Camellia Place
HEALTHCARE SERVICES

Date _____

PSYCHIATRIC INTAKE / ASSESSMENT FORM

Client Name _____ DOB _____

Presenting Problem / Recent Psychiatric History & Diagnoses / <u>Reason for being seen</u>:

_____

_____

_____

_____

Referral Source / Current Prescribers / Providers, Therapists / Community Agencies & Resources:

_____

_____

_____

SOCIAL HISTORY (Please provide information about your Marital Status, Work, Hobbies & Children (if applicable)

_____

_____

_____

PAST PSYCHIATRIC HISTORY:

Outpatient Care / Admissions & Approximate Dates:

Dates	Facility / Provider	Reason / Circumstances
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized / Had an <u>INPATIENT</u> psychiatric stay: ☐ YES ☐ NO

Dates	Facility	Reason / Circumstances
_____	_____	_____
_____	_____	_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ANY ALLERGIES? _____

MEDICATION ALLERGIES? _____

CURRENT MEDICATIONS & DOSES:

_____ _____

_____ _____

_____ _____

_____ _____

PRIOR MEDICATION TRIALS (Drug name) **(**Reason for Stopping **)**

_____ _____

_____ _____

_____ _____

_____ _____

Do You have a history of suicidal thoughts? ☐ YES ☐ NO

PRIOR SUICIDE ATTEMPTS

Dates Reason / Circumstances

_____ _____

_____ _____

_____ _____

I have had a prior history of (circle appropriate) Fire Setting Hurting Animals Property Destruction

Bed-wetting (beyond childhood)

FAMILY HISTORY OF MENTAL ILLNESS: (Including diagnosis, History of Suicide or Substance Abuse)

Relationship to Me Details / Circumstances

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MORE ABOUT MY CHILDHOOD, ADULTHOOD & SUPPORTS:

Born & grew up Where? _____

Siblings if any? Involved/ Supportive?

_____ _____

_____ _____

Parents: **Mother** Alive / Deceased? Supportive Y N **Father** Alive / Deceased? Supportive Y N

School - Highest level completed _____

On Disability? Y N _____

Any current legal problems ? Y N _____

Prior legal issues

Dates Details / Circumstances

_____ _____

_____ _____

ANY PRIOR HISTORY OF TRAUMA? Y N

*****If preferred, Rather than completing this section, We can discuss during the visit**

Circle applicable: **Physical** **Emotional** **Sexual**

	Details / Circumstances
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you had Flashbacks Y N **Persistent Nightmares** Y N

SUBSTANCE ABUSE HISTORY:

Do you smoke cigarettes ? Y N How much? _____

Any Smokeless Tobacco Products? Y N How often? _____

Age of 1st use / How many years have you smoked for? _____ _____

Are you interested in quitting? Y N

Have you ever had medication support to quit smoking? Y N What meds have you tried? _____

Do you have a Medical Marijuana Card? Y N

SUBSTANCE(s)	Circle if applies (C)**Current**? (F) **Former**?	Details of Use
_____	C F	_____
_____	C F	_____
_____	C F	_____
_____	C F	_____
_____	C F	_____

Provider Will Complete:

AIMS (Abnormal Involuntary Movement Scale - TD)
Mental Status Exam
Appetite / Nutritional Screen
ROS
Sleep
Unipol /Bipol (mani, hypomani)
Hallucinations, Delusions, PHQ9

☐ Scripts? Refills - Pharmacy