Hea Health
Adult Psychiatry Intake Form

Date_____

Name_____ Age_____

Address_____

Home phone_____ Work phone_____ Cell phone_____

What issue(s) bring(s) you to the Psychiatry Clinic?

_____
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_____
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_____
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What has been stressing you of late (e.g. Family, job, recent loss of loved ones, financial issues)?

_____
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Are you currently having any of the following problems (please circle)?

Depression? Loss of interest in activities? Feeling hopeless, worthless? Poor energy? Poor self-esteem? Change in appetite? Increased or decreased? Fatigue? Poor focus? Problems going to sleep? Thoughts of not being alive? Periods of euphoria or unusually good mood? Having very high energy for no reason? Going days without needing to sleep? Thoughts racing? Talking too fast? Acting impulsively (spending, speeding)?	Worrying excessively? Having tense muscles? So anxious you feel you cannot rest? Having panic attacks? Traumatic events that come back in nightmares, flashbacks? Feeling awkward in public? Thoughts that replay? Repetitive or compulsive behaviors? Phobias or fears? Grunts, tics, or jerks? Inattentiveness at work or school? If so, since what age? Hyperactive or fidgety?	Hearing voices? Seeing things? Feelings people were trying to watch or harm you? Concerns about alcohol use? Drug use? Concerns about eating too much? Eating too little? Memory problems? Getting lost easily? Forgetting how to do tasks? Problems finding words? Problems caring for yourself (cooking, dressing)?

Past Psychiatric Care

Have you been ever diagnosed with a mental health condition by a medical provider (e.g. Depression, bipolar, schizophrenia, ADHD)? If so, please list.

_____

_ _____

Have you ever been seen by a psychiatrist or therapist/counselor? Please list and describe.

Date(s) seen? By whom?	For what problem?	What treatment (meds, ECT, therapy)?

Have you ever been hospitalized for psychiatric care? Please list and describe.

Date(s)	Where and for what?	What treatment (meds, ECT, therapy)?

Have you ever been treated with any of the following medications? Circle all that apply and list any good or bad effects of the medications.

Med	Good/bad effects	Med	Good/bad effects	Med	Good/bad effects
Abilify		Haldol		Ritalin	
Ambien		Klonopin		Saphris	
Adderall		Invega		Serax	
Anafranil		Lamictal		Seroquel	
Antabuse		Latuda		Serzone	
Ascendin		Lexapro		Soma	
Atarax		Librium		Sonata	
Ativan		Lithium		Stelazine	
Buspar		Lunesta		Strattera	

Campral		Luvox		Suboxone/ subutex	
Celexa		Marplan		Symmetrel	
Chloral hydrate		Mellaril		Tegretol	
Clonidine		Methadone		Thorazine	
Clozaril		Miltown		Tofranil	
Cogentin		Nardil		Topomax	
Concerta		Norpramine		Traxene	
Cymbalta		Orap		Trazodone	
Dalmane		Pamelor		Trileptal	
Depakote		Parnate		Valium	
Dexedrine		Paxil		Vibryd	
Doral		Prosom		Vistraril	
Effexor		Pristiq		Vivitrol	
Elavil		Prolixin		Wellbutrin	
Fanapt		Remeron		Xanax	
Geodon		Restoril		Zoloft	
Halcion		Risperdal		Zyprexa	

Any other psychiatric medications you have taken?

_____

<u>Past Medical Care</u>

Do you have a primary care doctor? Name_____ Last Seen?_____

What medical illnesses do you have?

_____

_

_____

_

_____

_

What surgeries have you had?

_____

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_____

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_____

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Please list all medications you are currenly taking, including over-the-counter medications, herbals, and supplements.

Medication	Dosage	# times per day	For what condition	Who prescribes it

Describe any allergies you have (e.g. to medications, foods).

_____

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_____

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Are you currently having or have you recently had any of these physical symptoms?

Fevers	Headache	Constipation	Hot/cold flashes
Chills	Chest pain	Acid reflux	Decreased sex drive
Night sweats	Shortness of breath	Joint pains	Problems reaching orgasm

Unexplained weight loss/gain	Heart palpitations	Muscle pains or tension	Easy bruising or bleeding
Weakness in arms/legs	Cough	Pain or difficulty urinating	Rashes
Numbness in arms/legs	Sore throat	Dental problems	
Episodes of passing out	Nausea or vomiting	Changes in vision	
Problems walking	Diarrhea	Changes in hearing	

For women
Last menstrual period? _____ Usually regular? Yes/no

Do you use any birth control? Yes/no If yes, please list. _____

Have you been pregnant before? Yes/no If yes, how many times? _____

Miscarriages? Yes/no

Elective abortions? Yes/no

Any depression or unreal thoughts around pregnancies? Yes/no

Substance Use History

How often have you used the following substances?

	Last time used?	Approximately how often (# of times per week, month or year)?	How much do you use in a sitting if/when you do use?
Tobacco			
Alcohol			
Marijuana or K2/"spice"			
Cocaine			
Opiates (e.g. Heroin, morphine, Percocet,			

oxycodone, Tylenol #3, Dilaudid/hydromorphone)			
Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)			
PCP or LSD			
Mushrooms			
Others			

Family History

Please list blood relatives who have been diagnosed with the following conditions.
Alcoholism _____
Anxiety disorders _____
Bipolar disorder _____
Cancer _____
Depression _____
Diabetes _____
Drug abuse _____
Heart disease/high blood pressure/arrhythmias _____
Osteoporosis _____
Seizures _____
Schizophrenia _____
Strokes _____
Suicides _____
Thyroid disease _____

Social History

Where do you live? _____

Who lives with you?_____

How far did you go in school/highest level of education? _____

What is your current job/occupation?_____

What jobs have you had in the past?

