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Integrative Psychiatry & Psychotherapy

Intake Materials

Please fill out the following forms as completely as possible. Filling this out in advance of your appointment will help us to use our time together during your initial evaluation more efficiently. Feel free to ask family members for help to fill in information on family history. You may skip over anything you would rather discuss in person. Thank you for taking the time to carefully go through this packet. It is much appreciated!

Patient Information

Name:______________________________ Date of Birth:______________________

Address:____

Phone:_________________________ Email:______________________________

Marital Status: S M W D Spouse's Name:_____________________________

Children's Names & Ages:____

Patient Providers

Primary Care Physician:____

Current Therapist/Counselor:____

Preferred Pharmacy Information

Pharmacy Name:_______________________ Phone:________________________

Address:____

Emergency Contact (optional)

Name:______________________________ Relationship:______________________

Phone:_________________________

Responsible Party (Check here if self __)

Name:______________________________ Relationship:______________________

Address:____

Phone:_________________________ Email:______________________________

Primary Insurance Information

Policy Holder's Name: ____________________ Date of Birth:________________________

Relationship to patient:____________________ PH's Employer:______________________

Insurance Company Name:____

Address:____

Phone:____________________________ Policy #:_____________________________

Group #:___________________________ PH's SSN:____________________________

Reason for Treatment
What issues are you seeking treatment for?

What are your treatment goals?

Current Symptoms (check once for any symptoms present, check twice for major symptoms)

__Low mood	__Racing thoughts	__Excessive worry	__Unable to enjoy activities
__Impulsivity	__Anxiety attacks	__Trouble falling asleep	__Avoidance/ Withdrawal
__Loss of interest	__Increased libido	__Decreased libido	__Hallucinations
__Less need for sleep	__Suspiciousness	__Decreased Appetite	__Increased Appetite
__Excess energy	__Excess guilt	__Irritability	__Fatigue
__Tearful	__Concentration	__PMS	__Peri/Menopause
__Constipation	__Diarrhea	__Bloating	__Abdominal Pain
__Reflux	__Acne	__Rashes/Itching	__Aches & Pains
__Memory Issues	__Feeling cold	__Feeling hot	__Trouble staying asleep
__Waking up too early			

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live?	__Yes	__No
Do you currently feel that you don't want to live?	__Yes	__No
Have you ever tried to kill or harm yourself before?	__Yes	—No

Medical History
Height:________________ Weight:_______________
Drug Allergies:____
Environmental
Allergies:____
Food Allergies & Sensitivities:____

List *ALL* vitamins/supplements and prescription medications (including hormone replacements) you take on a regular basis (continue on back if needed).

Medication/Supplement *Total Daily Dose* *Estimated Start Date*

____
____
____
____
____
____
____
____

How often do you take Ibuprofen/Advil? ____

How often do you take Acetaminophen/
Tylenol?____

List current medical issues/ conditions:____

____

List past medical issues, non-psychiatric hospitalizations, surgeries:______________________________________

____

____

____

When was the date of your last physical exam? ____
If you have any lab results from the past year, I would appreciate a copy.

For Women Only

Are you menstruating? __Yes __No

Date of last menstrual period:_____________________ Average length of menstrual period:_____________

On average, how many days from the first day of your period to the first day of your next period? ___________

Are you currently pregnant or do you think you might be pregnant? __Yes __No

Are you planning on getting pregnant in the near future? __Yes __No

How many times have you been pregnant? _______________ How many live births?__________________

Are you sexually active? ________________________ Birth Control Method:_________________________

Do you have a gynecologist? __Yes __No

If yes, who? ____

Approx. date of most recent gynecologic exam: ____

Approx. date of most recent pap smear: ____

Have you ever had a positive pap?____

Approx. date of most recent mammogram: ____

Personal and Family Medical History
Make a check for each of the following conditions you or your family members have/had.

Condition/Disease	*You*	*Family*	*Which family member(s)?*
Allergies (family only)			
Anemia			
Asthma/ respiratory problems			
Autoimmune Disorders (__________________)			
Cancer (type: ________________________)			
Chronic Fatigue			
Chronic Pain			
Diabetes (Indicate Type I or Type II)			
Epilepsy or seizures			
Fibromyalgia			
Head trauma			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Insomnia			
Irritable Bowel Syndrome			
Kidney Disease			
Liver Disease			
Stomach or Intestinal problems			
Thyroid Disease (date of last lab)			
Other:_______________________________			

Additional personal or family medical history: ____

____

Past Psychiatric History

Outpatient Treatment (Include counseling, therapy, medication treatment)

Reason	Dates Treated	By Whom

Psychiatric Hospitalization or Intensive Outpatient Treatment

Reason	Date Hospitalized	Where

List any psychiatric medications you have been on in the past.

Medication/ Max Dose	*Comments*

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for any of the following:

Psychiatric Issue	*Yes*	*No*	*If yes, list family member.*
Bipolar Disorder			
Depression			
Anxiety			
Anger			
Suicide			
Schizophrenia			
Post-traumatic stress (PTSD)			
Alcohol Abuse			
Other Substance Abuse			
Psychiatric Hospitalization			
Violence			
Other:__________________			

Substance Use

Do you consume alcohol? If yes, on average, how many drinks per week?

____

Have you ever felt that your alcohol use was a problem? If yes, briefly explain.

____

Has anyone close to you ever felt that your alcohol use was a problem? If yes, briefly explain.

____

____

Do you use any other drugs? If yes, please list each substance, the amount, and frequency of use.

____

____

Have you ever felt that your drug use was a problem? If yes, briefly explain.

____

Has anyone close to you ever felt that your drug use was a problem? If yes, briefly explain

____

Do you use tobacco? If yes, how do you consume your tobacco (e.g. via e-cigarette) ***and*** how much do you use in a day?

____

Legal
Do you currently have any legal issues? If yes, please briefly explain.

____

Have you had legal troubles in the past? If yes, please briefly explain.

____

Toxin Exposure
Have you lived or worked in a building with known mold or water damage? If so when, and please describe.

____

How many days a week do you eat fish/seafood?

____

How many pets live in your home?

____

Does your occupation involve exposure to potentially toxic chemicals? If yes, describe.

____

Do any of your hobbies involve exposure to potentially toxic chemicals? If yes, describe.

____

How many silver colored fillings do you have in your mouth? how many have you had replaced?

____

Do you drink well water? __Yes __No

Occupational and Education History

What is your highest educational degree/level attained? ______________________________

Are you currently __working __not working by choice __unemployed __disabled __retired

What is/was your occupation? ____

Have you ever served in the military? __Yes __ No

Relationship History

Are you currently __Married __Divorced __Single __Widowed __Partnered

For how long? ____

If not married, are you currently in a relationship? __Yes __No

If yes, for how long?____

What is your spouse or significant other's occupation? ______________________________

Have you had any previous marriages? __Yes __No If yes, how many? ________________