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 don't 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 harming 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:

Past 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 you 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

___ Don't 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)										