Psychiatric Evaluation Intake Form

1. Patient Contact Information Date _____

Patient Name _____ Address _____

Best contact phone number _____ Email address _____

Emergency contact _____ Relationship _____ Phone No _____

Primary Care Physician _____Tel _____Fax_____

Pharmacy _____ Phone No _____

2. Date of Birth ☐☐/☐☐/☐☐☐☐ **M O DAY Y E A R** **3. Age** ☐☐ **Years Old**

4. Race/Ethnicity (Check one or more):

☐ American Indian/Alaskan Native ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other_____

5. Current marital status (Check one):

☐ Married, living together ☐ Married, not living together ☐ Separated ☐ Widowed ☐ Divorced

☐ Single, never married ☐ Cohabiting with partner

6. If you are married or cohabitating with partner, how long has this been? ☐☐ **Years** ☐☐ **Months**

7. Total number of marriages? _____ **How many children do you have? _____**

8. Spouse's/Partner's Name_____

9. Who else lives with you? _____

10. How many years of formal education have you completed? ☐☐ **Years**

11. Highest degree obtained: (Check only one)

☐ High school graduate ☐ G.E.D. ☐ 4-year college degree ☐ M.B.A./M.A./M.S./M.P.H. ☐ M.D.

☐ J.D. ☐ Ph.D ☐ Other_____

12. What best describes your current employment status? (Check one from each category A, B and C)

A. Employment Status

☐ Unemployed, not looking for employment

☐ Unemployed, looking for employment

☐ Full-time employed ☐ Part-time employed

☐ Retired ☐ Self-employed

☐ On welfare ☐ Social security disability

B. Student Status

☐ Part-time

☐ Full-time

☐ Not a student

C. Volunteer Status

☐ Volunteer Part-time

☐ Volunteer Full-time

☐ No Volunteer Work

14. What is your current occupation? _____

15. Current Residence

☐ Own house/condo ☐ Retirement Complex/Senior Housing ☐ Renting ☐ Apartment /Condominium

16. What is your spouse's occupation? _____

Are you currently seeing a therapist? (Name/contact #)_____

Have you ever seen a psychiatrist/psychotherapist before? If yes, please list:_____

Previous history: Have you ever been treated for any of the following (check all that apply):

_____Depression _____ADHD _____Bipolar (Manic/Depressive) Disorder
_____OCD _____Schizophrenia _____Panic Attacks _____Anxiety
_____Drug Problems _____Anorexia/Bulimia _____Binge-eating
_____Alcohol Problems (including AA) _____PTSD (Post Traumatic Stress Discorder) _____ECT treatment

Please list in chronological order all prior psychiatric hospitalizations (if any) below: None

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below: Never

Approximate date of attempt	How did you attempt (method)?

Please List *all* current medications below (include birth control pills, over the counter medication and herbal remedies – i.e. decongestants, St. John's Wort, etc.)

Name of Medication	Dosage(Mg)	How many times a day?	On this for how long?	Side effects (if any)	Prescribing physician

Please review the following list of medications. If you have taken any of these medications in the last **48 months**, please complete the appropriate boxes

