Outpatient Psychiatry Intake Form

Date:
Name:
DOB:

Please let me know more about why you are coming in. What symptoms have you been experiencing?

If not noted above, how has your mood been?_____

Please check all that apply with respect to your mood in the past 2 weeks:

___Depressed ___Anxious ___Irritable ____Elevated ___Labile/subject to change quickly

___Normal ____Happy ____Numb

Please describe any symptoms of anxiety you have been experiencing._____

_____

How many hours do you sleep per night?_____

With respect to your sleep, please check all that apply.

____Trouble falling asleep ____Waking up in the middle of the night

____Waking up earlier than you would like in the morning

____Sleeping too much

____Not needing much sleep/getting less sleep than usual but not feeling tired

____Do you snore?

How has your appetite been? _____

Have you had any changes in weight?_____

Have there been any recent stressors: _____

_____

_____

Please check off all that apply:

____Decreased/Increased Energy	____Not enjoying much	____Excessive Guilt
____Self-Critical	____Hopeless	____Withdrawn/Isolated
____Difficulty w/ Decisions	____Poor Concentration	____Anxious
____Impulsive/Risky Behavior	____Increased Productivity	____Racing Thoughts

Past Psychiatric Hx:

Current/Recent Clinicians:_____

When did you first seek treatment or start on medications, and what symptoms were you experiencing at the time?

Have you ever had any of the following? (Check all that apply)
___Depression ____Social Anxiety ___A lot of worry/anxiety ____Panic attacks ____OCD

___Mania or hypomania ____Diagnosis of bipolar disorder ____Eating disorder

Past Inpt Psych Admissions: ___Yes ___No # of Adm: _____ Date Last Admit:_____
Details of past psych admissions:_____
_____

Past suicide attempts: ___ Yes ____No Number of attempts: _____
Details of suicide attempts:_____
_____

Hx of Self Injurious Behavior (e.g., cutting or burning) ___ Yes ____No
Details:_____

Hx of violence/aggressive behavior: ___ Yes ____No
Details:_____

Past Psych Meds: Please indicate which medications you have had in the past and note whether the medication helped or not and whether you had any side effects

___**No prior antidepressant treatment**
___Prozac_____
___Paxil_____
___Zoloft_____
___Luvox_____
___Celexa_____
___Lexapro_____
___Effexor_____
___Pristiq_____
___Cymbalta_____
___Fetzima_____
___Wellbutrin_____
___Remeron_____
___Viibryd_____

___Trintellix/Brintellix_____
___Serzone_____
___Thyroid Hormone Augmentation _____
___Tricyclic Antidepressants _____
___MAO Inhibitors_____
___Deplin/l-methylfolate_____
___ECT/Electroconvulsive Therapy_____
___TMS/Transcranial Magnetic Stimulation_____
___Ketamine_____
___Vagal Nerve Stimulator_____
___Deep Brain Stimulator_____
___Fisher Wallace Stimulator_____
___Light Therapy_____
___Other Depression Treatment_____

___**No Prior Anxiety Treatment**
___Klonopin_____
___Ativan_____
___Xanax_____
___Valium_____
___Buspar_____
___Beta Blocker (for anxiety)_____
___Other anxiolytic _____

___**No Prior Sleep Medication**
___Trazodone_____ ___Ambien_____
___Lunesta_____ ___Sonata_____
___Rozerem_____ ___Melatonin_____
___Belsomra_____ ___Silenor_____
___Restoril (temazepam)_____
___Other hypnotic_____

___**No Prior Mood Stabilizer Treatment**
___Lithium_____
___Depakote_____
___Tegretol_____
___Trileptal_____
___Lamictal_____
___Topamax_____
___Other mood stabilizer_____

___**No Prior Antipsychotic Treatment**
___Haldol_____
___Risperdal_____
___Clozaril_____
___Geodon_____
___Zyprexa_____
___Abilify_____
___Seroquel_____

___Saphris_____
___Latuda_____
___Invega_____
___Vraylar_____
___Rexulti_____
___Fanapt_____
___Other antipsychotics_____
___Cogentin_____
___Beta Blocker (for akathisia)_____

___No Prior Stimulant Treatment
___Ritalin_____
___Dextroamphetamine_____
___Adderall_____
___Vyvanse_____
___Strattera_____
___Provigil or Nuvigil_____
___Other ADHD med_____
___Other psych meds not listed _____

Past Medical Hx:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you had any of the following:
___ Hypertension ___ Diabetes ___High cholesterol ___Heart attack/hardening of the arteries
____Congestive heart failure ___Arrhythmia ___Seasonal Allergies ___Asthma ___Seizure
___ Stroke ___History of head injury/Concussion ___Thyroid Dysfunction ___HIV ___ Hepatitis
____Cancer (if so specify)_____

Surgeries:
_____ _____
_____ _____

Allergies: _____

_____

_____

Medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Females:

Last menstrual period:_____ Are your periods regular?_____
Sexually Active:_____ Birth Control:_____
Pregnancies_____
Deliveries_____

Primary Care Physician (name and contact info): _____

Substance Abuse Hx:

____Tobacco:_____
___History of heavy alcohol use ___History of Illicit Drug Use __History of prescription drug Abuse

How much alcohol do you drink and how often do you drink? _____
_____

Have you ever had any of the following?
____Blackouts ____ Symptoms of alcohol withdrawal ✓__DUI's
____Cocaine/Crystal Meth: _____
____Marijuana:_____
____Heroin:_____
____LSD, mushrooms, ecstasy:_____
____Taking prescription medications for recreational purposes or taking more than you were supposed to.
____Other: _____
# of Detoxes_____ In AA/NA____ Has Sponsor_____ Longest Sobriety_____

Family History:

____ Depression: _____
____ Bipolar: _____
____Schizophrenia/Psychosis:_____
____Anxiety:_____
____Attempted or Completed Suicide: _____
____Attention Deficit Disorder/ADHD_____
____Substance Abuse:_____
____Unspecified Mental Illness: _____
____Other:_____

Social History:

Born and raised in: _____

Raised by: ___ Both parents ___Mother ___Father ___Other_____

Age Parents Divorced/Separated (if applicable)_____

Siblings:_____

Description of Mother:_____

_____

Description of Father:_____

_____

Other pertinent information about family of origin**:**_____

_____

_____

Hx of Trauma:

Education:

Highest grade: ___Some HS ___Grad HS ___GED ___Some College ___Bachelor's in_____

____ Graduate School:_____

Details of education hx:_____

_____

Employment:

Current Employment: _____

_____

Past Employment Hx:

Current living situations: _✔_Alone _✔_w/ spouse _✔_w/ spouse and kids _✔_w/ significant other _✔_w/ friend(s)/roommate(s) _✔_parent(s) ✔_other_____

Marital Status/Relationships (Past and Current):

Children and Step Children (Names and Ages):_____

_____

Legal Problems: _____

_____

_____