

# 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 # \_\_\_\_\_

Group #: \_\_\_\_\_ 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 _____	Increase need for sleep _____	Excessive guilt _____
Fatigue _____	Excessive energy _____	Increased irritability _____
Decreased Libido/sex drive _____	Crying spells _____	Other _____

**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 feeling or thoughts of harming another? \_\_\_\_\_  
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? \_\_\_\_\_

**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, non-psychiatric 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 \_\_\_\_\_

**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 psychiatric 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).

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**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      ViolenceOther Substance abuse \_\_\_ Yes No \_\_\_  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, who had what problems? \_\_\_\_\_

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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? \_\_\_\_\_

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**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? \_\_\_\_\_

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? \_\_\_\_\_

**If Yes How Long and when did you last use?**

**Have you ever tried any of the following**

Methamphetamines	___ Yes ___ No	_____
Cocaine	___ Yes ___ No	_____
Stimulants (pills)	___ Yes ___ No	_____
Heroin	___ 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? \_\_\_\_\_  
 Are your parents divorced? \_\_\_ Yes \_\_\_ No \_\_\_\_\_ If so, how old were you at the time? \_\_\_\_\_  
 If your parents are divorced, who did/do 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: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### HIPAA

I acknowledge that I have viewed/have been offered a copy of the Notice of Privacy Practices explaining HIPAA. This is also available on our website, [owenscounseling.com](http://owenscounseling.com)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
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 of \$110.00, case management (Which includes court letters, phone conversations with school representative, GAL meetings, letters, anything outside of the regular session with client.) Case management cost are billed in minutes (1-15 minutes=\$30.00, 16-30 minutes=\$60.00, 31-45 minutes=\$90.00, 46-60minutes=\$150.00).

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 \_\_\_\_\_