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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.

NAME _____

BIRTHDATE _____/_____/_____ TODAY'S DATE: _____/_____/_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

PRIMARY CARE PHYSICIAN

NAME _____Phone: _____

OTHER PHYSICIANS

SPECIALTY _____

NAME _____Phone: _____

SPECIALTY _____

NAME _____Phone: _____

BACKGROUND

What are the problem(s) you are seeking help for?

_____

_____

What are your treatment goals?

_____

CURRENT SYMPTOMS CHECKLIST

☐ Depressed mood
☐ Racing thoughts
☐ Excessive worry
☐ Unable to enjoy activities
☐ Impulsivity
☐ Anxiety attacks
☐ Sleep disturbance
☐ Increase risky behavior
☐ Avoidance
☐ Loss of interest
☐ Increased libido
☐ Hallucinations
☐ Poor concentration
☐ Decrease need for sleep
☐ Suspiciousness
☐ Change in appetite
☐ Excessive energy
☐ Excessive guilt
☐ Increased irritability
☐ Fatigue
☐ Crying spells
☐ Decreased libido
☐ Memory issues
☐ _____

YOUR MEDICAL HISTORY

Allergies: _____

Weight: _____Height: _____

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

NAME	DOSE	FREQUENCY	NAME	DOSE	FREQUENCY
	25 mg tablet	Every night		500 mg	Twice daily

Current over-the-counter medications or supplements:

_____

_____

Current medical problems:

_____

_____

Past medical problems, non-psychiatric hospitalization or surgeries:

_____

_____

Have you ever had an EKG? ☐ Yes ☐ No If yes, when? _____

What was the EKG result? ☐ Normal ☐ Abnormal ☐ Unknown

Any concerns about your physical health that you would like to discuss? ☐ Yes ☐ No

Date and place of last physical exam:

_____

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? _____

PERSONAL AND FAMILY MEDICAL HISTORY

Condition	You	Family	Which Family Member
Thyroid Disease	☐	☐	_____
Anemia	☐	☐	_____
Liver Disease	☐	☐	_____
Chronic Fatigue	☐	☐	_____
Kidney Disease	☐	☐	_____
Diabetes	☐	☐	_____
Asthma	☐	☐	_____
Intestinal Problems	☐	☐	_____
Cancer (list what type)	☐	☐	_____
Fibromyalgia	☐	☐	_____
Heart Disease	☐	☐	_____
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? ☐ Yes ☐ No
If yes, explain: _____

YOUR PAST PSYCHIATRIC HISTORY

Previous outpatient treatment? ☐ Yes ☐ No

If yes, please describe:

By whom?	Reason?	Dates treated?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior psychiatric Hospitalizations? ☐ Yes ☐ No
If yes, please describe:

Where?	Reason?	Dates hospitalized?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Psychiatric Medications? ☐ Yes ☐ No If yes, please describe:

NAME	DOSE	FREQUENCY	DATE TAKEN	RESPONSE	SIDE EFFECTS
	25 mg tablet	Every night	1/20/20 – 2/20/20		

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family been diagnosed with or treated for any of the following?

Issue	Yes	No	If yes, which Family Member
Depression	☐	☐	_____
Anxiety	☐	☐	_____
Bipolar Disorder	☐	☐	_____
Schizophrenia	☐	☐	_____
Suicide / Attempt	☐	☐	_____
PTSD	☐	☐	_____
Alcohol Abuse	☐	☐	_____
Substance Abuse	☐	☐	_____
Violence	☐	☐	_____

Other: _____

YOUR SUBSTANCE USE HISTORY

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No
If yes, for which substances?

_____

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?

_____

Have you ever tried any of the following substances?

Substance	Yes	No	If yes, how long and when did you last use?
Methamphetamine	☐	☐	_____
Cocaine	☐	☐	_____
Stimulants	☐	☐	_____
Heroine	☐	☐	_____
LSD or Hallucinogens	☐	☐	_____
Marijuana	☐	☐	_____
Methadone	☐	☐	_____
Sleeping Pills*	☐	☐	_____
Pain Killers*	☐	☐	_____
Alcohol	☐	☐	_____
Ecstacy	☐	☐	_____
Other	☐	☐	_____
Other	☐	☐	_____

*not prescribed

How many caffeinated beverages do you drink a day?

Coffee _____ Sodas _____ Tea _____

Do you currently smoke cigarettes? ☐ Yes ☐ No

How many packs per day on average? _____ And for how many years? _____

Have you smoked cigarettes in the past? ☐ Yes ☐ No

How many years did you smoke? _____

When did you quit? _____

YOUR FAMILY BACKGROUND AND CHILDHOOD HISTORY

Were you adopted? ☐ Yes ☐ No
Where did you grow up?

_____
List your siblings and their ages:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

What is/was your father's occupation? _____

What is/was your mother's occupation? _____

YOUR EDUCATIONAL HISTORY

Highest educational level/degree attained? _____

Which school? _____

When did you graduate? _____

YOUR OCCUPATIONAL HISTORY

Are you currently: ☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Retired

How long have you been in your present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you served in the military? ☐ Yes ☐ No

If so, what branch and when? _____

Type of discharge? _____

YOUR RELATIONSHIP HISTORY AND CURRENT FAMILY

Are you currently: ☐ Married ☐ Divorced ☐ Partnered ☐ Single ☐ Widowed

If you are in a relationship, for how long? _____

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

_____

_____

List everyone who currently lives with you?

_____

_____

LEGAL

Have you ever been arrested? ☐ Yes ☐ No
Do you have any pending legal problems? ☐ Yes ☐ No

TRAUMA

Have you ever been the victim of any violence or trauma? ☐ Yes ☐ No

Is there anything additional that you would like Dr. Taylor to know?

_____

_____

_____

_____

_____

_____

_____

EMERGENCY CONTACT

Name: _____

Relationship to You: _____

Emergency Contact's Tel Number: _____

Email Address: _____

PREFERRED PHARMACY

Name: _____

Address: _____

Tel Number: _____ Fax Number:_____

INSURANCE INFORMATION

Policy Holder's Name: _____

Policy Holder's Birthdate: _____

Relationship to patient: _____

Policy Holder's Tel: _____

Insurance Company: _____

ID Number: _____Group Number: _____

Member Service's Tel Number on the Back of Card: _____

Your Signature: _____

Today's Date: _____/_____/_____