Advanced Psychiatric Services, PLLC

Psychiatric Intake Form

(All information on this form is strictly confidential)
Please complete all information on this form and bring it to the first visit. 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. If assistance was required in filliug this form out, please indicate on form with name and relationship. Thank you!

Name_____Date_____
Date of Birth _____
Primary Care Physician_____
Current Therapist/Counselor_____
Therapist'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 ☐Racing thoughts ☐Excessive worry

☐Unable to enjoy activities ☐Impulsivity ☐Anxiety attacks

☐ Sleep pattern disturbance ☐ Increase risky behavior ☐ Avoidance

☐ Loss of interest ☐Increased libido ☐ Hallucinations

☐ Concentration/forgetfulness ☐ Decrease need for sleep ☐ Suspiciousness

☐ Change in appetite ☐ Excessive energy ☐ Excessive guilt ☐ Increased irritability

☐Fatigue ☐ Crying spells ☐Decreased libido ☐ Other_____

Suicide Risk Assessment

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

Do you currently feel that you don't want to live? ☐ Yes ☐ No
Have you ever tried to kill or harm yourself 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: _____
_____

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 Member**	**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? _____

Is there any history of brain injury, being knocked unconscious, or seizures? If yes, please explain:

_____

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 by placing check mark next to medication.

Antidepressants

☐Prozac (fluoxetine) ☐ Zoloft (sertraline) ☐ Luvox (fluvoxamine)

☐ Paxil (paroxetine) ☐ Celexa (citalopram) ☐ Lexapro (escitalopram)

☐Effexor (venlafaxine) ☐ Cymbalta (duloxetine) ☐ Wellbutrin (bupropion)

☐ Remeron (mirtazapine) ☐ Serzone (nefazodone) ☐ Anafranil (clomipramine)

☐ Pamelor (nortiptyline) ☐ Tofranil (imipramine) ☐ Elavil (amitriptyline) ☐ Other

Mood Stabilizers

☐ Tegretol (carbamazepine) ☐ Lithium ☐ Depakote (valproate)

☐ Lamictal (lamotrigine) ☐ Tegretol (carbamazepine) ☐ Topamax (topiramate)

Antipsychotics/Mood Stabilizers

☐ Seroquel (quetiapine) ☐ Zyprexa (olanzepine) ☐ Geodon (ziprasidone)

☐ Abilify (aripiprazole) ☐ Clozaril (clozapine) ☐ Haldol (haloperidol)

☐ Prolixin (fluphenazine) ☐ Other:_____

Sedative/Hypnotics

☐ Ambien (zolpidem) ☐ Sonata (zaleplon) ☐ Rozerem (ramelteon)

☐ Restoril (temazepam) ☐ Desyrel (trazodone) ☐ Other:_____

ADHD medications

☐ Adderall (amphetamine) ☐ Concerta (methylphenidate) ☐ Ritalin (methylphenidate)

☐ Strattera (atomoxetine) ☐ Other:_____

Antianxiety medications

☐ Xanax (alprazolam) ☐ Ativan (lorazepam) ☐ Klonopin (clonazepam)

☐ Valium (diazepam) ☐ Tranxene (clorazepate) ☐ Buspar (buspirone)

☐ Other: _____

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?

_____

_____

Any history of complicated withdrawal from substances including seizures or delirium tremens (DTs)? If yes, explain._____

_____

Are you currently using any alcohol, recreational drugs, or misusing prescription medications?

☐ Yes ☐ No. If yes, please describe. _____

_____

Tobacco History
Do you currently use any tobacco products such as cigarettes, cigars, pipes, or chewing tobacco? If yes, how much and how often. _____
Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect?

Educational History:
What is your highest educational level or degree attained?_____
Occupational History:

Are you currently: ☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled
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 ☐Partnered
How long? _____

If not married, are you currently in a relationship? ☐ Yes ☐ No. If yes, how long?

_____
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 so, how many? _____
How long? _____

Do you have children? ☐Yes ☐No. If yes, list ages and gender

_____

_____
Describe your relationship with your children:

_____
Legal:
Have you ever been arrested? _____
Do you have any pending legal problems? _____
Is there anything else that you would like the provider to know?

_____

_____

_____

_____
Signature_____Date_____
Emergency Contact _____
Telephone # _____
Reviewed by _____Date _____

This portion only needs be completed by patients over the age of 65

Geriatrics Health History:

Please check of the illnesses you have now or have had in the past and please indicate how much it interferes with your activities at present.

Illness	Have Or have had	Does not interfere at all	Interferes a little	Interferes a great deal
Arthritis				
Glaucome or Cataracts				
Breathing problems: (shortness of breath)				
Anemia				
Asthma				
Bronchitis				
Emphysema				
High Blood Pressure				
Tuberculosis				
Diabetes				
Circulation trouble in arms and legs				
Bleeding Problems				
Thyroid problems				
Cancer or Leukemia				
Seizures				
Parkinson's disease				

Digestive system problems:

Illness	Have or have had	Does not interfere at all	Interferes a little	Interferes a great deal
Ulcers				
Heartburn				
Hiatal hernia				
Colitis				
Diverticulitis				
Constipation				
Weight loss				

Urinary problems:

Wetness after				
Coughing or sneezing				
Urgency				
Frequency				
Burning				
Prostate problems				

Gate problems:

Dizziness				
Falling				
Broken bones				
Unsteadiness				

List any other medical problems you have had which are not listed above:----------