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NWA
PSYCHIATRY
a MANA clinic

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ADULT INTAKE FORM

NAME: ____TODAY'S DATE:_______________

DATE OF BIRTH: ____________________________ RACE: _________________ SEX: _________________

OTHER NAME YOU PREFER TO BE CALLED:____

NAME OF PERSON COMPLETING FORM:____

WHO REFERRED YOU TO OUR CLINIC:____

MAY WE CONTACT THEM: _____ YES ______NO

PRIMARY CARE DOCTOR: ____

MAY WE CONTACT THEM: _____ YES ______NO

PRIMARY CONCERNS FOR CONSULTATION: ____

____

____

HOW LONG HAVE THESE CONCERNS BEEN PRESENT: ____

PLEASE GIVE EXAMPLES OF THE PROBLEM(S): ____

____

____

WHAT ARE YOUR GOALS FOR TREATMENT: ____

____

____

Updated 2/2019

WHICH OF THE FOLLOWING SYMPTOMS/CONCERNS HAVE YOU EXPERIENCED IN THE LAST 60 DAYS:

_____ Sad or depressed mood _____ Withdrawn from family or friends

_____ Loss of interest in activities or hobbies _____ Feelings of guilt or worthlessness

_____ Feeling hopeless about the future _____ Sleep disturbance _____Change in appetite

_____Low energy or fatigue _____Trouble focusing or concentrating _____Thoughts of hurting self

_____Thoughts of suicide _____Thoughts of hurting or killing others _____Irritability

_____Severe angry outbursts (verbal or physical) _____Worrying too much

_____Feeling or acting restless _____Muscle tension _____Panic or anxiety attacks

_____Fear of looking stupid or being embarrassed _____Fear of offending others

_____Any other fears or phobias _____Drastic mood swings _____Episodes of decreased need for sleep

_____Extreme hyperactivity _____Racing thoughts _____Talking so fast it's hard to understand

_____Overly happy or euphoric _____Overly confident

_____Thoughts, feelings or images that come into your mind when you do not want them to?

_____Habits you feel you must do even if you know it does not make sense (for example excessive cleaning, checking, repeating, counting, organizing or hoarding things)?

_____Hearing voices that other people cannot hear _____Odd thinking or beliefs

_____Seeing things other people cannot see _____Feeling paranoid _____Poor body image

_____Trying to lose weight even though you are not overweight

_____Intentionally throwing up after eating _____Easily loses temper _____Easily annoyed

_____Defiant _____Argues with authority figures _____Annoying others on purpose

_____Blaming others for your mistakes _____Resentful, spiteful or vindictive _____Lying

_____Stealing _____Destroying property _____Setting fires _____Skipping school

_____Hurting other people or animals _____Difficulty learning

_____Trouble understanding social cues _____ Difficulty making/keeping friends

_____Sensitive to sound, light, touch or smell

HAVE YOU EXPERIENCED A TRAUMATIC EVENT: _____ Sexual abuse _____ Physical abuse

_____ Near death experience _____ Other traumatic event: ____________________________________

____

SOCIAL HISTORY:

WHO LIVES AT YOUR PRIMARY RESIDENCE: _____ Spouse/significant other _____ Children

_____ Parent _____Brother(s) _____ Sister(s) _____ Roommate _____ Grandparent

_____ Foster children _____ Other: ____

CURRENT EMPLOYER: ____

HOW LONG AT THIS JOB?: _____________

HIGHEST EDUCATION COMPLETED: _____ Post graduate degree _____ Bachelor's degree

_____ Associate's degree _____ Technical school _____ High school graduate

_____ Last grade completed if did not graduate

ARE THERE ANY CURRENT LEGAL PROCEEDINGS INVOLVING YOU? _____ YES ______NO

IF YES, PLEASE EXPLAIN: ____

____

PREGNANCY HISTORY:

WAS YOUR MOM'S PREGNANCY COMPLICATED IN ANY WAY, PLEASE EXPLAIN IF YES:

_____ YES ______NO ____

____

____

DEVELOPMENTAL HISTORY:

WERE THERE ANY PROBLEMS WITH YOUR EARLY CHILDHOOD DEVELOPMENTAL MILESTONES (SIT, WALK, TALK, TOILET TRAIN, ETC)?

_____ YES ______NO ____

____

____

PAST MEDICAL HISTORY:

HAVE YOU EVER HAD? _____ Headaches ______Seizures _____ Allergies (seasonal) ______Diabetes

_____ Thyroid condition ______Asthma _____ Other lung problems ______Cancer _____ Head injury/concussion ______ Hypertension ______ OTHER:_______________________________________

____

HAVE YOU EVER HAD ANY SURGERIES? _____ YES ______NO If yes, please list surgeries and dates:

____

____

____

____

CURRENT MEDICATIONS

Name	Dosage	Frequency	When started

MEDICATION ALLERGIES _____ NONE ______YES (please explain) ___________________________

____

OTHER ALLERGIES _____ NONE ______YES (please explain) ________________________________

____

BIOLOGICAL FEMALES ONLY:

WHAT FORM OF BIRTH CONTROL DO YOU USE?____

ARE PERIODS REGULAR? _____ YES ______NO DATE OF LAST MENSTRUAL CYCLE ____ / ____ / _____

IS THERE ANY CHANGE IN SYMPTOM SEVERITY WITH PERIODS? _____ YES ______NO

IF YES, PLEASE DESCRIBE____

ARE YOU PREGNANT? _____ YES ______NO   ARE YOU BREASTFEEDING? _____ YES ______NO

PAST PSYCHIATRIC HISTORY:

HAVE YOU EVER SEEN A PSYCHIATRIST OR THERAPIST/COUNSELOR BEFORE? ____ YES _____NO

Name of provider Dates seen Reason

____

____

____

____

HAVE YOU EVER BEEN ADMITTED TO A PSYCHIATRIC HOSPITAL? _____ YES ______NO

Name of the hospital Dates Reason

____

____

____

____

HAVE YOU ATTEMPTED SUICIDE? _____ YES ______NO If yes, please describe: _________________

____

____

DO YOU ENGAGE IN ANY SELF-HARM BEHAVIORS (LIKE CUTTING)? _____ YES ______NO

If yes, please describe: ____

____

____

HAVE YOU EVER BEEN VIOLENT OR AGGRESSIVE? _____ YES ______NO

If yes, please describe: ____

____

____

HAVE YOU EVERY USED ANY OF THE FOLLOWING? (MARK ALL THAT APPLY)

______Tobacco ______Vaping ______Marijuana ______Alcohol

______Opiates ______Benzos ______Ecstasy ______Methamphetamine

______Cocaine ______Heroin ______Other:________________________________

ARE YOU CURRENTLY USING ANY OF THOSE MARKED ABOVE? ______Yes ______No

PLEASE MARK ANY PSYCHIATRIC MEDICATIONS YOU HAVE TAKEN IN THE PAST:

_____Alprazolam (Xanax) _____Diazepam (Valium) _____Mirtazapine (Remeron)

_____Amitriptyline (Elavil) _____Duloxetine (Cymbalta) _____Nortriptyline (Pamelor)

_____Amphetamine (Adderall) _____Escitalopram (Lexapro) _____Olanzapine (Zyprexa)

_____Aripiprazole (Abilify) _____Fluoxetine (Prozac) _____Oxcarbazepine (Trileptal)

_____Asenapine (Saphris) _____Fluphenazine (Prolixin) _____Paliperidone (Invega)

_____Atomoxetine (Strattera) _____Fluvoxamine (Luvox) _____Paroxetine (Paxil)

_____Bupropion (Wellbutrin) _____Guanfacine (Intuniv) _____Quetiapine (Seroquel)

_____Buspirone (BuSpar) _____Haloperidol (Haldol) _____Risperidone (Risperdal)

_____Carbamazepine (Tegretol) _____Iloperidone (Fanapt) _____Sertraline (Zoloft)

_____Citalopram (Celexa) _____Imipramine (Tofranil) _____Topiramate (Topamax)

_____Clomipramine (Anafranil) _____Lamotrigine (Lamictal) _____Trazodone (Desyrel)

_____Clonazepam (Klonopin) _____Levomilnacipran (Fetzima) _____Valproic Acid (Depakote)

_____Clonidine (Kapvay) _____Lisdexamfetamine (Vyvanse) _____Venlafaxine (Effexor)

_____Clozapine (Clozaril) _____Lithium _____Vilazodone (Viibryd) _____Desipramine (Norpramin)

_____Lorazepam (Ativan) _____Vortioxetine (Brintellix) _____Desvenlafaxine (Pristiq)

_____Loxapine (Loxitane) _____Ziprasidone (Geodon) _____Dexmethylphenidate (Focalin)

_____Lurasidone (Latuda) _____ Other: ____

FAMILY MEDICAL HISTORY including great grandparents, grandparents, parents, great aunts, great uncles, aunts, uncles, cousins of any degree, siblings, nieces, nephews, etc.

Have any of your relatives ever had any of the following:

	Yes	No	Relationship to patient
Migraine/Chronic headaches			
Seizures			
Stroke			
High blood pressure			
Heart disease			
Heart attack			
Heart Murmur			
Lung disease			
Asthma			
Gastric reflux disease			
Diabetes			
High cholesterol			
Liver disease			
Kidney disease			
Thyroid disease			
Obesity			
Glaucoma			
Anemia			
Sudden unexplained death			
Dementia			
Cancer			

FAMILY PSYCHIATRIC HISTORY

Have any of your blood relatives ever had any of the following:

	Yes	No	Relationship to patient
Depression			
Bipolar disorder			
Suicide			
Anxiety disorders			
Panic disorder			
Agoraphobia			
Obsessive Compulsive Disorder			
PTSD			
Eating disorder			
Schizophrenia			
Other psychosis			
ADHD/ADD			
Oppositional Defiant Disorder			
Conduct disorder			
Personality disorders			
Tourette's syndrome			
Autism spectrum disorder			
Alcoholism			
Substance abuse			
Psychiatric hospitalizations			

____

Signature of person completing form Date