



Outpatient Adult Psychiatry/Psychology Intake Form

This form must be filled out in its entirety before coming in for an appointment. Failure to do so may result in your appointment being rescheduled.

Note: You are able to enter your answers directly onto this form.

Name of person completing this section (if different than patient) and relationship to patient: [Click here to enter text.](#)

Patient Information

Name: _____ Date of Birth: _____

Age: _____ Social Security Number: _____ Will provide at time of apt

Sex: Male Female

Email: _____

Marital Status: Single Married Divorced Separated Widowed

Address: _____

Home Phone: _____ Cell Phone: _____

Ethnicity: _____

Who were you referred to our clinic by: _____

PCP: _____

Emergency Contact Name _____

Phone _____

Relationship: _____

*****For all New Patients*****

I understand if I cancel my new patient appointment after the 48 hour cancellation policy or no show/miss my appointment my card will be charged the full amount of the appointment. Yes No

Type or initial name or sign: _____

Pharmacy Information

Name of Preferred Pharmacy: _____

Pharmacy Address: _____

Pharmacy Cross Streets: _____ & _____

Pharmacy City: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Patient Name: _____

Please answer the following Questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All the information you provide will be kept confidential.**

What problems are you having which prompted you to come to this clinic? (Be as thorough as possible)

What are your goals/expectations for treatment?

Past Psychiatric Treatment

Have you ever been hospitalized for psychiatric reasons? No Yes

If Yes, when and where? _____

Have you ever had outpatient treatment by a psychiatrist? No Yes

If yes, when and by whom? _____

Which psychiatric medications have you taken in the past and what were the benefits and/or side affects you had from them? None List: _____

Are you taking any psychiatric medications now? No Yes

Current Medication List – Please list all medications prescribed/otc/and supplements

Medication Name	Dose	Frequency

Are you allergic to any medications? No Yes

List medications and allergic reactions: _____

Have you undergone any surgical procedures? No Yes

Please list procedures & dates of surgery: _____

- Does your mind work overtime? No Yes
Do you have unexplained bursts of energy? No Yes
Do you often worry or feel nervous? No Yes
Do you have physical symptoms from anxiety? No Yes
Do you feel isolated? No Yes
Is anyone physically or emotionally abusing you? No Yes
How many hours do you get of sleep per night? 1-3 4-6 7-10
How many meals do you eat per day? 1 2 3 4 +

Do you have problems with chronic physical pain? No Yes

Rate average pain level: 1 2 3 4 5 6 7 8 9 10

Have you ever suffered a severe head injury with loss of consciousness or concussion? No Yes

Describe: _____

What are things that bother you the most – describe.

- | | |
|---|--|
| <input type="checkbox"/> Problems/losses within my family | <input type="checkbox"/> Problems/loses among my friends community |
| <input type="checkbox"/> educational problems | <input type="checkbox"/> Occupational problems |
| <input type="checkbox"/> Housing problems | <input type="checkbox"/> Financial/economic problems |
| <input type="checkbox"/> Can't get adequate health care | <input type="checkbox"/> Problems with law, legal system |
| <input type="checkbox"/> Discipline problems at work | <input type="checkbox"/> Careless, high-risk behavior |
| <input type="checkbox"/> Other – explain _____ | |

Past Medical History:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pace maker implant |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Seizures | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Motor difficulties | <input type="checkbox"/> Serious head injuries | <input type="checkbox"/> Recurring headaches |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Muscle stiffness | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Numbness | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Uncontrolled movements |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Other _____ | | | |

Alcohol drug and tobacco use Check if none

Alcohol current use: date of last use _____

Problems related to use? No Yes

Legal, financial, health, relationship) List: _____

Treatment required? No Yes

Describe: _____

Illicit drug and/or prescription drug abuse (continued on next page)

Substance	Date of last use	Problems related to use	Treatment required
Benzodiazepines (valium, Xanax, Ativan)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Marijuana		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cocaine		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Designer drugs (Club drugs: G,X)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hallucinogens (LSD, Mushrooms)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inhalants (gasoline, glue, aerosol)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Methamphetamines (Speed, ice, Ritalin)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Opiates/Methadone (Vicodin, OxyContin, heroin)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Social History

Where were you born? _____

Where did you grow up? _____

Did your parents stay together while you were growing up? Yes No

How old were you when they separated? _____

Father's occupation while you were growing up: _____

Mother's occupation while you were growing up: _____

Where there any complications at your birth (Premature birth, major medical problems?)

No Yes Describe: _____

Are you/were you a victim of any form of physical/sexual/emotional abuse?

Physical abuse: No Yes Age of occurrence: _____

Sexual abuse: No Yes Age of occurrence: _____

Emotional abuse: No Yes Age of occurrence: _____

Did you graduate from high school? No Yes Last grade attended: _____

What type of jobs have you had in the past? _____

Are you currently employed? No Yes If yes, where: _____

Are you currently involved in a romantic relationship? No Yes

Spouse's/partner's first name: _____

How long have you been together? _____

How would you describe your relationship? _____

What is your spouse's/partner's occupation? _____

Have you been involved in any previous significant intimate/romantic relationships? No Yes

Describe: _____

What are some things you enjoy doing (hobbies, sports, past times)? _____

Have you ever been convicted of any crimes, incarcerated in prison, or placed on probation?

No Yes Describe: _____

Family History

Is there any history of mental illness or substance abuse among your blood relatives?

No Yes

If yes, describe – Father's side: _____

Mother's side: _____

Social Supports

Is there anyone your trust or confide in during times of trouble? No Yes

Name supports: _____

Do you have any religious ties or involvement in a church? No Yes

Describe: _____

Current living situation

Do you live in a: House Apartment Manufactured Home other

Own or Rent

Do you live alone? Yes No If not, who else lives with you: _____

Do you have plans to move in the near future? Yes No Where: _____

Do you have any pets? Yes No List: _____

How many children do you have

_____ Boys _____ Girls

How many siblings do you have

_____ Brothers _____ Sisters

Advanced Directives

Do you have a psychiatric advanced directive? Yes No

Reviewed by: _____

Date: _____

Patient Name: _____