**Psychiatric Evaluation Intake Form**

Name_____
Address_____
Best contact phone number _____Email Address _____
Primary Care Physician_____ Phone _____ Fax_____
Race/Ethnicity _____
Current marital status _____
If you are married or cohabitating with a partner, how long has it been? _____
Total number of marriages?_____ How many children do you have?_____
Spouse's/Partner's Name_____
Who else lives with you?_____
Highest degree obtained in school?_____
Current employer and employment status:_____
Occupation: _____
Spouse's/Partner's occupation_____

Are you currently seeing a therapist? _____How long and how frequently?_____
If yes please provide the name and contact number: _____
Do I have permission to discuss information you tell me with them? _____
Have you ever been seen by a therapist or psychiatrist in the past? If yes, then please list:_____
_____

Have you ever been treated for by any of the following (check all that apply):

___ Depression ___ ADHD ___ Binge-eating ___ ECT Treatment
___ Anxiety ___ OCD ___ Schizophrenia
___ Panic Attacks ___ PTSD ___ Alcohol Problems (including AA)
___ Anorexia/Bulimia ___ Drug Problems ___ Bipolar (Manic/Depressive) Disorder

Please list in chronological order all prior psychiatric hospitalizations (if any) below:

| Approximate Date | Length of Stay | Name of Hospital | Reason for Admission |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below:

| Approximate date of attempt | How did you attempt (method)? |
|---|---|
| | |
| | |
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| | |

**Please list all current medications** (include birth control pills, over the counter medications, herbal remedies) (it may be helpful to bring them in)

| Name of Medication | Dosage (Mg) | How many times a day? | On this for how long? | Side effects (if any)? | Prescribing physician |
|---|---|---|---|---|---|
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Please review the following list of medications. If you have taken any of these medications please fill out the specific boxes related to that medication.

| Brand Name | Generic Name | Check if yes | How long did you take it? | What dosage did you take? | Did it help? | How often in a day? | Any side effects? |
|---|---|---|---|---|---|---|---|
| Luvox | Fluvoxamine | | | | | | |
| Paxil | Paroxetine | | | | | | |
| Celexa | Citalopram | | | | | | |
| Lexapro | Escitalopram | | | | | | |
| Zoloft | Sertraline | | | | | | |
| Prozac | Fluoxetine | | | | | | |
| Effexor | Venlafaxine | | | | | | |
| Pristiq | Desvenlafaxine | | | | | | |
| Cymbalta | Duloxetine | | | | | | |
| Desyrel | Trazodone | | | | | | |
| Serzone | Nefazodine | | | | | | |
| Wellbutrin | Bupropion | | | | | | |
| Viibryd | Vilazodone | | | | | | |
| Buspar | Buspirone | | | | | | |
| Asendin | Amoxapine | | | | | | |
| Elavil | Amitriptyline | | | | | | |
| Ludiomil | Maprotiline | | | | | | |
| Norpramin | Desipramine | | | | | | |
| Pamelor | Nortriptyline | | | | | | |
| | Doxepin | | | | | | |
| Tofranil | Imipramine | | | | | | |
| Anafranil | Clomipramine | | | | | | |
| Nardil | Phenelzine | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Parnate | Tranylcypromine | | | | | | |
| | Selegiline patch | | | | | | |

Continued list of medications taken. Please review the following list of medications. If you have taken any of these medications please fill out the specific boxes related to that medication.

| Brand Name | Generic Name | Check if yes | How long did you take it? | What dosage did you take? | Did it help? | How often in a day? | Any side effects? |
|---|---|---|---|---|---|---|---|
| Abilify | Aripiprazole | | | | | | |
| Risperdal | Risperidone | | | | | | |
| Invega | Paliperidone | | | | | | |
| Geodon | Ziprasidone | | | | | | |
| Zyprexa | Olanzapine | | | | | | |
| Seroquel | Quetiapine | | | | | | |
| Clozaril | Clozapine | | | | | | |
| Saphris | Asenapine | | | | | | |
| Latuda | Lurasidone | | | | | | |
| Fanapt | Illioperidone | | | | | | |
| Prolixin | Fluphenazine | | | | | | |
| Haldol | Haloperidol | | | | | | |
| Navane | Thiothixene | | | | | | |
| | Trifluperazine | | | | | | |
| | Pimozide | | | | | | |
| | Perphenazine | | | | | | |
| | Loxapine | | | | | | |
| | Thioridazine | | | | | | |
| | Loxapine | | | | | | |
| Mellaril | Thioridazine | | | | | | |
| Thorazine | Chlorpormazine | | | | | | |

| Brand Name | Generic Name | Check if yes | How long did you take it? | What dosage did you take? | Did it help? | How often in a day? | Any side effects? |
|---|---|---|---|---|---|---|---|
| Valium | Diazepam | | | | | | |
| Xanax | Alprazolam | | | | | | |
| Librium | Chlordiazepoxide | | | | | | |
| Klonopin | Clonazepam | | | | | | |
| Ativan | Lorazepam | | | | | | |
| Restoril | Temazepam | | | | | | |
| Lunesta | Eszopiclone | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Ambien | Zolpidem | | | | | | |
| Sonata | Zaleplon | | | | | | |
| Ramelteon | Rozerem | | | | | | |
| | Chloral Hydrate | | | | | | |

Continued list of medications taken. Please review the following list of medications. If you have taken any of these medications please fill out the specific boxes related to that medication.

