Regional Psychiatry
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# Adult Intake Form

***DEMOGRAPHICS**

Name _____ _____
_____
Last First Middle

Date of Birth _____ Age _____ Sex _____ Birthplace
_____

Home Address _____ _____ _____
_____
Street City State Zip

Mailing Address_____ _____ _____
_____ (If Different) Street
City State Zip

Phone / (Self / Emergency Contact) Phone / (Self / Emergency Contact) Type of Phone
Okay to leave message?
(Home / Work / Cell) (Non-Emergencies /
Routine)

_____ ⏮ Yes ⏮ No

_____ ⏮ Yes ⏮ No

_____ ⏮ Yes ⏮ No

_____ ⏮ Yes ⏮ No

_____
Email address (for emergencies only)

Please note, due to privacy, we do not use email routinely but under emergent circumstances may need to send you a "we cannot reach you by phone, please call our office" message if a scheduling issue comes up or you elect to receive reminders.

Please select how you would like to receive appointment reminders. You may choose multiple options:
Text ⏮ _____ Email ⏮ _____ Phone Call ⏮ _____

Please note, automated reminders are provided as a courtesy. Missed appointments are under 24 hour cancellations will incur a cancellation / no-show fee.

Who Referred You to Us? _____

Briefly, what is the primary reason for consultation / evaluation?

_____
__

## PAST PSYCHIATRIC HISTORY

### HOSPITALIZATIONS FOR PSYCHIATRIC REASONS (if applicable)

⏮ **None** Please list all hospitalizations you have had, dates, where and what for:

### COUNSELING OR THERAPY SERVICES (if applicable)

⏮ **None** Please indicate any current or past counseling or therapy sessions you have had, and if so, with whom, when, for how long, and what for? Are you happy with the treatment?

### PAST PSYCHIATRIC MEDICATIONS (if applicable)

⏮ **None** **Please list any psychiatric medications you have taken**

Name Dose (if known) What for ? Effective? Side effects?

Please indicate any other mental health treatment outside the usual scope of usual 'medical' practice (holistic treatments, church counseling, alternative treatments, dietary treatments etc.) ⏮ **None**

Have you been physically, sexually, or verbally abused? ⏮ **Yes** ⏮ **No** ⏮ **Prefer to discuss in person** Details (if applicable)

_____

Have you ever attempted suicide or are spending time thinking about it? ⏮ **Yes** ⏮ **No** ⏮ **Prefer to discuss in person** Details (if applicable)

_____

Have you ever engaged in cutting or other self-injurious behaviors? ⏮ **Yes** ⏮ **No** ⏮ **Prefer to discuss in person** Details (if applicable) _____

Have you ever had hallucinations ⏮ **Yes** ⏮ **No** ⏮ **Prefer to discuss in person**
(hearing voices that others do not or seeing things that other people do not)
Details (if applicable)

_____

## MEDICAL INFORMATION

Please list allergies_____ ⏮ No Known Allergies

Primary Care Physician _____City/ State_____

Please list all medical problems (including history of seizure, loss of conscious, or head trauma), medical hospitalizations and surgeries:

Please list your current medications:
Name Dose How many times a day What for ? Side effects?

## SOCIAL HISTORY

You are: ⏮ Partnered/Married ⏮ Single ⏮ Separated ⏮ Divorced ⏮ Widowed

How far did you go in school? (degree)
_____

Current occupation:_____

## FAMILY MENTAL HEALTH HISTORY ⏮ No known

Has anyone in your immediate or extended family ever been diagnosed with a psychiatric illness, had a psychiatric hospitalization, suicide attempt, or struggled with issues around drugs or alcohol? Please provide information on psychiatric medications taken if known. (Examples of conditions are depression, anxiety, PTSD, ADHD, autism, OCD, schizophrenia, bipolar, alcohol or other substance dependence.) Please indicate relation, condition, treatments and medications taken if known:

## Substance Use

**Smoking**: Current packs per day _____ Former Smoker last smoked _____(mo/yrs) ⏮ Nonsmoker

**Alcohol**: Current drinks a week _____ Choice and size of drink ____ Occasional ⏮ Do not drink

Have you ever tried to cut back? ⏮ Yes ⏮ No
Have you ever felt annoyed at someone for commenting on your drinking? ⏮ Yes ⏮ No
Do you feel guilty about anything you have done while drinking? ⏮ Yes ⏮ No

Do you ever have to have a drink to get you "going in the morning" ⏮ Yes ⏮ No

**Caffeine**: Current caffeinated beverages a day _____What type? _____ ⏮ No caffeine

**Other substances**_____

⏮ **Yes** ⏮ **No** ⏮ **Prefer to discuss in person**

Are there any other considerations not addressed in this intake form or specifically highlight that you want to talk about during our consultation? If so, please write them down.

