Psychiatric Intake Form

(All information on this form is subject to HIPAA compliance. All Personal Health Information (PHI) is protected to ensure confidentiality for all out clients)

Please complete all information on this form and bring it to the first visit. *The length of this medical intake form is to guarantee a thorough review of your current conditions, past issues, and medical history to ensure that Surya Psychiatric Clinic, PLLC is providing you with exceptional care that you deserve. You may need to ask family members about the family history. Thank you!*

Name:_____ DOB:_____ Date:_____

What concern(s) bring(s) you to the Surya Psychiatric Clinic?

_____
_____
_____

What has been stressing you as of lately (e.g. family, job, recent loss, financial issues, etc.)?

_____
_____
_____

What are your treatment goals?

_____
_____

Are you currently experiencing any of the following conditions?

☐ Depression?	☐ Worrying excessively?	☐ Hearing voices?
☐ Loss of Interest in activities?	☐ Having tense muscle?	☐ Seeing things?
☐ Feeling hopeless or worthless?	☐ So anxious you feel you can not rest or relax?	☐ Smelling things?
☐ Poor energy or fatigue?	☐ Having Panic attacks?	☐ Feeling abnormal sensations in skin?
☐ Change in appetite (⇑ or ⇓)?	☐ Traumatic events that come back in nightmares, flashbacks?	☐ Feeling people were trying to watch or harm you?
☐ Poor self-esteem?	☐ Feeling awkward in public?	☐ Concerns about alcohol or drug use?
☐ Poor focus or concentration?	☐ Thoughts that replay?	☐ Concerns about eating too much?

☐ Thoughts of not being alive?	☐ Repetitive or compulsive behaviors or rituals?	☐ Eating too little?
☐ Problems going to sleep?	☐ Phobias or fears?	☐ Memory Problems?
☐ Periods of euphoria or unusually good mood?	☐ Grunts, tics, or jerks?	☐ Getting lost easily?
☐ Going days without needing to Sleep?	☐ Inattentiveness at work or School? If so, since what age?	☐ Forgetting how to do tasks?
☐ Racing thoughts?	☐ Hyperactivity or fidgety?	☐ Problems finding words?
☐ Talking too fast?	☐ Acting impulsively(spending, Speeding, hypersexuality, etc.)?	☐ Problems with caring for self (cooking, dressing, etc.)?

Past Psychiatric Care

When was the first time you experienced any condition relating to your emotions?

Age_____ Year_____

Have you ever been diagnosed with any of the following?

☐ Depression	☐ Panic Disorder	☐ Alcoholism
☐ Bipolar Disorder	☐ Social Anxiety Disorder	☐ Drug addiction
☐ ADHD	☐ Generalized Anxiety Disorder	☐ Eating Disorder
☐ OCD	☐ Borderline Personality Disorder	☐ Other (please Specify)
☐ PTSD	☐ Schizophrenia or Schizoaffective d/o	

Have you ever been seen by a psychiatrist, psychology, therapist/counselor, or mental health professional? Please list and describe.

Name of Provider	Dates Treated	Condition Treated	Treatment Modes (Medication, Therapy, Nutrition, ECT and/or etc.)

Have you ever been hospitalized for psychiatric care? Please list and describe?

Date Treated	Condition Treated	Treatment Modes (Medication, Therapy, Nutrition, ECT and/or etc.)

Have you ever been treated with any of the following medications? (If you can't remember all the details, just write as much as you recall).

Medications Name AND Class	Dates, Dosages, Positive/Negative response, Side-effects, Purpose of Usage
Antidepressants	
Prozac (Fluoxetine)	
Zoloft (Sertraline)	
Paxil (Paroxetine)	
Luvox (Fluvoxamine)	
Celexa (Citalopram)	
Lexapro (Escitalopram)	
Effexor (Venlafaxine)	
Cymbalta (Duloxetine)	
Pristiq (Desvenlafaxine)	
Fetzima (Levomilnacipran)	
Viibryd (Vilazodone)	
Trintellix (Vortioxetine)	
Wellbutrin (Burpoprion)	
Remeron (Mirtazapine)	
Serzone (Nefazodone)	
Anafranil (Clomipramine)	
Pamelor (Nortriptyline)	
Elavil (Amitriptyline)	
Tofranil (Imipramine)	
Nardil (Phenelzine)	
Parnate (Tranylcypromine)	
Emsam (Selegiline) Patch	

