JEFFERSON COMMUNITY Health & Life

Psychiatry Intake Form

Patient Name:_____ **DOB:**_____

Preferred language: _____ **Gender/Identifier:** ☐ Male/he/him ☐ Female/she/her ☐ Nonbinary/they/them

Service(s) sought: ☐ Therapy ☐ Medication Management ☐ Both ☐ Not sure

Preferred Pharmacy:

Primary Physician: **Referred by:**

Allergies: ☐ No Known Medication Allergies ☐ No Known Environmental or Food Allergies

List allergies and describe the reactions:

Allergy	Reaction

Medications: (List Names of Medications, Supplements/Vitamins with Dosage and Frequency) ☐ None

If you have a list, please give it to the nurse to copy.

Medication	Dosage	Frequency

Surgeries: Please list any surgeries and the approximate date performed.

Surgery Type	Approximate Date Performed

Females only:

Are you currently pregnant? ☐ No ☐ Yes Plans for pregnancy within 6-12 months? ☐ No ☐ Yes

Number of pregnancies? ____ Number of live births? ____

Birth control used? ☐ None ☐ Pills/Injection/IUD/Implant/Barrier (circle all that apply)

Personal Medical History? *(Check all that apply.)*

☐ Anxiety/Depression	☐ GERD/Ulcers	☐ Lung Disease
☐ Asthma	☐ Heart Disease	☐ Migraines
☐ Arthritis/Fibromyalgia	☐ High Blood Pressure	☐ Skin Problems
☐ Atrial Fibrillation	☐ High Cholesterol	☐ Sleep Apnea/CPAP
☐ Bipolar Disorder/Schizophrenia	☐ HIV	☐ Stroke/TIA
☐ Blood Clots/DVT	☐ Kidney Failure	☐ Thyroid Disease
☐ Diabetes	☐ Liver Disease	☐ Weight Gain/Loss
	☐ Seizure disorder/Epilepsy	☐ Significant head injury/multiple concussions

Where did you grow up/who raised you? _____

Parents: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Deceased
Number of Siblings: _____

Developmental History:
Any complications with your birth? If yes, please describe_____

Was there substance use, by your mother, during your pregnancy? ☐No ☐Yes
If yes, please describe_____

Did you experience motor or language developmental delays/disability? If yes, please describe _____
_____

Family History? *(Check all that apply and place the letter corresponding to the family member.)*
M=Mother F=FATHER S=SISTER B=BROTHER

MEDICAL HISTORY:	MENTAL HEALTH HISTORY (Diagnosed):
☐ Bleeding Disorder _____	☐ Anxiety Disorder _____
☐ Cancer/Type _____	☐ Attention Deficit Hyperactivity Disorder _____
☐ Diabetes _____	☐ Bipolar Disorder _____
☐ Heart Disease _____	☐ Depression _____
☐ Stroke _____	☐ Intellectual Disability _____
☐ Other _____	☐ Obsessive Compulsive Disorder _____
	☐ Schizophrenia _____
	☐ Borderline Personality Disorder_____
	☐ Substance Use Disorder _____
	☐ Survivor of Abuse/Trauma/PTSD _____
	☐ Attempted or Died by Suicide _____

Current living situation:

☐Apartment ☐House ☐Group Home ☐Nursing Home ☐In Transition ☐Homeless

Current Relationship Status:

☐ Single ☐ In a Relationship ☐ Married ☐ Divorced/Separated ☐ Widowed

Children: ☐ None ☐ Yes If yes, how many children: _____

Who currently lives with you within your household? ☐ children ☐ significant other/spouse ☐ extended family members

Employment: ☐Retired ☐On Disability ☐Unemployed ☐Employed/Employer:_____
If currently employed, how long have you been in your current position? _____

Education (Current or highest level completed):

Are you currently in school? ☐ No ☐ Yes Grades/GPA while in school _____

Highest grade completed_____ Graduated/GED ☐ No ☐ Yes

Do/did you require special services in school (resource room, special education, IEP)? ☐ No ☐ Yes

Physical Activity/Nutrition/Wellness:

Do you exercise regularly? ☐ No ☐ Yes If yes, how many days per week? ☐ 1-2 ☐ 3-5 ☐ 5+

Diet: ☐ Good ☐ Poor Diet ☐ Diabetic ☐Comfort/Binge eating ☐ Restrictive dieting/purging

☐Describe recent appetite/significant weight change:_____

Are you satisfied with your current weight? ☐ No ☐ Yes

Social Media or Electronic Device Usage:

How many hours per week do you engage in social media?

☐ 0-5 hrs. weekly ☐ 5-10 hrs. weekly ☐ 10-15 hrs. weekly ☐ 15+ hrs. weekly

How many hours do you play video games per week?

☐ 0-5 hrs. weekly ☐ 5-10 hrs. weekly ☐ 10-15 hrs. weekly ☐ 15+ hrs. weekly ☐ N/A

Other interests/hobbies: _____

Still enjoying? ☐ No ☐ Yes

Spirituality:
Religion affiliation: _____

Military Service:

Military experience? ☐ No ☐ Yes (☐Airforce ☐Army ☐Marines ☐Navy ☐ Other) Combat? ☐ No ☐ Yes

Legal History:

Have you ever been arrested? ☐ No ☐ Yes Have you been in jail or prison? ☐ No ☐Yes If yes, when? _____

Are you currently on probation or involved in any legal issues? ☐ No ☐ Yes

Trauma History:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you'v experienced any of the following:

Nightmares or triggered thoughts about it when you did not want to? ☐ No ☐ Yes

Avoided situations/places that remind you of it? ☐ No ☐ Yes

Felt constantly on guard, watchful, or easily startled? ☐ No ☐ Yes

Felt numb or detached from others, activities, or your surroundings? ☐ No ☐ Yes

Emotional Health History:

Do you attend therapy? ☐ No ☐ Yes If yes, name of therapist/group _____

Have you ever been hospitalized for mental health? ☐ No ☐ Yes
If yes, dates/where admitted _____

Have you ever received ECT, Ketamine/Sprovato, TMS, or EMDR treatment? ☐ No ☐ Yes

Have you ever self-harmed (cutting, hitting self, etc.) ? ☐No ☐ Yes How long ago? _____

Have you ever attempted suicide? ☐ No ☐ Yes If yes, how and when _____

How many days per week do you think of self-harming and/or suicide? ☐None ☐ 1-2 days ☐ 3-5 days ☐Everyday

Is there a firearm in the home? ☐ No ☐ Yes

Substance Use: (check all substances below you have ever used)

	Substance	How Long?	Quit Date? *If still using move to next question*	How much?	Daily/ Weekly/ Monthly/ Yearly
☒	*Example: Alcohol*	*2 years*	*Still using*	*2 drinks*	*daily*
☐	Tobacco/nicotine/vaping				
☐	Caffeine (coffee, tea, energy drinks, caffeine pills)				
☐	Cocaine				
☐	Hallucinogens				
☐	Inhalants *(whippets, glue)*				
☐	Marijuana				
☐	Methamphetamine				
☐	Opioids				
☐	Other Synthetic Drugs Specify:				
☐	Prescription Drugs				
☐	Alcohol				
☐	Other				

Current Symptoms: (circle all that apply)

Sadness	Easily fatigued	Isolation/Withdrawn	Lack of motivation	Distracted/daydreaming
Hopelessness	Poor self-care/hygiene	Physical pain/symptoms	Sleep problems (increased/reduced)	Indecisive
Worthlessness	Poor body image	Appetite/weight change	Intrusive thoughts (stuck)/repetitive behaviors	Swings of mood
Joy is lost	Crying spells	Sexual problems	Nightmares/triggered flashbacks	Relationship problems
Guilt	Irritability/angry outbursts	Poor work/school attendance	Restless/Fidgeting/Muscle tension	Substance use
Worry/feelings of dread	Aggressiveness/start fights	Self-harm/suicidal thoughts	Hoarding items	Panic/panic attacks
Fear	Impulsivity (sex, spending, risk taking, gambling)	Avoidance	Hallucinations (sounds/voices, imagery)	Skin picking/pulling out hair

Check the medications you have trialed/taken in the past: (check all that apply)

Group 1

					Describe
amitriptyline (Elavil)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes☐No	
bupropion (Wellbutrin)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
citalopram (Celexa)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
clomipramine (Anafranil)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
desvenlafaxine (Pristiq)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
duloxetine (Cymbalta)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
escitalopram (Lexapro)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
fluoxetine (Prozac)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
fluvoxamine (Luvox)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
mirtazapine (Remeron)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
paroxetine (Paxil)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
sertraline (Zoloft)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
venlafaxine (Effexor)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
vilazodone (Viibryd)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
vortioxetine (Trintellix, Brintellix)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	

Group 2

					Describe
aripiprazole (Abilify)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes☐No	
asenapine (Saphris)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
chlorpromazine (Thorazine)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
clozapine (Clozaril)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
fluphenazine (Prolixin)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
haloperidol (Haldol)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
lurasidone (Latuda)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
olanzapine (Zyprexa)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
paliperidone (Invega)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
quetiapine (Seroquel)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
risperidone (Risperdal)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
thioridazine (Mellaril)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
thiothixene (Navane)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
trifluoperazine (Stelazine)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
ziprasidone (Geodon)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	

Group 3

					Describe
alprazolam (Xanax)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes☐No	
buspirone (BuSpar)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
clonazepam (Klonopin)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
diazepam (Valium)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
hydroxyzine (Atarax, Vistaril)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
lorazepam (Ativan)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	

Group 4

					Describe
Amphetamine (Dexedrine)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Amphetamine/dextroamphetamine (Adderall, Adderall XR)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Atomoxetine (Strattera)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Dexmethylphetamine (Focalin, Focalin XR)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
Dextroamphetamine (Dexedrine, Dexedrine ER, Zenzedi)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Guanfacine (Tenex), Guanfacine ER (Intuniv)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
Lisdexamfetamine (Vyvanse)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Methylphenidate (Ritalin, Ritalin SR, Concerta Metadate, Metadate CD, Daytrana Patch, Quillivant XR)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	

Group 5

					Describe
carbamazepine (Tegretol)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Depakote (Divalproex Sodium)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
gabapentin (Neurontin)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
lamotrigine (Lamictal)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
lithium (Lithobid)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
oxcarbazepine (Trileptal)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
topiramate (Topamax)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	

Please share any other pertinent information below/expectations of seeking treatment:

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