PSYCHIATRIST CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of
This form is used to collect information about new clients and for internal purposes only. The information you provide is confidential and will be treated accordingly.

Date: _____

PERSONAL INFO

Name: _____ **Medical Record Number**: _____

Phone Number: _____ Is it okay to leave a message? ☐ Yes ☐ No

REASONS FOR VISIT

What are the reasons for seeking help at this time?

What have you tried to help with the above problems?

Is there anything specific you are looking for? (check all that apply)

Psychotherapy?	☐ Yes	☐ No	☐ Maybe	☐ Not sure
Medication?	☐ Yes	☐ No	☐ Maybe	☐ Not sure
Advice only?	☐ Yes	☐ No	☐ Maybe	☐ Not sure

PSYCHIATRIC HISTORY

Past psychiatric history:

Prior psychiatric medications: ☐ Yes ☐ No (If yes, please list type, dosage, and dates, if known)

Prior psychotherapy: ☐ Yes ☐ No (If yes, please list provider(s) and dates, if known)

Prior psychiatric hospitalizations: ☐ Yes ☐ No (If yes, please list location(s) and dates)

PSYCHOLOGICAL ASSESSMENT

How much have the following problems bothered you in the <u>past week</u>?

0 = Not at all 1 = A little bit 2 = Somewhat 3 = Very much 4 = Extremely

Social anxiety	Rating
Fear of embarrassment causes me to avoid doing things or speaking to people.	☐0 ☐1 ☐2 ☐3 ☐4
I avoid activities in which I am the center of attention.	☐0 ☐1 ☐2 ☐3 ☐4
Being embarrassed or looking stupid are my worst fears.	☐0 ☐1 ☐2 ☐3 ☐4
Panic disorder	
It scares me when I feel shaky.	☐0 ☐1 ☐2 ☐3 ☐4
It scares me when I feel faint.	☐0 ☐1 ☐2 ☐3 ☐4
It scares me when my heart beats rapidly.	☐0 ☐1 ☐2 ☐3 ☐4
It scares me when I become short of breath.	☐0 ☐1 ☐2 ☐3 ☐4
Phobia	
I avoid (or feel distress in) situations for fear of getting trapped or that I may panic and not get help.	☐0 ☐1 ☐2 ☐3 ☐4
I have phobias (excessive or unreasonable fears of specific situations or objects). Describe specific phobia:	☐0 ☐1 ☐2 ☐3 ☐4
Trauma In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month, you had any of the following:	
I had nightmares about the event or thought about it when I did not want to.	☐0 ☐1 ☐2 ☐3 ☐4
I tried hard not to think about it or went out of my way to avoid situations that reminded me of the event.	☐0 ☐1 ☐2 ☐3 ☐4
I have been constantly on guard, watchful, or easily startled.	☐0 ☐1 ☐2 ☐3 ☐4
I have felt numb or detached from others, activities, or my surroundings.	☐0 ☐1 ☐2 ☐3 ☐4

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Obsessive-compulsion disorder Please rate how much you agree with each item. Please check your answer.	
Rate any: I am bothered by ideas, images, or impulses that seem silly, weird, nasty, or horrible, and I have trouble getting rid of them; or I fear doing something impulsively that might cause embarrassment or harm.	☐0☐1☐2☐3☐4
I check things too much (e.g., locks, switches, the stove) or do calculations repeatedly.	☐0☐1☐2☐3☐4
Rate any: I need to do things in a ritualized way, have things exactly symmetrical, or repeat actions until it feels “just right.”	☐0☐1☐2☐3☐4
Bipolar disorder	
I engage in behaviors that harm my body (e.g., cutting, hitting, or scratching self).	☐0☐1☐2☐3☐4
I have intense feelings of anger that I have difficulty controlling.	☐0☐1☐2☐3☐4
I react impulsively in ways that are either self-damaging or damaging to my relationships.	☐0☐1☐2☐3☐4
Somatic	
I have headaches.	☐0☐1☐2☐3☐4
I have stomach problems.	☐0☐1☐2☐3☐4
I have muscle or joint pains.	☐0☐1☐2☐3☐4
Mania	
I have gone for days at a time with excessive energy, little or no sleep, and have not felt tired.	☐0☐1☐2☐3☐4
I have had periods of euphoria or irritability, where my thoughts raced, and I could not slow my thinking down.	☐0☐1☐2☐3☐4
I have had trouble with grandiose plans, spending sprees, sexual acting out, or other impulsive behavior that seemed right at the time.	☐0☐1☐2☐3☐4
Attention deficit	
I have been impaired much of my life by difficulty in finishing projects I have started.	☐0☐1☐2☐3☐4
I have been impaired much of my life by a lack of organization.	☐0☐1☐2☐3☐4
I have been impaired much of my life by problems focusing on tasks.	☐0☐1☐2☐3☐4
I have been impaired much of my life by poor time management.	☐0☐1☐2☐3☐4
Eating disorder	
I engage in compulsive/binge eating (i.e., eating more than twice what others might eat in a single sitting).	☐0☐1☐2☐3☐4
I use purging, laxatives, or extreme exercise to control my weight.	☐0☐1☐2☐3☐4
I have a history of not eating with excessive weight loss.	☐0☐1☐2☐3☐4
Psychosis	
I believe that others can put thoughts into my head.	☐0☐1☐2☐3☐4
I hear voices talking to me or calling my name when no one is around.	☐0☐1☐2☐3☐4

