Psychiatric Intake Form

(All information on this form is strictly confidential)

Please complete all information on this form to place in your chart, OR print and bring to your first visit, along with any recent lab results. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date_____

*Name you prefer to be called by*_____ *Pronouns*_____

Date of Birth _____ Social Security Number_____

Address _____

Cell Phone _____ Email_____

Emergency Contact Person_____Phone_____

Responsible Party
Name_____ Relationship_____
Address_____
SSN_____ DOB_____ Phone_____

Referred By
Name_____ Phone_____

Address_____

Primary Care Physician_____

Current Psychiatrist_____ Psychiatrist's Phone_____ _____

What are the problem(s) you are seeking help for?
1._____
2._____
3._____

What are your treatment goals?
_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

- [ ] Depressed mood
- [ ] Unable to enjoy activities
- [ ] Sleep pattern disturbance
- [ ] Loss of interest
- [ ] Concentration/forgetfulness
- [ ] Change in appetite
- [ ] Excessive guilt
- [ ] Fatigue
- [ ] Decreased Libido/ sex drive

Decreased libido

- [ ] Racing thoughts
- [ ] Impulsivity
- [ ] Increased risky behavior
- [ ] Increased libido
- [ ] Decrease need for sleep
- [ ] Excessive energy
- [ ] Increased irritability
- [ ] Crying spells

- [ ] Excessive worry
- [ ] Anxiety attacks
- [ ] Avoidance
- [ ] Hallucinations
- [ ] Suspiciousness
- [ ] _____
- [ ] _____

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 Past Psychiatric History
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? _____

Homicide Risk Assessment

Have you ever had feelings or thoughts of harming another?) Yes No. If YES, please answer the following. If NO, please skip to Past Psychiatric History

Do you **currently** feel that you want to hurt someone? Yes No

How often do you have these thoughts? _____

When was the last time you had thoughts of hurting someone?_____

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 hurt someone else currently? _____

Would anything make it better? _____

Have you ever thought about how you would hurt someone else?_____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from hurting someone else? _____

Do you feel hopeless and /or worthless? _____

Have you ever tried to kill or harm someone else before? _____

Your Medical History:

Allergies_____ Current Weight _____ Height _____

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

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems:_____

*Head injuries or Concussions (give dates of occurrence and severity)*_____

_____

Past medical problems, nonpsychiatric hospitalization or surgeries _____

_____

Have you ever had an EKG? ☐ Yes ☐ No If yes, when _____ . Was the EKG: ☐ normal ☐ abnormal or ☐ unknown?

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ☐ Yes ☐ No. Are you planning to get pregnant in the near future? ☐ Yes ☐ No

Birth control method _____

How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with me? ☐ Yes ☐ No

Date and place of last physical exam:_____

Personal and Family Medical History:

	You	Family	Which Family Member
Thyroid Disease	☐	☐	_____
Anemia	☐	☐	_____
Liver Disease	☐	☐	_____
Chronic Fatigue	☐	☐	_____
Kidney Disease	☐	☐	_____
Diabetes	☐	☐	_____
Asthma/respiratory problems	☐	☐	_____
Stomach or intestinal problems	☐	☐	_____
Cancer (type)	☐	☐	_____
Fibromyalgia	☐	☐	_____
Heart Disease	☐	☐	_____
Epilepsy or seizures	☐	☐	_____
Chronic Pain	☐	☐	_____
High Cholesterol	☐	☐	_____
High blood pressure	☐	☐	_____
Head trauma	☐	☐	_____
Liver problems	☐	☐	_____
Other	☐	☐	_____

Is there any additional personal or family medical history? ☐ Yes ☐ No If yes, please explain

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History

Outpatient treatment ☐ Yes ☐ No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates treated By whom

_____

_____

_____

__ **Psychiatric Hospitalization** ☐ Yes ☐ No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

_____

_____

_____

_____

_____

_____

ADD Psychiatrist ROI here

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? _____

Family Psychiatric History:
Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	☐ Yes	☐ No	Schizophrenia	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Post-traumatic stress	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Alcohol abuse	☐ Yes	☐ No
Anger	☐ Yes	☐ No	Other substance abuse	☐ Yes	☐ No
Suicide	Yes	No	Violence	Yes	No

If yes, who had what problems?_____
_____
Has any family member been treated with a psychiatric medication? ☐ Yes ☐ No If yes, who was treated and what medications and how effective was the treatment?_____
_____
_____

