Adult Psychiatric Intake Form

GENERAL INFORMATION

Patient Name: _____ Date of Birth: _____

PLEASE DESCRIBE THE REASON FOR VISIT AND/OR CURRENT CONCERNS:

_____

_____

_____

RISK ASSESSMENT

Have you ever attempted suicide? ☐ Yes ☐ No

Have you ever harmed yourself by cutting, burning, etc.? ☐ Yes ☐ No

Have you recently engaged in risk-taking behavior? *(Check all that apply)*

☐ Alcohol/drug use
☐ Unprotected sex
☐ Shoplifting
☐ Reckless driving
☐ Gang involvement
☐ Drug dealing
☐ Trading sex for money, drugs or possessions
☐ Carrying/using a weapon
☐ Other: _____

Do you feel that you live in a safe place? ☐ Yes ☐ No

Are there guns in your home? ☐ Yes ☐ No

If yes, are the guns locked up? ☐ Yes ☐ No

Have you ever witnessed violence in the home? ☐ Yes ☐ No

LEGAL INVOLVEMENT

Have you ever been on probation? ☐ Yes ☐ No

Have you had any other involvement with the legal system? ☐ Yes ☐ No

If yes to any of the above, please explain:

_____

MENTAL HEALTH HISTORY *Please check all current and previous mental health care*

Provide details (location, dates, provider's name, etc.)

☐ Inpatient Hospitalization Details: _____
☐ Partial Hospitalization (PHP) Details: _____
☐ Intensive Outpatient (IOP) Details: _____
☐ Residential Treatment (IRTS) Details: _____
☐ Psychiatric Care Details: _____
☐ Therapy Details: _____
☐ Substance Abuse Treatment Details: _____
☐ Detox Details: _____
☐ Case Management Details: _____

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□ Other: Details: _____

ALL CURRENT *AND* PAST MEDICATIONS TRIED

Antidepressants
□ Prozac (fluoxetine)
□ Zoloft (sertraline)
□ Lexapro (escitalopram)
□ Celexa (citalopram)
□ Luvox (fluvoxamine)
□ Paxil (paroxetine)
□ Wellbutrin (bupropion)
□ Effexor (venlafaxine)
□ Pristiq (desvenlafaxine)
□ Cymbalta (duloxetine)
□ Viibryd (vilazodone)
□ Fetzima (levomilnacipran)
□ Trintellix (vortioxetine)
□ Elavil (amitriptyline)
□ Pamelor (nortriptyline)
□ Tofranil (imipramine)
□ Norpramin (desipramine)
□ Anafranil (clomipramine)
□ Emsam (selegiline)

Anti-Anxiety / Anti-Hypertensives
□ Catapres (clonidine)
□ Kapvay (clonidine ER)
□ Tenex (guanfacine)
□ Intuniv (guanfacine ER)
□ Buspar (buspirone)
□ Vistaril (hydroxyzine pamoate)
□ Atarax (hydroxyzine hcl)
□ Inderal (propranolol)
□ Tenormin (atenolol)

Benzodiazepines
□ Xanax (alprazolam)
□ Ativan (lorazepam)
□ Klonopin (clonazepam)
□ Valium (diazepam)
□ Restoril (temazepam)
□ Librium (chlordiazepoxide)

Stimulants
□ Adderall (dextroamphetamine/amphetamine)
□ Vyvanse (lisdexamfetamine)
□ Dexedrine (dextroamphetamine)
□ Adzenys (amphetamine ODT or liquid)
□ Concerta (methylphenidate ER)
□ Ritalin LA (methylphenidate LA)
□ Metadate (methylphenidate CD)
□ Daytrana (methylphenidate patch)
□ Quillivant (methylphenidate chew or liquid)
□ Focalin (dexmethylphenidate)
□ Strattera (atomoxetine)
□ Provigil (modafinil)
□ Nuvigil (armodafinil)

Mood Stabilizers
□ Lamictal (lamotrigine)
□ Trileptal (oxcarbazepine)
□ Lithobid/Eskalith (lithium)
□ Depakote (valproic acid/divalproex)
□ Tegretol (carbamazepine)
□ Topamax (topiramate)
□ Neurontin (gabapentin)

Antipsychotics / Neuroleptics
□ Risperdal (risperidone)
□ Abilify (aripiprazole)
□ Rexulti (brexpiprazole)
□ Seroquel (quetiapine)
□ Zyprexa (olanzapine)
□ Invega (paliperidone)
□ Latuda (lurasidone)
□ Geodon (ziprasidone)
□ Vraylar (cariprazine)
□ Saphris (asenapine)
□ Haldol (haloperidol)
□ Clozaril (clozapine)
□ Thorazine (chlorpromazine)
□ Fanapt (iloperidone)