| Brand Name | Generic Name | Check if yes | How long did you take it? | What dosage did you take? | Did it help? | How often in a day? | Any side effects? |
|---|---|---|---|---|---|---|---|
| | Lithium | | | | | | |
| Depakene<br>Depakote | Valproate<br>Valproic acid | | | | | | |
| Tegretol | Carbamazepine | | | | | | |
| Topamax | Topiramate | | | | | | |
| Lamictal | Lamotrigine | | | | | | |
| Trileptal | Oxcarbazepine | | | | | | |
| | Gabapentin | | | | | | |

| Brand Name | Generic Name | Check if yes | How long did you take it? | What dosage did you take? | Did it help? | How often in a day? | Any side effects? |
|---|---|---|---|---|---|---|---|
| Dexedrine | Dextroamphetamine | | | | | | |
| Ritalin, Metadate, Concerta | Methylphenidate | | | | | | |
| Cylert | Pemoline | | | | | | |
| Vyvanse | Lisdexamfetamine | | | | | | |
| Adderall | Amphetamine | | | | | | |
| Focalin | Dexmethylphenidate | | | | | | |
| Strattera | Atomoxetine | | | | | | |
| | Modafinil | | | | | | |
| | Clonidine | | | | | | |
| Intuniv | Guanfacine | | | | | | |

**Family History:** Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate put paternal or maternal)

| | Father | Mother | Aunt | Uncle | Brother | Sister | Children | Grandparent |
|---|---|---|---|---|---|---|---|---|
| Depression | | | | | | | | |
| Anxiety | | | | | | | | |
| Panic Attacks | | | | | | | | |
| Post Traumatic Stress | | | | | | | | |
| Bipolar Manic/Depression | | | | | | | | |
| Schizophrenia | | | | | | | | |
| Alcohol problems | | | | | | | | |
| Drug problems | | | | | | | | |
| ADHD | | | | | | | | |
| Suicide attempts | | | | | | | | |
| Psychiatric hospital stay | | | | | | | | |

**Medical History:** Do you have, or have you ever had any of the following? Please circle ones you have and write in details below.

| | | |
|---|---|---|
| High Blood Pressure | Gastrointestinal Problems (ulcers, pancreatitis, irritable bowel, colitis) | Viral Illness (Herpes, Epstein-Barr, Chronic Hepatitis) |
| Lung Disease | Arthritis or Rheumatoid Problems | Cancer |
| Diabetes | Liver Damage or Hepatitis | Genital Problems |
| Heart Disease | Other Endocrine/Hormone Problems | Eating Disorder |
| Thyroid Disease | Neurological Problems (stroke, brain tumor, nerve damage) | Eye Problems |
| Anemia | Gynecological/hysterectomy | Chronic Pain |
| Asthma | Urinary Tract or Kidney Problems | Fibromyalgia |
| Skin Disease | Migraine or Cluster Headaches | HIV Positive or AIDS |
| Seizures | Ear/Nose/Throat Problems | Head Injury |
| Other medical issues: | High Cholesterol | Sleep Apnea |

List all prior surgeries and hospitalizations for medical illnesses:

_____
_____
_____
_____

Are you allergic to any medication or food? If so, please list below:

_____
_____

Last Menstrual Period (if applicable):_____
Contraceptive method _____

What is your normal diet like?
Breakfast:_____
Lunch: _____
Dinner _____

What type of exercise do you do?_____
How much and how often do you exercise?_____
_____

When was your last drink of alcohol?_____
In the past 30 days, about how many days have you had at least one alcoholic drink?_____
What is the maximum number of drinks you have had in one day in the past month?_____
Circle any of the following you have had: DUI, DWI, Public Intoxication, Seizures, DT's

Please check the appropriate boxes that apply to you for the following substances:

| | Never used: | Age 1st used: | Last used on this approx date: | Age peak use: | Current use and frequency: |
|---|---|---|---|---|---|
| Cocaine | | | | | |
| Amphetamine/Speed | | | | | |
| Marijuana/THC | | | | | |
| Diet Pills | | | | | |
| Hallucinogens (LSD, Mushrooms, Mescaline) | | | | | |
| Ecstasy | | | | | |
| Diuretics | | | | | |
| Tranquilizers | | | | | |
| Pain Pills | | | | | |
| Inhalants | | | | | |
| Sleeping Pills | | | | | |
| Laxatives | | | | | |
| Cigarettes, cigars or tobacco | | | | | |
| PCP or Angel Dust | | | | | |
| IV Drug use | | | | | |
| Heroin | | | | | |
| GHB | | | | | |
| Anabolic Steroids | | | | | |
| Caffeine (coffee, tea, cola's, energy drinks) | | | | | |
| Benzodiazepines (Xanax, Valium, Ativan, Restoril, Librium) | | | | | |
| Other: | | | | | |

## The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

| Over the past 2 weeks, how often have you been bothered by any of the following problems? | Not At all | Several Days | More Than Half the Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling asleep, staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. 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 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**Column Totals** _____ + _____ + _____

**Add Totals Together** _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

**Generalized Anxiety Disorder Screener (GAD-7)**

| Over the *last 2 weeks*, how often have you been bothered by the following problems? | Not at all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritated | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| | Add columns | | | |
| | Total Score | | | |
| 8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |

When did the symptoms begin? _____