**Psychiatric Review of Systems**

1. Have you had periods of feeling sad, despondent or hopeless? ⏮ Yes ⏮ No
2. Have you noticed a change in your interest in things you normally enjoy? ⏮ Yes ⏮ No
3. Have you been feeling down on yourself? Guilty about anything? ⏮ Yes ⏮ No
4. Have you tended to feel more tired than usual? As if all your energy is drained? ⏮ Yes ⏮ No
5. Have you had trouble concentrating? Making decisions? ⏮ Yes ⏮ No
6. Have you had any changes in your appetite? Lost or gained weight? ⏮ Yes ⏮ No
7. Have you felt restless or agitated? Have you been feeling slowed down? ⏮ Yes ⏮ No
8. Have you had trouble sleeping? ⏮ Yes ⏮ No

9. Have you ever felt that life isn't worth living? Thought about taking your own life? ⏮ Yes ⏮ No

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1. Have you ever experienced a sudden attack of panic or fear? ⏮ Yes ⏮ No
2. Did you feel as if you were going to die or go crazy? ⏮ Yes ⏮ No
3. Ever been afraid of going outside, so that you tended to stay home all the time? ⏮ Yes ⏮ No
4. Are you ever bothered by persistent ideas that you can't get out of your head, such as being dirty or contaminated? ⏮ Yes ⏮ No
5. Is there anything you have to do over and over, such as washing your hands or checking the stove? ⏮ Yes ⏮ No

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1. Have you ever felt extremely good or high, clearly different from your normal self? ⏮ Yes ⏮ No
2. Have you felt your thoughts are racing through your mind? ⏮ Yes ⏮ No
3. Did you need less sleep than usual to feel rested? ⏮ Yes ⏮ No
4. Have you done anything that caused trouble for you or your family/friends? ⏮ Yes ⏮ No
5. Have you had periods of excessive involvement in pleasurable activities? ⏮ Yes ⏮ No
6. Did people say you talked too fast or excessively? ⏮ Yes ⏮ No

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1. Are you a moody person? ⏮ Yes ⏮ No
2. Do you often feel empty inside? ⏮ Yes ⏮ No
3. When something goes really wrong in your life, like getting rejected, do you ever do something to hurt yourself, like cutting yourself or overdosing? ⏮ Yes ⏮ No
When you're under stress, do you feel like you lose touch with your environment or with yourself? ⏮ Yes ⏮ No
4. During those times, do you feel like people are ganging up against you? ⏮ Yes ⏮ No
5. When someone abandons you or rejects you, do you feel terrified? ⏮ Yes ⏮ No
6. Do you ever get really impulsive and do crazy things, like going on spending sprees, having a lot of sex, driving like a maniac and so forth? ⏮ Yes ⏮ No
7. Do your relationships tend to be stormy with lots of ups and downs? ⏮ Yes ⏮ No
8. Do you make yourself sick (induce vomiting) because you feel uncomfortably full from eating? ⏮ Yes ⏮ No
9. Do you worry that you have lost control over how much you eat? ⏮ Yes ⏮ No
10. Have you recently lost more than 15lbs in a three-month period? ⏮ Yes ⏮ No
11. Do you think you are too Fat, even though others say you are too thin? ⏮ Yes ⏮ No
12. Would you say that Food dominates your life? ⏮ Yes ⏮ No

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1. Have you felt that people are against you? Trying to harm you in any way? ⏮ Yes ⏮ No

2. Do you have any special powers, talents or abilities? ⏮ Yes ⏮ No

3. Have you heard your own thoughts out loud, as if they were a voice outside your head? ⏮ Yes ⏮ No

4. Have you felt that your thoughts were broadcast so that other people could hear them? ⏮ Yes ⏮ No

**Medical Review of Systems:**

Please check if you have recently had any of the following:

| | |
|---|---|
| Fatigue? | ⏮ No ⏮ Yes: |
| Changes to vision? | ⏮ No ⏮ Yes: |
| Changes to hearing? | ⏮ No ⏮ Yes: |
| Palpitations/Chest Pain/Dizziness? | ⏮ No ⏮ Yes: |
| Shortness of breath? | ⏮ No ⏮ Yes: |
| Nausea or vomiting? | ⏮ No ⏮ Yes: |
| Frequent urination? | ⏮ No ⏮ Yes: |
| Muscle or joint pain? | ⏮ No ⏮ Yes: |
| Rashes? | ⏮ No ⏮ Yes: |
| Dry mouth? | ⏮ No ⏮ Yes: |
| Headaches? | ⏮ No ⏮ Yes: |
| Numbness/Tingling/Weakness? | ⏮ No ⏮ Yes: |
| Increased or decreased sweating? | ⏮ No ⏮ Yes: |
| Easy bruising or bleeding? | ⏮ No ⏮ Yes: |