Psychiatric Intake Form

(All information on this form is strictly confidential)
Please complete all information on this form, print and bring with you to your first appointment with Owens & Associates Counseling & Therapy, LLC.

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?

_____

_____

_____

Insurance Information:

Name of Company: _____ ID #_____

Policy#: _____Authorization#_____

Current Symptoms Checklist: (check all that apply)

Depressed mood	_____	Racing thoughts	_____	Excessive worry	_____
Unable to enjoy activities	_____	Impulsivity	_____	Anxiety attacks	_____
Loss of interest	_____	Increased libido	_____	Hallucinations	_____
Concentration/forgetfulness	_____	Decrease need for sleep	_____	Suspiciousness	_____
Change in appetite	_____	Decrease need for sleep	_____	Excessive guilt	_____
Fatigue	_____	Excessive energy	_____	Increased irritability	_____
Decreased Libido/sex drive	_____	Crying spells	_____		

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 your 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 feeling or thoughts of harming another? _____
If Yes, please answer the following. If No, please skip to Past Psychiatric History.
Do your 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? _____

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 ____

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?

_____

_____

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 for what reason, when and where.

Reason Date Treated By Whom

_____

_____

_____

Psychiatric Hospitalization Yes _____No_____ if yes please 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).

_____

_____

_____

_____

_____

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
Suicide	_____Yes _____No	Other Substance abuse	___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 hoe 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 do2n on your drinking or drug use? _____
Have People annoyed you by criticizing your drinking or drug use? _____
Have you ever felt bad or guilty about your drinking or drug use? _____
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? _____

Have you ever tried any of the following		**If Yes How Long and when did you last use?**
Methamphetamines	___Yes ____No	_____
Cocaine	___Yes ____No	_____
Stimulants (pills)	___Yes ____No	_____
Heroine	___Yes ____No	_____
LSD or Hallucinogens	___Yes ____No	_____
Marijuana	___Yes ____No	_____
Pain Killer/Narcotics	___Yes ____No	_____
Methadone	___Yes ____No	_____
Tranquillizers/sleeping pills	___Yes ____No	_____
Alcohol	___Yes ____No	_____
Ecstasy	___Yes ____No	_____
Other	___Yes ____No	_____

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

Tobacco History
Have you ever smoked cigarettes, cigars, and pipes or used chewing tobacco? ____Yes ____No
Currently? ___Yes ____No How many packs per day on average? How many years? ____
In the past? ___Yes ____No How many packs per day on average? How many years? ____

Family Background and Childhood History

Were you ever 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 parent's divorce? ___Yes ___No _____If so, how ole were you when they divorces? _____
If your parent's 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? _____
Honorable discharge? ___Yes ___No other type of 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
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 you 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 _____more stressful

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

_____

_____

_____

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.

Signature:_____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: case management, letters, 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.

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 _____Date_____

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 _____Date_____