Name: _____
Date: _____
Phone number: _____

Initial Intake Form

History of Present Problem

How long ago did the problem(s) begin: _____

Please describe the problems that you would like help with:

Psychiatric History

Place a check for each symptom that applies.

	Suicidal thoughts		Explosive anger
	Self-mutilates		Rapid mood changes
	Emotional		Aggressive
	Shy and withdrawn		Decreased need for sleep
	Homicidal thoughts		Racing thoughts
	Loss of interest in almost all activities		Euphoria (feel on top of the world)
	Feelings of hopelessness		Risk-taking
	Apathy		Is very fidgety
	Difficulty sleeping		Exhibits sexually inappropriate behavior
	Fatigue		Visual or auditory hallucinations
	Unmotivated		Bizarre behavior
	Poor self esteem		Sexual problems
	Quiet		Overeating
	Feeling worthless		Anorexia or Bulimia
	Depression/sadness		Stomach aches
	Loss of appetite		Significant concerns with physical problems
	Weight loss		Destroys other people's property
	Anxiety/nervousness		cruel to other people
	Recurrent/intrusive thoughts		Fire setting
	Overwhelming need to perform certain behaviors/rituals		Cruel to animals
	Excessive fears or phobias		Starts fights with others
	Resists change		Breaks into other people's property
	Nightmares		When fighting, has used a weapon
	Recurrent/intrusive disturbing recollections or dreams		Other unusual behavior:

	Poor frustration tolerance		

Life Stress Indicate which stressors you have experienced currently (within last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
		Death of family member			Conflicts with friends			Verbal/emotional abuse
		Illness of family member			Conflicts at work			Sexual assault
		Illness of friend			Change in residence			Physical abuse
		Personal injury/illness			Legal problems			Other problems
		Separate from spouse			Work difficulties			
		Divorce from spouse			Involved in accident			
		Conflicts with family						

Prior Treatment

Have you received therapy in the past?_____
From who?_____

When did you start therapy? _____

For what problems(s)? _____

Have you received psychiatric medication(s) in the past?_____
From who?_____

For what problems(s)? _____

Do you currently have a medication provider? Who? _____

List all **current** psychiatric medications and dosages (medications that you are taking now):
_____

List all **past** psychiatric medications and dosages (medications that you have taken but are no longer taking)

List past psychiatric medications:_____

Have you even been hospitalized for psychological problems? _____
When?_____ Where were you hospitalized? _____

Drug Screen

	Past	Current	Current Amount
Tobacco			
Marijuana			

Barbiturates ("Downers")			
Tranquilizers			
Amphetamines ("Speed")			
Crank			
Crack			
Cocaine			
Opiates (Heroine, Opium, Codeine, etc.)			
Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) PCP ("angel dust") Other: _____			

Have you had a prior **psychological or neuropsychological evaluation**? Yes ___ No ___

If yes, complete this

information:

Name of psychologist: _____

Address: _____

Phone: _____ Date of and reason for this evaluation: _____

Findings of the evaluation: _____

Medical History

Please check all the conditions that have been diagnosed.

___ AIDS, ARC or HIV+ ___ Diabetes ___ Immune system disease ___ Poisoning

___ Allergies ___ Enzyme deficiency ___ Jaundice ___ Polio

___ Arthritis ___ Encephalitis ___ Kidney problems ___ Parkinson's Disease

___ Asthma ___ Ear Infections ___ Liver disorder ___ Rheumatic Fever

___ Abscessed ears ___ Fevers (104 or higher ___ Lung disease ___ Radiation exposure

___ Arteriosclerosis ___ Genetic disorder ___ Lead poisoning ___ Scarlet fever

___ Bleeding disorder ___ Head injury/concussion ___ Leukemia ___ Senility (Dementia)

___ Blood disorder ___ Heart problems ___ Metabolic disorder ___ Stroke or TIA

___ Broken bones ___ Hereditary disorder ___ Meningitis ___ Tuberculosis

___ Brain disease ___ Headaches ___ Measles ___ Tumor

___ Cerebral palsy ___ Hearing problems ___ Mumps ___ Thyroid disease

___ Colds (excessive) ___ Huntington's disease ___ Malnutrition ___ Venereal disease

___ Chicken pox ___ Hypertension ___ Multiple sclerosis ___ Vision problems

___ Hormone problems ___ Oxygen deprivation ___ Carbon monoxide poisoning ___ Pneumonia

___ Cancer ___ Hazardous substance exposure ___ Whooping cough

___ Other medical/physical problems_____

Have you ever been diagnosed with epilepsy or a seizure disorder

Yes ___ No ___

List any medications currently being taken (over-the-counter or prescription), and the dosage.

Medication Dose

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

List any medications you are ALLERGIC or sensitive to: _____

Past Hospitalizations (When, where and for what):

_____

_____

_____

Outpatient Surgeries (When, where and for what):

_____

_____

_____

Name of family physician:_____

Address:_____

Phone:_____

Date of your last medical check-up:_____

Educational History

Current grade (Or highest grade/degree completed): _____

Learning problems (what subjects): _____

Special education placement (Type): _____

During which grades: _____

Extracurricular activities (Music, Sports, Clubs, etc.)

_____

Expulsions/suspensions/conduct problems (Type of problem and date):

_____

Additional schooling or non-academic training:

_____

Occupational History

Present employer: _____ Position: _____

Length of employment: _____ Hours worked per week _____ Current responsibilities:

_____

List previous employment (Include dates and type of work):

_____

_____

Legal History

Present legal problems (Describe): _____

Past arrests (For what?): _____

Convictions (For what?): _____

Time served in juvenile hall, jail or prison (Give dates and locations):

_____

Please write down any other information you would like to discuss that may not be listed elsewhere:

_____

_____

_____

_____