Psychiatric Services of Prescott P.L.L.C.

PATIENT INTAKE FORM- Confidential

Please complete all the following information prior to your first visit. If there are questions you are unable to answer, or are uncomfortable answering, just leave them blank. Providing us with thorough information prior to your evaluation helps make your appointment time more efficient. If you wish to add supplementary information, please attach an extra page or add to the last page. Thank you for your time.

REFERRAL INFORMATION

Name _____ Date of Birth _____ Age_____

What are the problem(s)/ issues that bring you to this appointment?

_____

_____

What are your treatment goals/ what do you hope to achieve from your appointment?

_____

_____

Depressed mood		Irritability		Paranoia/suspiciousness	
Fatigue		Anger problems		Hallucinations	
Lack of enjoyment in activities		Decreased sleep		Social Media Issues	
Decreased sex drive		Increased sex drive		Disorganized thoughts	
Feelings of hopelessness		Racing thoughts		Homicidal thoughts	
Sleep problems		Excessive energy		Self-harm thoughts	
Weight change		Impulsivity		Marital problems	
Avoidance of activities		Thoughts of hurting others		School problems	
Crying spells		Excessive worry		Problems with family/friends	
Excessive guilt		Muscle tension		Problems with work	
Lack of concentration		Anxiety Attacks		Legal problems	
Feelings of worthlessness		Obsessions or compulsions		Housing problems	
Memory problems		Flashbacks to trauma		Physical reactions to stress	
Mood swings		Nightmares		Bullying	
Gambling		Mania		Sexual problems	
Substance abuse		Purging/Laxatives/Binge Eating		Other Addictions	

List other history /symptoms here:

Suicide /Safety Risk Assessment:

Have you ever harmed yourself on purpose? ( ) YES ( ) NO

Have you ever assaulted anyone? ( ) YES ( ) NO
Do you have thoughts of harming anyone? ( ) YES ( ) NO
Do you have plans to harm anyone? ( ) YES ( ) NO
Have you ever had feelings that you don't want to live? ( ) YES ( ) NO
If yes, answer the following. (If no, skip to next section.)

Do you currently feel that you don't want to live? ( ) YES ( ) NO
Do you have a plan for suicide at this time? ( ) YES ( ) NO
Is the method readily available? ( ) YES ( ) NO
When was the last time you had thoughts of dying? _____
How often are these thoughts present? _____
Have you ever attempted suicide before? ( ) YES ( ) NO
If so, what was the method, and when did this occur? _____
Access to weapons in the home ( ) YES ( ) NO

MEDICAL HISTORY

Primary Care Physician: _____ Phone number: _____

Date of last physical exam: _____ Date of last labs: _____

Allergies: _____Preferred Pharmacy: _____

List All Current Medications/Supplements*: (include psychiatric and medical)* Attach a list if necessary.

Medication	Dose	Reason	Prescribed by

Exercise level:
How frequently do you exercise? _____

What type of exercise do you do? _____
Do you eat a healthy diet? ( ) YES ( ) NO

Medical illnesses/surgeries please list:

History of head injury: ( ) YES ( ) NO **If yes, please explain:**

Seizures: ( ) YES ( ) NO

Review of *current* physical symptoms:

General ( ) YES ( ) NO
(Fever, weight changes, fatigue)

Cardiovascular ( ) YES ( ) NO
(Chest pain, palpitations)

Eyes/Ears/nose
Throat/mouth ( ) YES ( ) NO
(Vision change, hearing loss, dental)

Dermatologic ( ) YES ( ) NO
(Rash, sensitivities)

Genitourinary ( ) YES ( ) NO
Painful or frequent urination, Impotence

Hematological ( ) YES ( ) NO
(Bruising, blood loss)

Gastrointestinal ( ) YES ( ) NO
(Diarrhea, constipation)

Musculoskeletal ( ) YES ( ) NO
(Pain, injury, stiffness)

Respiratory ( ) YES ( ) NO
(shortness of breath, wheezing)

Other physical symptoms- _____

For women only: If not applicable, skip to next section.
Date of last menses: _____
Are you now pregnant? ( ) YES ( ) NO
Are you planning to get pregnant? ( ) YES ( ) NO
Current birth control ( ) YES ( ) NO
If yes, which type _____

PSYCHIATRIC/SUBSTANCE ABUSE TREATMENT HISTORY

Outpatient treatment: ( ) YES ( ) NO
Reason: _____

Dates: _____
By whom: _____

Current Therapist/counselor: _____Phone number: _____
How often do you see your therapist? _____

Inpatient Treatment history: ( ) YES ( ) NO If no, skip to next section.

