem(s) you are seeking help for?
1.________________________________________________________________________________________
2.________________________________________________________________________________________
3.________________________________________________________________________________________

What are your treatment goals?
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

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

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 Past Psychiatric History
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? ______________________________________________
Your Medical History:
Allergies ___________________________ Current Weight ___________ Height ___________

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

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Total Daily Dosage</th>
<th>Estimated Start Date</th>
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</table>

Current over-the-counter medications or supplements: ____________________________

Current medical problems:

Past medical problems, nonpsychiatric hospitalization or surgeries ________________________

Have you ever had an EKG? ( ) Yes ( ) No If yes, when ___________. Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only: Date of last menstrual period ________ 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 __________________________

How many times have you been pregnant? ________ How many live births? ________

Do you have any concerns about your physical health that you would like to discuss with me? ( ) Yes ( ) No

Date and place of last physical exam: ____________________________________________

Personal and Family Medical History:

<table>
<thead>
<tr>
<th>Family History</th>
<th>You</th>
<th>Family</th>
<th>Which Family Member</th>
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</thead>
<tbody>
<tr>
<td>Thyroid Disease</td>
<td>( )</td>
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<tr>
<td>Anemia</td>
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<tr>
<td>Liver Disease</td>
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<tr>
<td>Chronic Fatigue</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Asthma/respiratory problems</td>
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<td>Stomach or intestinal problems</td>
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<tr>
<td>Cancer (type)</td>
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<tr>
<td>Fibromyalgia</td>
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<tr>
<td>Heart Disease</td>
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<tr>
<td>Epilepsy or seizures</td>
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<tr>
<td>Chronic Pain</td>
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<tr>
<td>High Cholesterol</td>
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<tr>
<td>High blood pressure</td>
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<tr>
<td>Head trauma</td>
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<td>( )</td>
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<tr>
<td>Liver problems</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
Is there any additional personal or family medical history? ( ) Yes ( ) No  If yes, please explain

______________________________________________________________________________________
__________________________________________________________________________________________

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

Past Psychiatric History
Outpatient treatment  ( ) Yes  ( ) No  If yes, Please describe when, by whom, and nature of treatment.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Dates treated</th>
<th>By whom</th>
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</table>

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

<table>
<thead>
<tr>
<th>Reason</th>
<th>Date Hospitalized</th>
<th>Where</th>
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Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can’t remember all the details, just write in what you do remember).

<table>
<thead>
<tr>
<th>Antidepressants</th>
<th>Dates</th>
<th>Dosage</th>
<th>Response/Side-Effects</th>
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</thead>
<tbody>
<tr>
<td>Prozac (fluoxetine)</td>
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<tr>
<td>Zoloft (sertraline)</td>
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<tr>
<td>Luvox (fluvoxamine)</td>
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<tr>
<td>Paxil (paroxetine)</td>
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<tr>
<td>Celexa (citalopram)</td>
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<tr>
<td>Lexapro (escitalopram)</td>
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<tr>
<td>Effexor (venlafaxine)</td>
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<tr>
<td>Cymbalta ( duloxetine)</td>
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<tr>
<td>Wellbutrin (bupropion)</td>
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<tr>
<td>Remeron (mirtazapine)</td>
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<tr>
<td>Serzone ( nefazodone)</td>
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<tr>
<td>Anafranil (clomipramine)</td>
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<tr>
<td>Pamelor (nortrpyline)</td>
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<tr>
<td>Tofranil (imipramine)</td>
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<tr>
<td>Elavil (amitriptyline)</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Mood Stabilizers

<table>
<thead>
<tr>
<th>Mood Stabilizers</th>
<th>Dates</th>
<th>Dosage</th>
<th>Response/Side-Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tegretol (carbamazepine)</td>
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<td></td>
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<tr>
<td>Lithium</td>
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<tr>
<td>Depakote (valproate)</td>
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<tr>
<td>Lamictal (lamotrigine)</td>
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<tr>
<td>Tegretol (carbamazepine)</td>
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<tr>
<td>Topamax (topiramate)</td>
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<td>Other</td>
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</tbody>
</table>
Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers

Seroquel (quetiapine)
Zyprexa (olanzepine)
Geodon (ziprasidone)
Abilify (aripiprazole)
Clozaril (clozapine)
Haldol (haloperidol)
Prolixin (fluphenazine)
Other

Sedative/Hypnotics

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

ADHD medications

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

Antianxiety medications

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

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? ____________________________________

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 what problems? ______________________________________

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated and what medications and how effective was the treatment? __________________________
Substance Use:
Have you ever been treated for alcohol or drug 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 most 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 drug 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 abused prescription medication? (  ) Yes (  ) No
If yes, which ones and for how long________________________________________
____________________________________________________________________
Check if you have ever tried the following: Yes No If yes, how long and when did you last use?
Methamphetamine (  ) (  ) ____________________________________________
Cocaine (  ) (  ) ____________________________________________________
Stimulants (pills) (  ) (  ) ____________________________________________
Heroin (  ) (  ) _____________________________________________________
LSD or Hallucinogens (  ) (  ) __________________________________________
Marijuana (  ) (  ) __________________________________________________
Pain killers (not as prescribed) (  ) (  ) _________________________________
Methadone (  ) (  ) __________________________________________________
Tranquilizer/sleeping pills (  ) (  ) ________________________________________
Alcohol (  ) (  ) _____________________________________________________
Ecstasy (  ) (  ) _____________________________________________________
Other _____________________________________________________________
How many caffeinated beverages do you drink a day? Coffee _______ Sodas ________ Tea ________

Tobacco History
How you ever 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? ______ What often per day on average? ______ How many years? ______
Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No  Where did you grow up? ___________________________________________
List your siblings and their ages: ______________________________________________________________________

What was your father’s occupation? _________________________________________________________________
What 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? _______________________________________________________
Describe your father and your relationship with him: _____________________________________________________
_______________________________________________________________________________________________
Describe your mother and your relationship with her: _____________________________________________________
_______________________________________________________________________________________________
How old were you when you left home? ________________________________________________________________
Has anyone in your immediate family died? ______________________________________________________________
Who and when? _____________________________________________________________________________________

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:
Did you attend college? _______ Where? ________________________Major? ________________________
What is your highest educational level or degree attained? ________________________________________________

Occupational History:
Are you currently: ( ) Working   ( ) Not working by choice ( ) 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? ______________________________
Honorable discharge ( ) Yes ( ) No  Other type discharge ______________________________________________

Relationship History and Current Family:
Are you currently: ( ) Married ( ) 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
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 so, how many? __________________________
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: Have you ever been arrested? ______ Do you have any pending legal problems? _______________

Spiritual life
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____________________________
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like Dr. Melvin to know?
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Signature_________________________________________ Date_____________________________

Emergency Contact ____________________________________ Telephone # _______________________

Reviewed by ________________________________________ Date ____________________________