Mood Stabilizers	
Lithium	
Depakote (Valporate)	
Tegretol (Carbamazepine)	
Trileptal (Oxcarbazepine)	
Topamax (Topiramate)	
Lamictal (Lamotrigine)	
Antipsychotics/Mood Stabilizers	
Risperdal (Risperidone)	
Zyprexa (Olanzapine)	
Seroquel (Quetiapine)	
Geodon (Ziprasidone)	
Abilify (Aripripazole)	
Clozaril (Clozapine)	
Invega (Paliperidone)	
Saphris (Asenapine)	
Fanapt (Iloperidone)	
Latuda (Lurasidone)	
Rexulti (brexpripazole)	
Haldol (Haloperidol)	
Prolixin (Fluphenazine)	
Orap (Pimozide)	
Trilafon (Perphenazine)	
Thorazine (Chlorpromazine)	
Anti-Anxiety Medications	
Xanax (Alprazolam)	
Ativan (Lorazepam)	
Klonopin (Clonazepam)	
Valium (Diazepam)	
Tranxene (Clarazepate)	
Librium (Chlordiazepoxide)	
Buspar (Buspirone)	
ADHD Medications	
Adderall (Amphetamine Salts)	
Ritalin (Methylphenidate)	
Strattera (Atomoxetine)	
Vyvance (Lisdexamfetamine)	
Dexedrine(Dextroamphetamine)	
Sedative/Hypnotics	
Ambien (Zolpidem)	
Sonata (Zaleplon)	

Rozerem (Ramelteon)	
Restoril (Temazepam)	
Lunesta (	
Trazodone	
Other	
Revia/Vivitrol (Naltrexone)	
Campral (Acamprosate)	
Methadone	
Neurontin (Gabapentin)	
Suboxone/Subutex	
Symmetrel (Amantadine)	
Any Other Psychiatric Meds?	

Past Medical Care

Primary Care Doctor: _____

Last Seen Date: _____

List of Current Medical Conditions:

_____

_____

List of Past Surgeries:

_____

_____

Please list all medications you are currently taking, including over-the-counter medications, herbals, and supplements.

Medication	Dosage	# times per day	Condition Treated	Prescribing Provider

History of Head Injury: ☐ **Yes** ☐ **No**
If yes, please explain:_____
_____

Describe any allergies you have (e.g. to medications, foods)

_____
_____

*** WOMEN ONLY ***
Last menstrual period: _____
Usually regular? ☐ **Yes** ☐ **No**
Do you use any birth control? ☐ **Yes** ☐ **No**
If yes, please list _____
Have you been pregnant before? ☐ **Yes** ☐ **No**
If yes, how many times? _____
Have you experienced any miscarriages? ☐ **Yes** ☐ **No**
Have you ever elected for an abortion? ☐ **Yes** ☐ **No**
Any depression and/or unreal thoughts around pregnancies? ☐ **Yes** ☐ **No**
If yes, please explain_____
Are you post-menopausal/had a hysterectomy/ had tubal ligation? ☐ **Yes** ☐ **No**

At this time, do you have any concerns about your physical health that you would like to discuss with our providers?

Substance Use History

How often have you used the following substances?

	Approximately how often (# of times per week, month, or year)?	How much do you use in a sitting if/when you do use?
Tobacco		
Alcohol		
Marijuana or K2/ "Spice"		
Cocaine		
Opiates (e.g. heroin, morphine, Percocet, oxycodone, Tylenol #3, Dilaudid /hydromorphone etc.)		
Tranquilizers/sedative (e.g. Xanax, Ativan, Klonopin, Valium etc.)		
PCP or LSD		

Mushrooms		
Others_____		

Have you had any history of Substance Use Treatment: ☐ **Yes** ☐ **No**

If yes, please describe_____

Did you ever face legal issues due to substance use? ☐ **Yes** ☐ **No**

If yes, please describe_____

Have you ever felt you ought to cut down on your drinking /drug use? ☐ **Yes** ☐ **No**

Have people annoyed you by criticizing your drinking or drug use? ☐ **Yes** ☐ **No**

Have you ever felt bad or guilty about your drinking or drug use? ☐ **Yes** ☐ **No**

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ **Yes** ☐ **No**

Do you think you may have a problem with alcohol or drug use? ☐ **Yes** ☐ **No**

Have you ever abused prescription medication or take any medication that is not prescribed for you (such as opiates) ☐ **Yes** ☐ **No**

If yes, please describe the medication used and length of usage:_____

_____

Family History:

Were you adopted ☐ **Yes** ☐ **No**

Relative	Alive/Deceased	Age	Quality of relationship with them:
Father			
Mother			
Sibling #1			
Sibling #2			
Sibling #3			
Sibling #4			

Did your parents divorce? ☐ **Yes** ☐ **No**

If so, how old where you when they divorced? _____

If your parents divorce, who did you live with? _____

Please list blood relatives who have been diagnosed with the following conditions.

Conditions	Relatives
Alcoholism	
Anxiety Disorders	
Bipolar Disorder	
Caner	
Depression	
Diabetes	
Drug Use	
Heart disease/high blood pressure/arrhythmias	
Osteoporosis	
Seizures	
Schizophrenia	
Stokes	
Suicide/Self harm behaviors	
Thyroid Disease	
Any other psychiatric/ Medical conditions (please specify)	

Has any family member been treated with a psychiatric medications?

☐ Yes ☐ No ☐ Not Sure

If yes, who was treated and what medications and how effective was treatment?

_____

Social History

Where do you live? _____

Who lives with you? _____

Highest level of education? _____

What is your current job/occupation? _____

What jobs have you had in the past? _____

What is your relationship status? _____

If married or in relationship, how long? _____
Have you been married in the past? ☐ **Yes** ☐ **No** _____ **# of times**

Do you have children? ☐ **Yes** ☐ **No**
If so, how many, what are their ages? _____

What do you do in your free time to relax? _____

Do you have religious beliefs? ☐ **Yes** ☐ **No**
If so, describe _____
How important are your religious/spiritual beliefs to your life?
_____

Have you experienced any legal issues (e.g. arrests, charges, time in jail/prison, probation/parole)? **Yes** ☐ **No** ☐
If so, please describe
_____

Have you ever been the victim of a violent crime? ☐ **Yes** ☐ **No**
If so, please describe_____
Have you ever been a victim of physical, emotional, verbal, sexual abuse or rape? If so, please explain (as much as you can)
_____

Have you ever served in military? ☐ **Yes** ☐ **No**
If so, what branch and when? _____
Any combat experience? ☐ **Yes** ☐ **No**
Honorable discharge ☐ **Yes** ☐ **No** ☐ **Other**

Safety

Do you currently have thoughts of hurting yourself or others? ☐ **Yes** ☐ **No**
If yes, SELF ☐ **OTHER** ☐
How often do you have these thoughts? _____
When was the last time you had these thoughts? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10 (10 being strongest), how strong is your desire to kill self or others? _____
Would anything make it better? _____
Have you thought about how you would kill (self or others)? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____

Is there anything that would stop you from killing yourself or others? _____
Do you feel hopeless and/or worthless? _____
Have you tried to hurt yourself/others in the past? If so, please explain _____
_____
Do you own or have access to any guns or weapons? _____

Is there anything else that you would like your provider to know? We wish to hear everything from our clients (positive or negative). Please don't hesitate to tell us your thoughts.

_____
_____
_____
_____

QUICK CHECKLIST: Review of Symptoms

CHECK ONLY IF YOUR WISH TO RESPOND WITH A "YES"

Yes	SYMPTOMS	Yes	SYMPTOMS
	Weight Loss		Joint Pain/Swelling
	Fatigue		Stiffness
	Fever		Muscle Pain
	Glasses/Contacts		Back Pain
	Eye Pain		Heartburn/reflux
	Double Vision		Nausea/Vomiting
	Cataracts		Constipation
	Difficulty Hearing		Jaundice
	Ringing in Ears		Black or bloody Bowel Movement
	Burning/frequency of urination		Change in Bowel Movements
	Nighttime Urination		Abdominal Pain
	Blood in Urine		Diarrhea
	Erectile Dysfunction		Easy Bruising
	Abnormal Discharge		Gums Bleed Easily
	Bladder Leakage		Enlarged Glands
	Vertigo		Rash/Sores
	Sinus Trouble		Lesions
	Nasal Stuffiness		Itching/burning
	Frequent Sore Throat		Loss of Strength
	Hives/Eczema		Numbness/Tingling
	Hay Fever		Headaches
	Murmur		Tremors
	Chest Pain		Memory Loss

	Palpitations		Cough Easily
	Dizziness		Coughing Blood
	Fainting Spells		Wheezing
	Shortness of breath		Chills
	Difficulty lying Flat		Loss of Hair
	Swelling Ankles		Heat/Cold Intolerance

I, attest, I have filled this form out to the best of my knowledge.

Print Name:_____ **Date: _____**

_____

Signature of Patient