**Patient Intake Form**

1. **Full name** (required)
2. **Date of Birth** (required)
3. **Gender Identification** (required)
4. **Home Address** (required)
5. **Phone Number** (required)
6. **Email address** (required)
7. **Reason for visit** (required)
8. **Referred By** (if applicable)

**PRESENTING SYMPTOMS:**

***(Type YES to applicable symptoms)***

□ Depressed or sad mood

□ Difficulty enjoying usual activities

□ Unintentional weight loss or weight gain

□ Sleeping too much or not enough

□ Feeling agitated or sluggish

□ Lacking energy/always tired

□ Feeling guilty or worthless

□ Poor focus and concentration

□ Thoughts of death or suicide

□ Inflated self-esteem

□ Decreased need for sleep or going for days without sleeping

□ Excessive talking

□ Racing thoughts

□ Feeling highly distractible

□ Try to do or accomplish way too much in a day

□ Impulsive behavior

□ Seeing or hearing things that may not be real

□ Feeling like people are watching you or out to get you

□ Often tense or unable to relax

□ Excessive worrying

□ Panic Attacks

□ Afraid/unable to leave home

□ Extreme unreasonable fears

□ Intense fear of social situations

□ Cannot prevent repetitive thoughts

□ Cannot prevent repetitive behaviors

□ Intrusive, upsetting memories of past events

□ Always on guard or never feel safe

□ Body overreacts to "stress”

**LIFE PROBLEMS THAT CURRENTLY AFFECT YOU**:

***(Type YES to applicable symptoms)***

□ Problems within my family

□ Problems among my friends/community

□ Educational problems

□ Occupational/Job problems

□ Housing problems

□ Financial/Economic problems

□ Problems with the law, legal system

□ Destructive/violent thoughts or behaviors

□ Attempts to hurt, harm, or mutilate self

□ Anger outbursts

□ Discipline problems at work

□ Careless, high-risk behavior

**PSYCHIATRIC HISTORY**

• **First Contact** **with Psychiatric Services** – age, reason

**• Past Psychiatric Diagnosis** – if any

• **Psychiatric Medications** – current medications, doses, duration, prescriber, side effects, attitude toward medications, compliance, reason for discontinuation, medications used in the past, most helpful medications

• **Previous Psychiatric Hospitalizations** – first one, last one, reason, symptoms, total average number (or total in last year)

• **Prior Suicide Attempts (or Self-Harm Behavior**) – first one, last one, most serious one (hospitalized/intubated), reason, number of attempts

• **Outpatient Follow-up (Psychiatrist or Therapist)** – current or past OP providers (names and numbers), duration of contact, reasons for discontinuation, whether helpful

**MEDICAL HISTORY**

• **Primary Care Physician** – name, phone number, address

• **Date of Last Physical Exam**

• **Date of Last Lab-work**

• **Current or Previous Medical Conditions:**

***(Type YES to applicable symptoms; describe if possible)***

□ Thyroid Disease

□ Diabetes

□ Seizure

□ Neurological Disorder (declining memory, weakness, dizziness, numbness, headache, fainting, tremor, difficulty walking)

□ Head Trauma (loss of consciousness or concussion)

□ Liver Disease (jaundice, hepatitis)

□ Kidney Disease

□ Stomach or Intestinal problem (ulcer, nausea/vomitting, pain, unusual diet)

□ Chronic Fatigue (fibromyalgia)

□ Chronic Pain

□ Arthritis (stiffness, muscle cramp)

□ Lung Disease (asthma, emphysema, bronchitis, chronic cough, pneumonia, tuberculosis)

□ Heart Disease (heart attack, chest pain, palpitations, surgery, pacemaker)

□ High Blood Pressure

□ High Cholesterol

□ Stroke

□ Coronary Artery Disease

□ Blood Disease (anemia, bruise easily, chronic nose bleeds)

□ Recurrent Infections (fever, depressed immune function)

□ Skin problem (rash, ulcer, lesion)

□ Eye problem (glaucoma, double vision, visual spot)

□ Hearing problem

□ Speaking problem

□ Sexual problem (STD, HIV, gynecological, prostate)

□ Hormone problem

□ Cancer (type)

□ Surgery (type)

□ Other:

• **Medical Treatments / Medications** – current and past, dosages, compliance, over-the-counter medications, herbal or dietary supplements, or vitamins

• **Previous hospitalizations** – reason for each hospitalization

• **Last Menstrual Period / Pregnancies** – if applicable

**ALLERGIES**   
• Drugs and food. Include the specific reaction.

**SUBSTANCE USE**

(caffeine, tobacco, marijuana, alcohol, benzodiazepines, Xanax, heroin, painkillers, Methadone, Adderall, cocaine/crack, methamphetamines, hallucinogens, designer drugs/synthetics, steroids, inhalants)

**• Type** of Substance(list all substances)

• **First** use & **Last** use

• **Route** of use (if IV, HIV testing?)

• **Duration** of use

• **Frequency** of use

• **Amount** of use (Quantity or Cost)

• **Withdrawal symptoms** (cravings, blackouts) or **Overdoses** – including life-threatening ones (Alcohol, Benzodiazepines, Barbiturates)

• **Longest Period of Sobriety**– reason for sobriety & reason for any relapses

• **OP** and **IP Rehabs / Alcohol Anonymous** or **Narcotics Anonymous**

**FAMILY HISTORY**

• **Psychiatric illness** in family – nature, medications, hospitalizations

• **Drug and Alcohol** Use in family

• **Suicides or Suicide Attempts** in the family

**BIO-PSYCHO-SOCIAL**

• **Where** born and raised

• Details of **Birth (complications) & Milestones** – premature birth, major medical problems, early development problems (walking, talking, reading)

• Details of **Early Childhood** – raised by who, siblings, attachment with family, death or separation, foster homes

• **Abuse** (neglect, sexual, physical) or **Trauma**

• **Education** – highest education, life in school, friends, behavior problems, relation with teachers, grades

• **Employment** – current & past jobs, type of jobs, duration, reason for leaving jobs, longest job, welfare/disability, source of income

• **Relationships** – current romantic relationship, age of first relationship, number, duration, longest, marital status, children, relationship with spouse/children, contact with children, any domestic violence

**• Living situation** – current status, members of household, support by family/friends, ability to return to current place of residence

**• Legal** – Type of legal problems, number of arrests, reason for arrests, duration of incarceration, current probation status, name and phone number of probation officer.

**• Military** – Age of joining services, duration, branch of service (Army, Navy, etc.), type of job, type of discharge and current benefits, any participation to active combat

**• Hobbies** or **Interests**

**ADDITIONAL INFO**  
(anything else you would like Dr. Zaman to know)