Sometimes I receive messages from the TV or radio that are specifically directed at me.	☐0 ☐1 ☐2 ☐3 ☐4
Suicide	
I have thoughts of suicide	☐0 ☐1 ☐2 ☐3 ☐4
I have a specific plan to commit suicide.	☐0 ☐1 ☐2 ☐3 ☐4
I have a current intent to commit suicide.	☐0 ☐1 ☐2 ☐3 ☐4
I have guns in my home.	☐Yes ☐No
Prior history of suicide attempts?	☐Yes ☐No
Intimate partner abuse	
In your relationship, has there been any hitting, insulting, threatening to hurt, or screaming?	☐0 ☐1 ☐2 ☐3 ☐4
I do not feel safe in my home.	☐0 ☐1 ☐2 ☐3 ☐4

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

Patient health questionnaire Over the last **two weeks**, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things?	☐0 ☐1 ☐2 ☐3
Feeling down, depressed, or hopeless?	☐0 ☐1 ☐2 ☐3
Trouble falling asleep or staying asleep, or sleeping too much?	☐0 ☐1 ☐2 ☐3
Feeling tired or having little energy?	☐0 ☐1 ☐2 ☐3
Poor appetite or overeating?	☐0 ☐1 ☐2 ☐3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	☐0 ☐1 ☐2 ☐3
Trouble concentrating on things, such as reading the newspaper or watching television?	☐0 ☐1 ☐2 ☐3
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	☐0 ☐1 ☐2 ☐3
Thoughts that you would be better off dead or of hurting yourself in some way?	☐0 ☐1 ☐2 ☐3
Anxiety	
Feeling nervous, anxious, or on edge.	☐0 ☐1 ☐2 ☐3
Not being able to stop or control worrying.	☐0 ☐1 ☐2 ☐3
Feeling unproductive at work or other daily activities.	☐0 ☐1 ☐2 ☐3
Having trouble focusing on achieving your goals.	☐0 ☐1 ☐2 ☐3

ALCOHOL OR OTHER DRUG USE

In the last 12 months, have you abused alcohol or drugs? ☐Yes ☐No

Do you have a drug or alcohol problem? ☐Yes ☐No

If you drink alcohol, please indicate current use: (1 drink = 1 shot of liquor, 1 beer, or 1 glass of wine)

☐ 4 or more drinks per day ☐ 3-1 drinks per day ☐ 1 drink per day ☐ less than 5/week

Last drink (time and amount): _____

Do you use drugs (including marijuana)? ☐ Yes ☐ No

-If yes, what drugs? _____

-How much? _____ How often? _____

Have you ever tried cutting down on your drinking/drug use? ☐ Yes ☐ No

Have you ever felt angry/annoyed when asked about your drinking/drug use? ☐ Yes ☐ No

Have you ever felt guilty about your drinking/drug use? ☐ Yes ☐ No

Have you ever been arrested for a DUI? ☐ Yes ☐ No

PERSONAL INFO

Occupation: _____ **Employer**: _____

How long have you lived in your current area? _____

Highest education level attained: _____

Marital status: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed

Ethnicity: _____ **Religion**: _____

FAMILY INFO

Name	Living w/ you?	Age, if living	Occupation	History of mental illness, if any (please describe)
Spouse/partner				
	☐			
Children				
	☐			
	☐			
	☐			
	☐			
Any other family members with mental health issues				
	☐			
	☐			
	☐			

CONFIDENTIALITY DISCLOSURE

Federal and state law protects the confidentiality of chemical dependency records. Violation of federal confidentiality laws related to chemical dependency programs is a crime. Suspected violations may be reported to the appropriate authorities.

Except under limited circumstances (see examples below), _____ may not, without your written permission, disclose information about your care to anyone outside of the therapist-patient relationship. For your privacy, psychotherapy records of your mental health and chemical dependency visits are kept separate from your outpatient medical record. Regardless of the type of visit, however, for your personal safety, your medication visits, the list of medications, laboratory results, a description of medication results, and prognosis are included in your medical record, either on paper or electronically.

Exceptions to Confidentiality Rules

Sometimes, the law authorizes us to disclose information about you without your permission, such as disclosures:

- In medical and psychiatric emergencies in which the information is essential to an individual's safety.
- To warn potential victims of violent acts.
- To qualified personnel for audit, program evaluation, or research; for example, patient surveys.
- For reporting of suspected child abuse or neglect.
- To report the commission of crimes on our premises or against our program personnel.
- In response to court orders that comply with the standards for the type of record covered by the order.
- In reports to the Department of Motor Vehicles due to lapses of consciousness as required by law.

If at any time you have concerns about your privacy, you are encouraged to request clarification from your therapist or a staff member.

ACKNOWLEDGMENT

Patient signature: _____ Date: _____

Print name: _____

Representative signature (if required) _____ Date: _____

Print name: _____ Relationship to patient: _____