PSYCHIATRIC DIAGNOSTIC INTAKE

Please complete all the information on this form.

Name _____Date _____

Primary Care Provider _____Primary Care Provider Phone _____

Can we contact your primary care provider to discuss your care? Y N

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

Current Symptoms Checklist: (please circle) Depressed Mood, Crying, Unable to Enjoy Activities, Increased Irritability, Sleep Pattern Disturbances, Decrease need for sleep Loss of Interest, Excessive energy, Concentration/forgetfulness Change in appetite, Excessive Guilt, Fatigue, Avoidance, Hallucinations, Excessive worry, Increase risky behavior, Impulsivity, Racing thoughts Decreased libido, Increased libido, Suspiciousness, Anxiety attacks

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No

If YES, please answer the following. If NO, please skip to next section.

Do you currently feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts?

When was the last time you had thoughts of dying?

Has anything happened recently to make you feel this way?

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?

Would anything make it better?

Have you ever thought about how you would kill yourself?

Is the method you would use readily available?

Have you planned a time for this?

Is there anything that would stop you from killing yourself?

Do you feel hopeless and/or worthless?

Have you ever tried to kill or harm yourself before?

Do you have access to guns? If yes, please explain.

Past Medical History: _____

Allergies _____

List ALL current prescription medications and how often you take them: (if none, write none)

_____

_____

_____

Current medical problems:

Past Psychiatric History: Outpatient treatment: ( ) Yes ( ) No If yes, please describe when, by whom, and the nature of the treatment.

Psychiatric Hospitalization: ( ) Yes ( ) No If yes, please describe for what reason, when, and where.

Past Psychiatric Medications: If you have ever taken any of the following medications, please circle:

Antidepressants Prozac (fluoxetine) Zoloft (sertraline) Luvox (fluvoxamine) Paxil (paroxetine) Celexa (citalopram) Lexapro (escitalopram) Effexor (venlafaxine) Pristiq (desvenlafaxine), Fetzima (levomilnacipran), Cymbalta (duloxetine) Wellbutrin (bupropion) Remeron (mirtazapine) Desyrel (trazodone Serzone (nefazadone) Anafranil (clomipramine) Pamelor (nortriptyline) Tofranil (imipramine) Elavil (amitriptyline), Exxua (gepirone) Other:

Mood Stabilizers Lithium Tegretol (carbamazepine) Topamax (topiramate) Depakote (valproate) Lamictal (lamotrigine)

Antipsychotics/Mood Stabilizers Seroquel (quetiapine) Zyprexa (olanzapine) Geodon (ziprasidone) Prolixin (fluphenazine) Risperdal (risperidone) Other: Rozerem (ramelteon)) Abilify (aripiprazole) Clozaril (clozapine) Haldol (haloperidol)

ADHD medications Adderall Adzenys Evekeo Vyvanse Mydayis ProCentra Zenzedi Xelstry (amphetamine) Concerta Ritalin Adhansia Aptensio Daytrana Focalin XR Jornay PM Metadate Quillivant XR (methylphenidate) Strattera (atomoxetine) Auvelity (dextromethorphan/bupropion) Clonidine

Sedative/Hypnotics Ambien (zolpidem) Sonata (zaleplon) Restoril (temazepam) Rozerem (ramelteon) Xanax (alprazolam) Klonopin (clonazepam) Tranxene (clorazepate) Ativan (lorazepam) Valium (diazepam) Buspar (buspirone)

Substance Use History: Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No If yes, for which substances?

If yes, where were you treated and when?

How many days per week do you drink *any* alcohol?

What is the *least* number of drinks you will drink in a day?

What is the *greatest* number of drinks you will drink in a day?

In the past three months, what is the *largest number* of alcoholic drinks you have consumed in one day?

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or dug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No If yes, which ones?

Have you ever abused prescription medication? ( ) Yes ( ) No If yes, which ones and for how long?

Circle if you have ever tried the following: Methamphetamine, Stimulants, LSD or Hallucinogens Cocaine Pain Killers (not as prescribed) Ecstasy Heroine Marijuana Methadone Tranquilizers/sleeping pills Alcohol

If yes, how long and when did you last use it?

How many caffeinated beverages do you drink a day? Coffee Sodas Tea

Have you smoked cigarettes? ( ) Yes ( ) No Currently? ( ) Yes ( ) No How many packs per day on average? How many years? In the past? ( ) Yes ( ) No How many years did you smoke? When did you quit?

Pipe, Cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No What kind? How often per day on average? How many years?

Your Exercise Level: Do you exercise regularly ( ) Yes ( ) No How many days a week do you get exercise? How much time each day do you exercise? What kind of exercise do you do?

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:

Educational History: Highest Grade Completed? Where? Did you attend College? Where? Major? What is your highest educational level or degree attained?

Occupational History: Are you currently: Working Student Unemployed Disabled . How long is the present position? What is/was your occupation? Where do you work?

Have you ever served in the military? If so, what branch and when?

Relationship History and Current Family: Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed How long? If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? Are you sexually active? ( ) Yes ( ) No How would you identify your sexual orientation? ( )straight /heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual ( ) unsure/questioning ( ) asexual ( ) prefer not to answer

What is your spouse or significant other's occupation? Describe your relationship with your spouse or significant other: Have you had any prior marriages? ( ) Yes ( ) No If yes, how many and for how long Do you have children? ( ) Yes ( ) No Describe your relationship with your children: List everyone who currently lives with you:

Legal History: Have you ever been arrested? ( ) Yes ( ) No Do you have any pending legal problems? ( ) Yes ( ) No

Family Background and Childhood History: Were you adopted? ( ) Yes ( ) No Where did you grow up? _____ List your siblings and their ages: _____ _____ What is or was your father's occupation? _____

_____ What is or was your mother's occupation? _____ Did your 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? _____

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for any of the following (circle): Bipolar Disorder Depression Anxiety Suicide Anger Alcohol Abuse Schizophrenia Post-Traumatic Stress Trauma Other Substance Abuse Violence.

Has any family member been treated with a psychiatric mediation? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment?