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Intake Form

Name: ____Date of Birth: _____________

For what problems are you seeking consultation today?
____

What would you like to get out of this visit?

____
Whose idea was it for you to be seeking help?
____

If someone other than you, are you okay with this idea? ________________________________

Psychiatric History:

Have you ever seen a therapist or psychiatrist in the past?
If yes,
Whom?____

When? ____

Why? ____

Was it helpful? ____

Are you or have you ever been on psychiatric medications?
If yes,
What? ____

When? ____

Why? ____
Was it helpful? ____

Name(s) of the Prescribing psychiatrist?
____

Have you ever been psychiatrically hospitalized?
____

If yes,

When? ____

Where? ____

Why? ____

Was it helpful?
____

Family History:
Who do you live with? Ages and relationships to you:

____
__

Indicate if any family members or relatives have any of the followings: Please indicate whom:

___ADD/ADHD:
___Alcohol/Drug abuse:
___Depression:
___Anxiety/OCD/Phobias, etc:
___Eating disorders:
___Suicide:
___Serious illness:
___Physical handicaps:
___Abuse victim:
___Abusive to others:
___Aggressive behaviors:

Additional comments:
____
_

Medical History:
Do you have or have you ever had any significant medical problems or been hospitalized, including past surgeries?
____

If yes, please list:
Are you currently in treatment for any medical condition?
____

Are you currently taking any medications, including herbal and over the counter medicines?
If yes, please list: ____

Do you have allergies to any type of food or medications?
____

Name of primary care physician and any specialty physician, you are currently under their care:
____

Are you currently working with any other health professional, such as nutritionist, acupuncturist, etc? ____

If yes, please indicate name(s) and phone number(s):
____

Alcohol and Drug Use:

Do you use alcohol?
____

If yes, how much and how often:
____

____

Do you use recreational drugs?
If yes, what kind, how much and how often:
____

Do you feel you have or have had a problem with use of alcohol or drugs?
If yes, explain:

____
Indicate any previous treatment for alcohol or drug use:
____

Have you had any history of DUI?
____
If yes, when? ____

Please check items below that apply to your current condition:

Please note specifics as indicated:

___Headaches:
___Dizziness:
___Stomach/bowel problems:
___Pain:
___Tremors/Tics:
___Sleep Problems:
    ___Falling sleep:
    ___Staying sleep:
    ___Sleeping too much: average number of hours:
    ___Sleeping too little: average number of hours:
___Weight loss:
___Weight gain:
___Loss of appetite:
___Eat little to lose weight:
___Vomit food intentionally:
___Binge and/or overeat:
___Low energy:
___Feelings of worthlessness:
___Feeling apart from others:
___Memory Problems:
___Concentration Problems:
___Feeling depressed:
___Self injury
___Thoughts of suicide:
___Planning suicide:
___Crying a lot:
___Unable to have a good time:
___Anxiety:
___Fears:
___Always worried:
___Nightmares:
___Panic attacks:
___Recurring unwanted thoughts and behaviors:
___Restlessness:
___Decreased need for sleep:
___Mood swings:
___Excess energy&/or feeling wired:
___Confusion:
___Elated/euphoric mood:
___Excessive spending:
___Racing/overflow of thoughts
___Irritable:
___Impulsive behaviors:
___Grandiose thoughts/plans:
___Anger/explosiveness:
___Hear voices other do not hear:
___See things other do not see:
___Strange experiences:
___Feel people plot against me:

___Constant suspiciousness/distrust
___Usual thoughts:
___Someone physically harming you:
___Thoughts of physically harming another person:
___Violent/aggressive behaviors:
___Physical abuse:
___Sexual abuse:
___Relationship problems:
___Financial problems:
___Conflicts in family:

Additional Comments:
____

____