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Psychiatric Evaluation Intake Form

What are your goals and how can I help you?
_____
_____
_____
_____

Name _____ DOB _____

Address_____

Best contact phone number_____ Email Address _____

Insurance plan name(s): _____

Do you have Medicaid or Medicare (or are you eligible for Medicare)? _____

***If yes- please note that I am **unable** to accept patients with Medicaid or Medicare (even if a claim is not submitted)*

Primary Care Physician _____ Phone _____

Relationship status: ☐ Married ☐ Single ☐ Domestic Partnership

Do you have children? _____. ___ sons ___ daughters Age range of children ___ - ___.

Who lives with you? _____

Your highest degree obtained in school? _____ _____

Current employer and employment status: _____

Occupation: _____

Spouse's/Partner's occupation _____

Are you currently seeing a therapist? _____

If yes please provide the name and contact number: _____

Do I have permission to discuss information you tell me with them? _____

Have you ever been seen by a therapist or psychiatrist in the past? If yes, then please list:
_____
_____

Have you ever been treated for by any of the following (Mark with and "X" all that apply):

___ Depression ___ ADHD ___ Binge-eating ___ ECT Treatment
___ Anxiety ___ OCD ___ Schizophrenia
___ Panic Attacks PTSD ___ Alcohol Problems (including AA)
___ Anorexia/Bulimia ___ Drug Problems ___ Bipolar (Manic/Depressive) Disorder

Please list prior psychiatric hospitalizations (if any) below:

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? _____

If so, please list the occurrences below:

Approximate date of attempt	How did you attempt

Current Medications (including over the counter, birth control, herbal, etc):

Name of Medication	Dosage (Mg)	How many times a day?	On this for how long?	Side effects (if any)?	Prescribing physician

Do you have any food or drug ALLERGIES? If yes, please list each and the reaction you had.

Family History: Has anyone in your family ever been treated for any of the following (please mark with an "X" for all that apply)

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression								
Anxiety								
Panic Attacks								
Post-Traumatic Stress								
Bipolar Manic/Depression								
Schizophrenia								
Alcohol problems								
Drug problems								
ADHD								
Suicide attempts								
Psychiatric hospital stay								

Medical History: Do you have, or have you ever had any of the following? (mark with an "X" all that apply)

High Blood Pressure	Gastrointestinal Problems (ulcers, pancreatitis, irritable bowel, colitis)	Viral Illness (Herpes, Epstein-Barr, Chronic Hepatitis)
Lung Disease	Arthritis or Rheumatoid Problems	Cancer
Diabetes	Liver Damage or Hepatitis	Genital Problems
Heart Disease	Other Endocrine/Hormone Problems	Eating Disorder
Thyroid Disease	Neurological Problems (stroke, brain tumor, nerve damage)	Eye Problems
Anemia	Gynecological/hysterectomy	Chronic Pain
Asthma	Urinary Tract or Kidney Problems	Fibromyalgia
Skin Disease	Migraine or Cluster Headaches	HIV Positive or AIDS
Seizures	Ear/Nose/Throat Problems	Head Injury
Other medical issues:	High Cholesterol	Sleep Apnea

Last Menstrual Period (if applicable): _____

Method of Contraception : _____

Prior surgeries/hospitalizations for medical illnesses: _____

Please mark with an "X" the appropriate boxes that apply to you for the following substances:

	Never used:	Age of 1st use:	Last used on this approx date:	Age of peak use:	Current use and frequency:
Cocaine					
Amphetamine/Speed					
Marijuana/THC					
Hallucinogens (LSD,					
Ecstasy					
Pain Pills					
PCP or Angel Dust					
IV Drug use					
Heroin					
Benzodiazepines					
Cigarettes, cigars or tobacco					
Caffeine (coffee, tea, cola's, energy drinks)					
Other:					

When was your last drink of alcohol? _____

In the past 30 days, about how many days have you had at least one alcoholic drink? _____

What is the maximum number of drinks you have had in one day in the past month? _____

Check if you have had any of the following: ☐ DUI ☐ DWI ☐ Seizures ☐ DT's

Please review the following list of medications. If you have taken any of these medications please fill out the specific boxes related to that medication.

Type: Anti-depressant/Anxiolytic/Sleeping medication

Brand Name	Generic Name	Mark with an "X" if yes	How long did you take it?	What dosage did you take?	Did it help?	How often in a day?	Any side effects?
Luvox	Fluvoxamine						
Paxil	Paroxetine						
Celexa	Citalopram						
Lexapro	Escitalopram						
Zoloft	Sertraline						
Prozac	Fluoxetine						
Effexor	Venlafaxine						
Pristiq	Desvenlafaxine						
Cymbalta	Duloxetine						
Desyrel	Trazodone						
Serzone	Nefazodine						
Wellbutrin	Bupropion						
Viibryd	Vilazodone						
Buspar	Buspirone						
Asendin	Amoxapine						
Elavil	Amitriptyline						
Ludiomil	Maprotiline						
Norpramin	Desipramine						
Pamelor	Nortriptyline						
	Doxepin						
Tofranil	Imipramine						
Anafranil	Clomipramine						
Nardil	Phenelzine						
Valium	Diazepam						
Xanax	Alprazolam						
Librium	Chlordiazepoxi						
Klonopin	Clonazepam						
Ativan	Lorazepam						
Restoril	Temazepam						
Lunesta	Eszopiclone						
Ambien	Zolpidem						

Type: Antipsychotic/Mood Stabilizer

Brand Name	Generic Name	Mark with an "X" if yes	How long did you take it?	What dosage did you take?	Did it help?	How often in a day?	Any side effects?
Abilify	Aripiprazole						
Risperdal	Risperidone						
Invega	Paliperidone						
Geodon	Ziprasidone						
Zyprexa	Olanzapine						
Seroquel	Quetiapine						
Clozaril	Clozapine						
Saphris	Asenapine						
Latuda	Lurasidone						
Fanapt	Illioperidone						
Prolixin	Fluphenazine						
Haldol	Haloperidol						
Navane	Thiothixene						
	Trifluperazine						
	Pimozide						
	Perphenazine						
	Loxapine						
	Thioridazine						
	Loxapine						
Mellaril	Thioridazine						
Thorazine	Chlorpormazine						
	Lithium						
Depakene	Valproate						
Tegretol	Carbamazepine						
Topamax	Topiramate						
Lamictal	Lamotrigine						
Trileptal	Oxcarbazepine						
	Gabapentin						

Medications not listed: _____