PSYCHIATRIC ASSESSMENT INTAKE

Please note that these pages are confidential and to insure your privacy are to be given directly to the doctor.

Please fill out as accurately as possible.

PRESENTING PROBLEM —in your own words, summarize in one to two brief sentences.

PURPOSE OF VISIT —In your own words, please describe your goals for this assessment in one to two brief sentences.

Please describe any **current stressful event** in your life (home. work family, social. etc):

MEDICAL HISTORY

Personal Medical History

Have you ever had any of the following? Check all that apply:

	Chest Pain/Pressure/Tightening		Asthma		Shortness of Breath
	Hypertension		Dizzy Spells/Fainting		TB/Lung Disorder
	Heart Attack		Cancer		Ulcers
	Stroke		Diabetes		Skin Disorders
	Headache		Arthritis		Hepatitis
	Glaucoma		Difficulty Hearing		Cataracts
	Allergies		Memory Loss		Digestive Problems
	Eczema		Hemorrhoids		Frequent Urinary Infections
	Depression		Kidney Disease		Blood in Stool
	Seizures		Movement Disorder		Tics (motor or verbal)
	Other Neurological Disorders		High Cholesterol		High Triglycerides

Past History of Head Trauma (please specify):

Past Surgeries, Hospitalizations, or other Medical Problems (please specify with dates):

Allergies

Allergies to medications (please specify):

Allergies (e.g. itchiness or hives) to specific kinds of soaps/laundry detergents/perfumes:

Allergies to food:

Current Medications and Dosages (please list all names dosages. lengths of time, purposes of medication, results and side effects):

Psychiatric:

Psychiatric medications were prescribed by: __Psychiatrist __ Primary Care Provider

__Nurse Practitioner __Other

Medical:

Over-the-Counter:

Herbal:

Occasional Reason for Use (i.e., Tylenol for headaches, etc.):

Females Only

Type of Birth Control (if applicable) and specify type, name, and dose (if pills):

Are you pregnant? __YES __NO

Are you breast-feeding? __YES __ NO

Number of previous pregnancies? ____

Number of previous live births: ____

Number of living children: _____

CHILDHOOD DEVELOPMENT

Milestones

Were Motor/Walking Milestones met at appropriate age? YES ___ NO ___
Were Vocalizations/Talking Milestones met at appropriate age? YES ___ NO ___
Did the patient have friends as a child? MANY ___ FEW ___ NONE ___
Does the patient have friends currently? MANY___ FEW ___ NONE ____

Abuse History

History of abuse as a child (please describe in detail):

Physical:

Sexual:

Emotional:

History of abuse as a teen and/or adult (please describe in detail):

Physical:

Sexual:

Emotional:

Please describe any traumatic events you have witnessed or experienced if different than above abuse (such as witnessing a murder, being beaten or raped, etc.):

As a Child:

As a Teenager:

As an Adult:

FAMILY STRUCTURE:

Family of Origin

With whom did you grow up (please include family members and relationships)?

Current Family Living Arrangements/Family Structure (please include relationships and ages):

Please list any significant changes in your family/living arrangements that occurred as a child or teenager (such as divorce, deaths. etc.):

DRUG AND ALCOHOL HISTORY

Cigarettes/Tobacco

Do you currently smoke or chew? YES___ NO___

If yes: Number of years: ___ Number of packs per day: ___ How long has it been since your last cigarette? _____

If you don't currently smoke chew have you in the past? YES ___ NO ___

Caffeine

Do you drink coffee or other caffeinated beverages? YES___ NO____

Number of cups or 8oz. servings per day: _____ Type of beverage: _____

Alcohol Do you drink alcohol currently or have you within the past year? YES ___ NO ___

How many times per week?_____ Type of beverage: _____ Average amount consumed each week? _____

How long have you been drinking? _____

If not currently drinking, have you consumed alcohol in the past? YES___NO__

Type of beverage: _____ How much and for how long? _____

How long since last use at this level?_____

Current Drug History

Do you use drugs or illicit substances currently/past year? YES ___ NO ___

Type: _____

How Much / How Often / How Long? _____

Past Drug History

Have you used drugs in the past7 YES ___ NO ___

Type: _____ How Much ?How Often? How Long?

_____

How long since last use? _____

Do you participate in any programs for remaining clean and sober7 YES ___ NO ___

If yes, please identify programs:

_____

Are you currently involved in a recovery program7 YES___N0 ___

If yes. please describe:_____

Risk Assessment

Do you have thoughts of harming yourself? YES___ NO___

Do you have a plan for how you would harm yourself? YES___ NO ___

Have you attempted to harm yourself in the past? YES ___ NO___

Have any relatives committed suicide7 YES___ NO___

Do you have thoughts of harming someone else? YES___ NO ___

Have you assaulted or threatened anyone recently? YES___ NO____

Have you ever been in trouble because of your temper/violence? YES___ NO ___

Does drinking/drugging ever lead you to become violent? YES___ NO___

Do you own a gun or a lethal weapon? YES ___ NO ___

Have you ever considered/planned harming yourself or others with this gun or other lethal weapon? YES _ NO __

FAMILY HISTORY:

IN THE TWO SECTIONS BELOW PLEASE CHECK AS APPLICABLE TO YOUR INDIVIDUAL FAMILY HISTORY

Family Medical History

Please pay special attention to anyone with symptoms similar to your presenting symptoms

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Siblings	Children	Maternal Relatives	Paternal Relatives
High Blood Pressure										
Epilepsy										
Seizures										
Cancer										
Heart Attack										
Stroke										
Diabetes										
Asthma										
Dizzy Spells/Fainting										
Movement disorders										
Tics (motor or verbal										
Other Neurological Disorders										

Family History of Mental Illness/Alcoholism/Drug Abuse

Please pay special attention to anyone with symptoms similar to your presenting symptoms, not necessarily diagnosed

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Siblings	Children	Maternal Relatives	Paternal Relatives
Depression										
Bipolar Disorder/ Manic Depression										
Schizophrenia										
Attention Deficit Hyperactivity Disorder										
Concentration Problems										
Hyperactivity										
Anger Outbursts										
Periods of Severe Agitation										
Nervous Breakdowns										
Anxiety										
Panic Attacks										
Phobias										
Obsessive Thinking/Worrying										
Compulsions										
Attempted Suicides										
Completed Suicides										
Alcoholism										
Drug Abuse										
History of past/present abuse (as abuser)										
History of past/present abuse (as victim)										
Other Family History (Please Specify)										

PAST PSYCHIATRIC HISTORY

Psychiatric Hospitalizations (dates, locations, and length of time):

Past psychotherapy / counseling (dates, length of time. and focus of treatment):

Present occurring psychotherapy / counseling (dates, lengths of time and focus of treatment):

Any current treatment by a Psychiatrist (dates, length of time, and focus of treatment):

Any previous treatment by a Psychiatrist (dates, length of time, and focus of treatment):

Any past psychiatric medications (names, dosages, length of time, purpose of medication, results, and side effects)? Please list all medications separately:

Psychiatric medications were prescribed by: Psychiatrist___ Primary Care Provider____

Nurse Practitioner ____ Other____(Specify)_____