Sleep Aids / Sedatives

□ melatonin
□ Unisom (doxylamine)
□ Benadryl (diphenhydramine)
□ Desyrel (trazodone)
□ Remeron (mirtazapine)
□ Ambien (zolpidem)
□ Lunesta (eszopiclone)
□ Sonata (zaleplon)
□ Silenor (doxepin)
□ Rozerem (ramelteon)

FAMILY MENTAL HEALTH HISTORY

□ Suicide attempt Who:_____
□ Death by suicide Who:_____
□ Schizophrenia Who:_____
□ Bipolar disorder Who:_____
□ Depression Who:_____
□ Anxiety Who:_____
□ ADHD Who:_____
□ Autism Spectrum Disorder Who:_____
□ OCD Who:_____
□ Personality Disorder Who: _____
□ Eating Disorder Who: _____
□ Alcoholism Who:_____
□ Drug addiction Who:_____

□ Other: _____

EDUCATION HISTORY

Highest Level of Education Completed:_____

School: _____

Any Academic Difficulties or Learning Disabilities: _____

_____

EMPLOYMENT

What is your employment status? (*Check one*)

□ Employed full-time

□ Employed part-time

□ Not employed and NOT seeking employment

□ Not employed and seeking employment

If employed, what is your occupation?

_____

MEDICAL CONCERNS

Head
- ☐ Concussion
- ☐ Head injury
- ☐ Headaches
- ☐ Migraines
- ☐ Traumatic brain injury
- ☐ Other: _____

Eyes
- ☐ Needs glasses/contacts
- ☐ Eye pain
- ☐ Double vision
- ☐ Decreased vision
- ☐ Other: _____

Ears, Nose, Throat
- ☐ Difficulty hearing
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Difficulty swallowing
- ☐ Pain
- ☐ Other: _____

Cardiovascular
- ☐ Murmur
- ☐ Chest pain
- ☐ Palpitations
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Shortness of breath
- ☐ Difficulty lying flat
- ☐ Swelling ankles
- ☐ Other: _____

Respiratory
- ☐ Cough

Gastrointestinal
- ☐ Heartburn/reflux
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Black or bloody bowel movement
- ☐ Other: _____

Genitourinary
- ☐ Increased urinary frequency
- ☐ Bedwetting
- ☐ Blood in urine
- ☐ Erectile dysfunction
- ☐ Abnormal discharge
- ☐ Bladder leakage
- ☐ Menstrual issues
- ☐ Other: _____

Musculoskeletal
- ☐ Joint pain/swelling
- ☐ Stiffness
- ☐ Muscle pain
- ☐ Back pain
- ☐ Other:_____

Neurological
- ☐ Loss of strength
- ☐ Numbness
- ☐ Headaches
- ☐ Tremors
- ☐ Memory Loss
- ☐ Seizures
- ☐ Tourette's syndrome
- ☐ Other: _____

Skin

Constitutional
- ☐ Weight gain
- ☐ Sleep difficulties
- ☐ Poor appetite
- ☐ Weight loss
- ☐ Fatigue
- ☐ Fever
- ☐ Other: _____

Sensory Concerns
- ☐ Sound/noise
- ☐ Touch/tactile
- ☐ Oral/textures
- ☐ Clothing/tactile
- ☐ Scent/smell
- ☐ Other: _____

Endocrine
- ☐ Unexplained wght loss
- ☐ Unexplained wght gain
- ☐ Hot/cold intolerance
- ☐ Diabetes
- ☐ Thyroid issues
- ☐ Other: _____

□ Pain
□ Shortness of breath
□ Use of inhaler
□ Use of oxygen
□ Other: _____

□ Hair loss
□ Rash/hives
□ Lesions/sores
□ Itching
□ Easy bruising

□ Other: _____

SUBSTANCE USE (PAST AND CURRENT) – PLEASE LIST AMOUNT, FREQUENCY AND PRODUCT

□ Caffeine _____

□ Nicotine/Tobacco _____

□ Alcohol _____

□ Marijuana _____

□ CBD _____

□ Other Drug Use _____

Have you ever been in treatment for substance abuse?

□ Yes

□ No

If yes list dates, location, and completed or not completed:

_____

_____

_____