# CONFIDENTIAL

**PLEASE TURN IN COMPLETED FORM TO FRONT DESK PERSONNEL**

**Patient Name**: _____ **DOB**: _____

**Date**: _____

# ADULT PSYCHIATRIC ASSESSMENT INTAKE

**PRESENTING PROBLEM**—in your own words, summarize in one to two brief sentences.

**PURPOSE OF VISIT**—In your own words, please describe your goals for this assessment in one to two brief sentences.

Please describe any **current stressful event** in your life (home, work, family, social, etc.)

**Please circle any problems that you experience:** (circle all that apply)

| | | | | |
|---|---|---|---|---|
| appetite | sleep disturbance | bladder problems | excessive drinking | pain |
| anger | headaches | difficulty relaxing | sexual difficulties | fainting |
| drug use | nervousness | fatigue | fears/phobias | obsessive thoughts |
| confusion | loneliness | anxiety | impulse control | feelings of unreality |
| nightmares | tense | dizziness | intrusive thoughts | bowel problems |
| flashbacks | allergies | stomach problems | low self-esteem | impulsive behaviors |
| depression | suicidal ideations | heart palpitations | difficulty concentrating | |

**Personal Well-Being**

How is the quality of your sleep? _____

Has this changed from the past? If so, how? _____

How is your level of physical activity? _____

Has this changed from the past? If so, how? _____

How is your diet? _____

Has this changed from the past? If so, how? _____

## PSYCHIATRIC HISTORY

Psychiatric Hospitalizations (dates, locations, and length of time):

Past psychotherapy / counseling (dates, lengths of time, and focus of treatment):

Present occurring psychotherapy / counseling (dates, lengths of time, and focus of treatment):

Any current treatment by a psychiatrist (dates, length of time, and focus of treatment):

Any past treatments by a psychiatrist (dates, length of time, and focus of treatment):

Any current psychiatric medications: (names, dosages, length of time, purpose of medication, results, and side effects)? Please list all medications separately:

Any past psychiatric medications (names, dosages, length of time, purpose of medication, results, and side effects)? Please list all medications separately:

Psychiatric medications were prescribed by: ___Psychiatrist ___Primary Care Provider ___Nurse Practitioner

___Other (specify): _____

## DRUG AND ALCOHOL HISTORY

### Cigarettes/Tobacco

Do you currently smoke or chew? ___YES ___NO If yes: Number of years: ____ Number of packs a day:____

How long has it been since your last cigarette? _____

If you do not smoke or chew, have you in the past? ___YES ___NO

### Caffeine

Do you drink coffee or other caffeinated beverages? ___YES ___NO

Type of beverage: _____

Number of cups of 8oz. servings per day: _____

### Alcohol

Do you drink alcohol currently or have you within the past year? ___YES ___NO

How many times per week? _____ Type of beverage: _____

Average amount consumed each week? _____ How long have you been drinking?_____

If not currently drinking, have you consumed alcohol in the past? ___YES ___NO

Type of beverage: _____ How much and for how long? _____

How long since last use at this level? _____

### Current Illicit Drug History

Do you use drugs or illicit substances currently/past year? ___YES ___NO

Type: _____

How Much/How Often/How Long? _____

### Past Illicit Drug History

Have you used drugs in the past? ___YES ___NO

Type: _____

How Much/How Often/How Long? _____

Do you participate in any programs for remaining clean and sober? ___YES ___NO

If yes, please identify programs: _____

Are you currently involved in a recovery program? ___YES ___NO

If yes, please describe: _____

_____

**Risk Assessment**

Do you have thoughts of harming yourself? ___YES ___NO
Do you have a plan for how you would harm yourself? ___YES ___NO
Have you attempted to harm yourself in the past? ___YES ___NO If yes, how?_____
Have any relatives committed suicide? ___YES ___NO
Do you have thoughts of harming someone else? ___YES ___NO
Have you assaulted or threatened anyone recently? ___YES ___NO
Have you ever been in trouble because of your temper/violence? ___YES ___NO
Does drinking/drugging ever lead you to become violent? ___YES ___NO
Do you own a gun or a lethal weapon? ___YES ___NO
Have you ever considered/planned to harm yourself or others with this gun or other lethal weapon? ___YES ___NO

**MEDICAL HISTORY**

Have you ever had or currently have any of the following? Check all that apply:

| | | | | | |
|---|---|---|---|---|---|
| | Accident Prone | | Frequent Urinary Infections | | Movement Disorder |
| | Allergies | | Gallbladder Problems | | Muscle Soreness |
| | Arthritis | | Head Injury | | Nose Bleeds |
| | Asthma | | Headache | | Orthopedic/Osteo |
| | Back Problems | | Hearing/Ear Problems | | Other Neurological Disorders |
| | Black Outs | | Hemorrhoids | | Ovarian/Prostrate |
| | Blood in Stool | | Hepatitis | | Pneumonia |
| | Broken Bones/Fractures | | Hernia | | Seizures |
| | Cancer | | High Blood Pressure | | Shortness of Breath |
| | Chest Pain/Pressure/Tightening | | High Cholesterol | | Skin Disorders |
| | Depression | | High Triglycerides | | STDs |
| | Diabetes | | Hypertension | | Stroke |
| | Dietary Issues | | Injuries/ Broken Bones | | TB/Lung Disorder |
| | Difficulty Hearing | | Irregular Sleep | | Thyroid Problems |
| | Digestive Problems | | Kidney Problems | | Tics (motor or verbal) |
| | Dizzy Spells/Fainting | | Liver Problems | | Ulcers |
| | Eczema | | Memory Loss | | Vision/Eye Health |