Brand Name	Generic Name	✓ if yes	How long did you take it?	What dosage did you take? Mg/d	Did it help? ✓ if yes	How often In a day? Indicate 1, 2, or 3 times per day	Any side effects
Selective Serotonin Reuptake Inhibitors (SSRIs)							
Luvox	Fluvoxamine						
Paxil	Paroxetine						
Paxil CR	Paroxetine						
Celexa	Citalopram						
Lexapro	Escitalopram						
Zoloft	Sertaline						
Prozac	Fluoxetine						
Serotonin - Norepinephrine Reuptake Inhibitors (SNRIs)							
Effexor	Venlafaxine						
EffexorXR	Venlafaxine						
Pristiq	Desvenlafaxin						
Cymbalta	Duloxetine						
Other Antidepressants							
Desyrel	Trazadone						
Serzone	Nefazodine						
Wellbutrin XL/SR	Bupropion XL/SR						
Remeron	Mirtazapine						
Serzone	nefazodone						
Tricyclic Antidepressants							
Adapin	Doxepin						
Anafranil	Clomipramine						
Asendin	Amoxapine						
Elavil	Amitriptyline						
Ludiomil	Maprotiline						
Norpramin	Desipramine						
Pamelor	Nortriptyline						
Sinequan	Doxepin						
Surmontil	Trimipramine						
Tofranil	Imipramine						
Vivactil	Protriptyline						
Other Psychotropics (Have you taken any of these?) *Please circle those you have taken...*							
Abilify	Buprenorphin	Dexedrine	Ambien	Klonopin	Emsam	Provigil	Thorazine
Risperidal	Campral	A dderall	Buspar	Ativan	Nardil	Depakote	Dalmane
Invega	Antabuse	Vyvanse	Restoril	Xanax	Parnate	Lithium	Orap
Geodon	Suboxone	Strattera	Sonata	hydroxyzine	Halcion	Lamictal	Navane
Zyprexa	Naltrexone	Concerta	Buspar	Valium	Niravam	Phentermine	Trilafon
Seroquel	Ambien CR	Dexedrine	Halcion	vistaril	Tranxene	Tegretol	Mobane
Symbyax	Valproic Acid	Focalin	Atarax	Methadone	Cylert	Topamax	Stelazine
Clozapine	Adderall XR	Ritalin	Librium	Synthoid		Mellaril	Haldol
Rozerem	Metadate	Daytrana	Lunesta	Meridia		Loxitane	Prolixin

Family History: Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate indicate paternal or maternal)

	Father	Mother	Brother	Sister	Aunt	Uncle	Children	Grandparent
ADHD								
Alcohol Problems								
Anxiety								
Bi-polar/Manic Depression								
CHI/TBI - Brain Injury								
Depression								
Drug Problems								
Panic Attacks								
Post Traumatic Stress (PTSD)								
Psychiatric Facility Stay								
Schizophrenia								
Suicide Ideation								

Medical History: *(please check all that apply to you)*

	Mark ✔		Mark ✔		Mark ✔
High Blood Pressure		Gastrointestinal Problems (ulcers, pancreatits, irritable bowel, colitis)		Viral Illness (herpes, Epstein-Barr, chronic hepatitis)	
Lung Disease		Arthritis or Rheumatoid Problems		Cancer	
Diabetes		Liver Damage or Hepatitis		Genital Problems	
Heart Disease		Other Endocrine/Hormone Problems		Eating Disorder	
Thyroid Disease		Neurological Problems (stroke, brain tumor, nerve damage)		Eye Problems	
Anemia		Gynecological / hysterectomy		Chronic pain	
Asthma		Urinary Tract or Kidney Problems		Fibromyalgia	
Skin Disease		Migraine or Cluster Headaches		HIV Positive or AIDS	
Seizures		Ear/Nose/Throat Problems		Head Injury	
Other (print below) _____		High Cholesterol		Sleep apnea	

Regarding alcohol, when was your last drink?_____

In the past 30 days, about how many of those days have you had at least one alcoholic drink? _____

What is the maximum number of drinks you have had in one day in the past month? _____ drinks

DUI _____ **DWI** _____ **Public Intoxication** _____ **Seizures** _____ **DT's** _____

Please check the appropriate boxes that apply to you for the following substances:

	Never Used	Age first used	Last used approx date	Age peak use	Rx abuse?	Current use and frequency
Amphetamine or Speed						
Anabolic Steroids						
Benzodiazepines (Xanax, Valium, Ativan Restoril, Librium)						
Caffeine (coffee, tea, colas, iced tea)						
Cigarettes, cigars, or tobacco						
Cocaine						
Diet Pills						
Diuretics						
Ecstasy						
GHB						
Hallucinogens (LSD, mushrooms, Mescaline)						
Heroin						
Inhalants						
IV Drug use						
Laxatives						
Marijuana						
Pain Pills						
PCP or Angel Dust						
Sleeping Pills						
Tranquilizers						
Other:						

List all prior surgeries and hospitalizations for medical illness:

_____

_____

Are you allergic to any medication or food? If so, please list below:

_____

Last menstrual period (if applicable) _____ **Contraceptive method:**_____