_____
_
_____
_

Are you married? Yes/no If so, for how long? _____

Have you been married in the past? Yes/no # of times? _____

Do you have children? Yes/no If so, how many, what are their ages?_____

What do you do in your free time to relax?

_____

Do you have any religious beliefs? Yes/ No

How important are your religious/spiritual beliefs to your life?_____

Have you had any legal issues (arrests, charges, time in jail)? If so, please describe.

_____
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_____
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_____
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Have you ever been the victim of a violent crime? Yes/No

Have you ever been a victim of physical abuse? Emotional? Sexual abuse or rape? If so, please explain.

_____
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Safety

Do you currently have thoughts of hurting yourself? Yes/no Please explain.

_____
_

Have you tried to hurt yourself in the past? If so, please explain.

_____
_
_____
_
_____
_

Do you currently have thoughts of hurting anyone else? Yes/no Please explain.

_____
_

Have you tried to hurt anyone in the past? If so, please explain.

_____
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_____
_
_____
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Do you own any guns or knives? _____

The Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING (0–3)
Sitting and reading	
Watching Television	
Sitting inactive in a public place (e.g.a theater or meeting	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
As a passenger in a car for an hour without a break	
Total Score	

SCORE RESULTS:

1-6 Congratulations, you are getting enough sleep!

7-8 Your score is average

9 and up Very sleepy and should seek medical advice

Johns, M.W. (1991). A new method for measuring daytime sleepiness: The Epworth sleepiness scale. *Sleep*, *14*, 540-545. Permission for single-use of the information contained in this material was obtained from the Associated Professional Sleep Societies, LLC, September 2006.

CHECKLIST: Review of Systems

Patient Name: _____ Date of visit: _____

CONSTITUTIONAL:
Yes No
☐ ☐Weight Loss
☐ ☐ Fatigue
☐ ☐ Fever

EYES:
Yes No
☐ ☐ Glasses/Contacts
☐ ☐ Eye Pain
☐ ☐ Double Vision
☐ ☐ Cataracts

EAR,NOSE,THROAT:
Yes No
☐ ☐ Difficulty Hearing
☐ ☐ Ringing in Ears
☐ ☐ Vertigo
☐ ☐ Sinus Trouble
☐ ☐ Nasal Stuffiness
☐ ☐ Frequent Sore Throat

CARDIOVASCULAR:
Yes No
☐ ☐ Murmur
☐ ☐ Chest Pain
☐ ☐ Palpitations
☐ ☐ Dizziness
☐ ☐ Fainting Spells
☐ ☐Shortness of Breath ☐ ☐ Difficulty lying Flat
☐ ☐ Swelling Ankles

ENDOCRINE:
Yes No
☐ ☐ Loss of Hair
☐ ☐ Heat/Cold Intolerance

RESPIRATORY:
Yes No
☐ ☐ Cough Easy
☐ ☐ Coughing Blood
☐ ☐ Wheezing
☐ ☐ Chills

GASTROINTESTINAL:
Yes No
☐ ☐ Heartburn/Reflux
☐ ☐ Nausea/Vomiting
☐ ☐ Constipation
☐ ☐ Change in BMs
☐ ☐ Diarrhea
☐ ☐ Jaundice
☐ ☐ Abdominal Pain
☐ ☐ Black or Bloody BM

GENITOURINARY:
Yes No
☐ ☐ Burning/Frequency
☐ ☐ Nighttime
☐ ☐ Blood in Urine
☐ ☐ Erectile Dysfunction
☐ ☐ Abnormal Discharge
☐ ☐ Bladder Leakage

ALLERGIC/IMMUNOLOGIC: Yes No
☐ ☐ Hives/Eczema
☐ ☐ Hay Fever

PSYCHIATRIC:
Yes No
☐ ☐ Anxiety/Depression
☐ ☐ Mood Swings
☐ ☐ Difficult Sleeping

HEMATOLOGY/LYMPH
Yes No
☐ ☐ Easy Bruising
☐ ☐ Gums Bleed Easily
☐ ☐ Enlarged Glands

MUSCULOSKELETAL:
Yes No
☐ ☐ Joint Pain/Swelling
☐ ☐ Stiffness
☐ ☐ Muscle Pain
☐ ☐ Back Pain

SKIN:
Yes No
☐ ☐ Rash/Sores
☐ ☐ Lesions
☐ ☐ Itching/Burning

NEUROLOGICAL:
Yes No
☐ ☐ Loss of Strength
☐ ☐ Numbness
☐ ☐ Headaches
☐ ☐ Tremors
☐ ☐ Memory Loss

FEMALES ONLY:
Date Last Mammogram_____
Normal_____
Abnormal_____
Date last PAP_____
Normal_____Abnormal_____
__
Age Onset Periods_____ Age Onset Menopause_____
Periods Regular?
Yes_____No____
Number Pregnancies_____