If you have experienced any other physical conditions or difficulties not listed above, please share them in the space provided below:

History of head trauma (please specify):

Past surgeries or hospitalizations (please specify with dates):

**Allergies**

Allergies to medications (please specify):

Allergies (e.g., itchiness or hives) to specific kinds of soaps/laundry detergents/perfumes:

Allergies to food:

**Current Medications and Dosages (please list all names, dosages, lengths of time, purposes of medication, results, and side effects):**

Prescription:

Over-the-Counter:

Herbal:

Type of Birth Control (if applicable):

Name of your Primary Care Physician_____

List any other physicians treating you_____

List any accidents you have had as an adult:

_____

_____

Please give a general history of previous prescription medications you have taken. Understanding that you may not recall each type of antibiotic or its purpose, etc…

_____

_____

Have you worked with any alternative medicine programs such as: acupuncture, herbal, alternative healers? If so, please give an overview of why, the effectiveness of the treatment, and approximate dates.

_____

**Family Background and Childhood History**

Were you adopted ___ YES ___NO Where did you grow up_____

List your siblings and their ages: _____

Did you parents divorce? ___YES ___NO If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

**Trauma History**

Do you have a history of being abused emotionally, sexually, physically, or by neglect? ___YES ___ NO

Please describe when, where, and by whom_____

_____

**Reproductive History (if applicable)**

Are you pregnant? ___YES ___NO Are you breast-feeding? ___YES ___NO

Number of previous pregnancies: ____
Number of previous live births: ____
Number of living children: ____

**Education History**

What is your highest education level or degree attained? _____

**Occupational History**

Are you currently: ___Working ___Not working by choice ___Unemployed ___Disabled ___ Retired

What is/was your occupation? _____

How long have you been in your present position? _____

Have you ever served in the military? _____

**Sex/Gender Identity**

Do you identify as: ___ Male ___ Female ___ Transgender ___ Other: _____

Please list any questions, concerns, or comments you have, if any, about your gender or gender identity (sense of your femaleness/maleness). _____

_____

_____

**Relationship History and Current Family**

Are you currently: ___Married ___Divorced ___Single ___Widowed ___Other: _____

How long? _____

If not married, are you currently in a relationship? ___YES ___NO If yes, how long?_____

Are you sexually active? ___YES ___NO

Do you think of yourself as: ___Straight/heterosexual ___Gay/lesbian/homosexual ___Bisexual ___
Do not know/Questioning ___ Other: _____

Describe your relationship with your spouse or significant other: _____

_____

Do you have children? ___YES ___NO. If yes, list ages and gender_____

_____

List anyone who currently lives with you. _____

**Legal**

Have you ever been arrested? ___YES ___NO

If yes, for what? _____

Do you have any pending legal issues? ___YES ___NO

**Spiritual Life**

Do you belong to a particular religion or spiritual group? ___YES ___NO

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you?

_____

_____

_____

**Cultural**

Languages Spoken: _____

List any cultural values, beliefs, or practices that should be considered in your treatment:

_____

_____

_____

**PHARMACY OF CHOICE** (For e-prescriptions)

Pharmacy Name: _____ Store #: _____

Address: _____

_____

Phone #: _____

**FAMILY HISTORY:**

***IN THE TWO SECTIONS BELOW PLEASE CHECK AS APPLICABLE TO YOUR INDIVIDUAL FAMILY HISTORY***
*Please pay special attention to anyone with symptoms similar to your presenting symptoms*

| | Father | Mother | Father's Father | Father's Mother | Mother's Father | Mother's Mother's | Siblings | Children | Maternal Relatives | Paternal Relatives |
|---|---|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | | | | | | | | | | |
| Epilepsy | | | | | | | | | | |
| Seizures | | | | | | | | | | |
| Cancer | | | | | | | | | | |
| Heart Attack | | | | | | | | | | |
| Stroke | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| Dizzy Spells/Fainting | | | | | | | | | | |
| Movement Disorders | | | | | | | | | | |
| Tics (motor or verbal) | | | | | | | | | | |
| Other Neurological Disorders | | | | | | | | | | |

**Family History of Mental Illness/Alcoholism/Drug Abuse**
*Please pay special attention to anyone with symptoms similar to your presenting symptoms, not necessarily diagnosed*

| | Father | Mother | Father's Father | Father's Mother | Mother's Father | Mother's Mother | Siblings | Children | Maternal Relatives | Paternal Relatives |
|---|---|---|---|---|---|---|---|---|---|---|
| Depression | | | | | | | | | | |
| Bipolar Disorder/Manic Depression | | | | | | | | | | |
| Schizophrenia | | | | | | | | | | |
| ADHD | | | | | | | | | | |
| Concentration Problems | | | | | | | | | | |
| Hyperactivity | | | | | | | | | | |
| Anger Outbursts | | | | | | | | | | |
| Periods of Severe Agitation | | | | | | | | | | |
| Nervous Breakdowns | | | | | | | | | | |
| Anxiety | | | | | | | | | | |
| Panic Attacks | | | | | | | | | | |
| Phobias | | | | | | | | | | |
| Obsessive Thinking/Worrying | | | | | | | | | | |
| Compulsions | | | | | | | | | | |
| Attempted Suicides | | | | | | | | | | |
| Completed Suicides | | | | | | | | | | |
| Alcoholism | | | | | | | | | | |
| Drug Abuse | | | | | | | | | | |
| History of past/present abuse (as abuser) | | | | | | | | | | |
| History of past/present abuse (as victim) | | | | | | | | | | |
| Other Family History (Please Specify) | | | | | | | | | | |