Date	Name of Facility	Location	Reason

Substance Use History:
Have you ever been treated for alcohol or drug abuse? ( ) YES ( ) NO
If yes, for which substance, when and where was the treatment? _____
Do you think that you may have a problem with alcohol or drugs? ( ) YES ( ) NO
If yes, which ones? _____
How many days weekly do you drink alcohol? _____
Longest period of sobriety_____
History of IV use: ( ) YES ( ) NO

Substance	No Use	Last Use	Amount	Frequency	Duration (years)
Alcohol					
Opiates					
Benzodiazepines					
Amphetamines					
Marijuana					
Cocaine					
Nicotine					
Hallucinogens					
Inhalants					
Other					

Past Psychiatric medications: Please skip if never tried medication

Antidepressants	Helpful	Not helpful	Never Took		Mood Stabilizers	Helpful	Not Helpful	Never Took
Celexa/citalopram					Depakote/valproic acid			

Cymbalta/duloxetine					Lamictal/lamotrigine			
Effoxor/venlafaxine					Lithium			
Lexapro/escitalopram					Tegretol			
Paxil/paroxetine					Topamax/topiramate			
Pristiq/desvenlafaxine					Gabapentin			
Remeron/mirtazapine					Trileptal			
Prozac/fluoxetine					Other			
Viibryd/vilazodone					**Sedatives/hypnotics**	**Helpful**	**Not Helpful**	**Never Took**
Wellbutrin/bupropion					Ambien/zolpidem			
Zoloft/sertraline					Doxepin			
Trintellix/vortioxetine					Lunesta/eszopiclone			
Other					Restoril/temazepam			
Antipsychotic/Mood Stabilizers	**Helpful**	**Not Helpful**	**Never Took**		Rozerem			
Vraylar/cariprazine					Trazodone			
Abilify/aripiprazole					Belsomra			
Clozaril/clozapine					Other			
Geodon/ziprasidone					**Stimulants**	**Helpful**	**Not Helpful**	**Never Took**
Haldol/haloperidol					Ritalin/methylphenidate			
Invega/paliperidone					Adderall/amphetamine			
Latuda/larasidone					Strattera/atomoxetine			
Rexulti					Concerta			
Risperdal/risperidone					Intuniv/guanfacine			
Seroquel/quetiapine					Vyvanse			
Saphris/asenapine					Other			
Zyprexa/olanzapine					**Other**	**Helpful**	**Not Helpful**	**Never Took**
Other					Vivitrol/naltrexone			
Anxiolytic	**Helpful**	**Not Helpful**	**Never Took**		Methadone			
Valium/diazepam					Clonidine			
Buspar/buspirone					Suboxone			
Klonopin/clonazepam					Other			
Xanax/alprazolam								
Hydroxyzine								
Ativan/lorazepam								
Other								

Family background and Childhood History:

Where were you born? _____

Where did you grow up? _____

Were you adopted? _____

Did you have any problems with early development (learning to walk and talk, etc.)? ( )YES ( ) NO

Did you or any family members suffer from any major illness while you were growing up?

( )YES ( ) NO Please describe:

List your siblings and their ages._____

What was your mother's occupation? _____

Describe your mother and your relationship with her. _____

What was your father's occupation? _____

Describe your father and your relationship with him._____

Did your parents' divorce? ( )YES ( ) NO

If so, who did you live with and what was your age at the time of the divorce? _____

Trauma history:

Do you have a history of emotional, physical, sexual abuse or neglect? ( )YES ( ) NO

If so, please describe when, where and by whom. _____

Have you lived through an experience that you or others consider to be traumatic? ( )YES ( ) NO

If so, what and when? _____

Has anyone close to you died? ( ) YES ( ) NO

If so, who and when? _____

Family Mental Health History:

Has anyone in your family been diagnosed with a psychiatric illness? ( ) YES ( ) NO

If yes, who had what problems? _____

Have any family members been treated with psychiatric medications? ( ) YES ( ) NO

If so which medications? _____

Is there any family history of suicide? ( ) YES ( ) NO

Is there any family history of substance abuse/ dependence? ( ) YES ( ) NO

If yes, who had what problems? _____

Educational History:

If a currently student, where do you attend school and which grade are you in?

_____

For adults:

Did you attend college? ( ) YES ( ) NO

What is the highest level of education you have achieved? _____

Occupational History:

Are you currently ( ) a full time student ( ) working ( ) not working by choice ( ) unemployed ( ) disabled ( ) retired

If applicable what is or was your occupation? _____

Where do you work and for how long? _____

Relationship History and Living Situation:

Are you currently ( ) in a relationship ( ) single ( ) married ( ) divorced ( ) widowed for how long? _____

How many marriages have you had? _____

If in a relationship what is or was your spouse's/partner's occupation? _____

Describe your relationship._____

What is your sexual orientation? _____

What are your preferred pronouns? _____

If you have children, list ages and gender._____

Describe your relationship with your children._____

For children and Adults:

Who lives in your home with you at this time? _____

Do you have someone who you can confide in when you are under stress? ( ) YES ( ) NO

Do you have any pets? ( ) YES ( ) NO If yes, what type? _____

Legal history:

Have you ever been arrested? If so, for what and when? _____

Do you have any pending legal issues? If so, for what and when? _____

Spirituality:

If you were raised practicing any religion, which one? _____

Do you belong to any spiritual group or religion now? _____

Which religion_____

Is your spiritual life important to you? _____

Do you practice your faith regularly? _____

is your spirituality/faith available and helpful to you when you are in difficult situations? ( ) YES ( ) NO

Additional information that you would like the doctor to know:

Signature: _____

Name: _____

Date: _____