

Psychiatric Intake Form

Instructions: Please complete this intake form to the best of your ability. If a question does not apply, please put N/A on the line.

Patient Information:

Name: _____

Age: _____ Biological Sex: _____ Date of Birth: ___/___/_____

Preferred Pronouns: _____ Preferred Name/Nickname: _____

Address: _____

Home Phone: _____ Ok to leave message? Yes No

Cell Phone: _____ Ok to leave message? Yes No

Name of Insurance Carrier: _____

Insurance ID #: _____ Group #: _____

Primary Care Information:

Who is your primary care provider (PCP)? _____

When was your last physical? _____

Office number to PCP: _____

Social Information:

Relationship Status: Single Married Separated Divorced Widowed

Education History: High School Trade School Some College Graduated College

Employment History: Unemployed Employed Retired

Reason for Visit:

What psychiatric symptoms are you seeking help with? _____

When did they begin? _____

Please check what you are experiencing (this is not an exhaustive list):

- | | |
|------------------------------|--|
| Mind racing | Decreased interest in activities |
| Unable to relax | Irritability or agitation |
| Anxiety | Excessive guilt |
| Easily startled | Decreased energy |
| Nightmares | Decreased concentration or focus |
| Social withdrawal/isolation | Decreased appetite or increased appetite |
| Sleep too much or too little | Self-harm behavior |

Other: _____

Safety Assessment:

Do you have a history of a suicide attempt? Yes No

Do you have suicidal thoughts? Yes No

Do you have a plan? Yes No

What is it? _____

On a scale of 1 to 5 with 5 being most likely, what is your intent (to carry through with the suicide plan)? _____

Previous Medical History:

Please check the medical and psychiatric condition(s) below if it applies to you:

- | | | |
|---------------------|------------------|------------------------|
| High blood pressure | Heart disease | Traumatic brain injury |
| Diabetes | Heart failure | Stroke |
| High cholesterol | Irregular rhythm | Seizure disorder |
| Thyroid disease | Pacemaker | Migraines |
| Digestive problem | Defibrillator | Dementia |
| Kidney disease | Anemia | Parkinson's disease |
| Liver disease | Cancer | Other: |

Previous Psychiatric History:

- | | |
|------------------------------|--|
| ADHD | Disruptive Mood Dysregulation Disorder |
| Generalized anxiety disorder | Borderline Personality Disorder |
| Panic Disorder | Schizophrenia |
| PTSD | Binge Eating Disorder |
| Bipolar Disorder | Anorexia |
| Major Depressive Disorder | Bulimia |

Other Conditions: _____

Surgical History: _____

Over the counter medications and supplements: _____

Medication allergies: _____

Therapist Information:

Have you ever had therapy? _____

When was your last session? _____

If you do not have a therapist, are you open to seeing one if recommended? Yes No

Inpatient Psychiatric Admissions:

Have you ever been admitted to a psychiatric facility? _____

How many times? _____

Where was your last admission? _____

Do you have a history of a suicide attempt? _____

Substance Use History:

Do you have a history of substance abuse? _____

Which substance? _____

Are you currently in treatment? _____

Have you used the following (check all that apply):

Marijuana

Mushrooms

Cigarettes

Methamphetamines

Cigars

Heroin

Vape

Cocaine

When did you start using it/them? _____

How often do you use them? _____

What other substances do you take for recreational use? _____

Do you have a history of misusing/abusing prescription medications? _____

Which ones? _____

Alcohol Use:

What type(s) of alcohol do you drink? _____

How many drinks do you have per week? _____

Legal history:

Do you have a history of being in legal trouble? _____

Do you have a pending court date? _____

Is there anything I may have missed that you believe is important for me to know prior to your appointment? _____