Substance Use:
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 most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount 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 drug 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 abused prescription medication? Yes No
If yes, which ones and for how long?
_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamines	☐	☐	
Cocaine	☐	☐	_____
Stimulants (pills)	☐	☐	_____
Heroine	☐	☐	_____
LSD or Hallucinogens	☐	☐	_____
Marijuana	☐	☐	_____
Pain killers/Narcotics	☐	☐	_____
Methadone	☐	☐	_____
Tranquilizers /sleeping pills	☐	☐	_____
Alcohol	☐	☐	_____
Ecstasy	☐	☐	_____
Other	☐	☐	_____

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

Tobacco History
How you ever 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? _____

Family Background and Childhood History:
Were you adopted? ☐ Yes ☐ No Where did you grow up?
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What 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? _____
Describe your father and your relationship with him : _____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when? _____
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:
Did you attend college? _____ Where? _____Major?_____
What is your highest educational level or degree attained?_____
Current School _____
Attendance:___ Daily ___Regularly ___Intermittent ___Refuse/Reason_____
Occupational History:
Are you currently: ☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge? ☐ Yes ☐ No Other type discharge _____

Relationship History and Current Family:
Are you currently: ☐ Married ☐ Divorced ☐ Single ☐ Widowed
How long? _____
If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long?_____
What is your *spouse/partner/significant* other's occupation? _____
Describe your relationship with your *spouse/partner/significant* other:
_____
Have you had any prior marriages? ☐ Yes ☐ No If so, how many? _____
How long? _____
Do you have children? ☐ Yes ☐ No If yes, list ages and gender _____
_____
Describe your relationship with your children: _____
List everyone who currently lives with you? _____
_____

Legal: Have you ever been arrested? _____ Do you have any pending legal problems? _____

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? ☐ more helpful ☐ stressful

Is there anything else that you would like your Therapist- to know?

_____
_____
_____
_____
_____

Prescriptions:

Medication prescriptions should be written during sessions with your psychiatric nurse practitioner. This allows them to discuss how they are working and how long you should take them. Very occasionally, you may need a refill between sessions. Please call your pharmacy as soon as possible if this should happen to you. Keep an eye on your dosage amount to avoid a rush, and to give the pharmacy and doctors enough time to get your refill processed.

Please allow SEVEN BUSINESS DAYS for the office staff to check against your records and acquire clinician approval. We will not authorize refills if you have no future appointment, since we are legally required to ensure that you are in active treatment if we prescribe medications. Please note that in the event of a missed, rescheduled, or cancelled appointment, you medications may not be refilled.

We are unable to provide refills of medications provided by other doctors or for other medical conditions, including narcotic pain medications, and may not prescribe any medications on your first visit.

Consent for Treatment

I hereby authorize Owens & Associates Counseling & Therapy, LLC. to render mental health services to me. I have read and understand these policies and have received a copy for myself.

Signed:_____ Printed Name:_____

Date: _____

Responsible Party for minors under the age of 13:

Signature:_____ Date:_____

Printed Name:_____ Relationship: _____

HIPPA
I acknowledge that I have received the Notice of Privacy Practices explaining HIPAA.
Signature:_____ Date:_____

Printed Name:_____ Relationship: _____

Financial Responsibility:
I authorize provider to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies including: copays, coinsurance, deductibles, insurance plan refusal to pay for failure to obtain authorization, and missed and late cancellation fees.
If it becomes necessary to effect collections of any amount owned, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.

Signature:_____ Date: _____

Signature of Responsible Party:_____ Date: _____

MUST BE COMPLETED AT TIME OF INTAKE

Please provide the following credit card information. It is understood that despite your means of payment, your credit card account will be charged for any outstanding balance. Your credit card will only be charged if there has been no activity on your account for two months and no response to statements sent monthly.
THIS INFORMATION MUST BE COMPLETED. ALL INFORMATION IS KEPT CONFIDENTIAL AND WILL ONLY BE USED TO CLEAR UP ANY OUTSTANDING BALANCE.

Account Number _____ Expiration Date _____

V-Code (3 digits) _____ Name as it appears in card _____

Signature _____

Please sign below if you would like us to charge your credit card after each visit.

Same as above? ___ YES ___ NO

Account Number _____ Expiration Date _____

V-Code (3 digits) _____ Name as it appears in card _____

Signature _____