Germantown Private Psychiatry PLLC

7505 Capital Drive, Germantown TN 38138

www.germantownpsychiatry.com

Phone: 901.730.0575 Fax: 901.730.0389

Adult Psychiatry Intake Form

Date:_____

Name_____ Age:_____DOB:___/____/____
Address_____
Home phone_____ Work phone_____ Cell phone_____

What issue(s) bring(s) you to our office today?

_____
_____
_____
_____

What has been stressing you of late (e.g. Family, job, recent loss of loved ones, financial issues)?

_____
_____
_____
_____

Are you ***currently*** having any of the following problems (please circle)?

[ ]Depression? [ ]Loss of interest in activities? [ ]Feeling hopeless, worthless? [ ]Poor energy? [ ]Poor self-esteem? [ ]Change in appetite?Increased or decreased? [ ]Fatigue? [ ]Poor focus? [ ]Problems going to sleep? [ ]Thoughts of not being alive? [ ]Periods of euphoria or unusually good mood? [ ]Having very high energy for no reason? [ ]Going days without needing to sleep? [ ]Thoughts racing? [ ]Talking too fast? [ ]Acting impulsively (spending, speeding)?	[ ]Worrying excessively?Having tense muscles? [ ]So anxious you feel you cannot rest? [ ]Having panic attacks? [ ]Traumatic events that come back in nightmares, flashbacks? [ ]Feeling awkward in public? [ ]Thoughts that replay? [ ]Repetitive or compulsive behaviors? [ ]Phobias or fears? [ ]Grunts, tics, or jerks? [ ]Inattentiveness at work or school? If so, since what age? [ ]Hyperactive or fidgety?	[ ]Hearing voices? [ ]Seeing things? [ ]Feelings people were trying to watch or harm you? [ ]Concerns about alcohol use? Drug use? [ ]Concerns about eating too much? [ ]Eating too little? [ ]Memory problems? [ ]Getting lost easily? [ ]Forgetting how to do tasks? [ ]Problems finding words? [ ]Problems caring for yourself (cooking, dressing)?

Past Psychiatric Care

Have you been ever diagnosed with a mental health condition by a medical provider (e.g. Depression, bipolar, schizophrenia, ADHD)? Yes/No, If so, please list.

_____

_____

Have you ever been seen by a psychiatrist or therapist/counselor? Yes/No, Please list and describe.

Date(s) seen? By whom?	For what problem?	What treatment (meds, ECT, therapy)?

Have you ever been hospitalized for psychiatric care? Yes/No, Please list and describe.

Date(s)	Where and for what?	What treatment (meds, ECT, therapy)?

Have you ever been treated with any of the following medications? Yes/No, Circle all that apply and list any good or bad effects of the medications.

Med	Good/bad effects	Med	Good/bad effects	Med	Good/bad effects
Abilify		Haldol		Ritalin	
Ambien		Klonopin		Saphris	
Adderall		Invega		Serax	
Anafranil		Lamictal		Seroquel	
Antabuse		Latuda		Serzone	
Ascendin		Lexapro		Soma	
Atarax		Librium		Sonata	
Ativan		Lithium		Stelazine	
Buspar		Lunesta		Strattera	

Campral		Luvox		Suboxone/ subutex	
Celexa		Marplan		Symmetrel	
Chloral hydrate		Mellaril		Tegretol	
Clonidine		Methadone		Thorazine	
Clozaril		Miltown		Tofranil	
Cogentin		Nardil		Topomax	
Concerta		Norpramine		Traxene	
Cymbalta		Orap		Trazodone	
Dalmane		Pamelor		Trileptal	
Depakote		Parnate		Valium	
Dexedrine		Paxil		Vibryd	
Doral		Prosom		Vistraril	
Effexor		Pristiq		Vivitrol	
Elavil		Prolixin		Wellbutrin	
Fanapt		Remeron		Xanax	
Geodon		Restoril		Zoloft	
Halcion		Risperdal		Zyprexa	

Any other psychiatric medications you have taken?

_____

Past Medical Care

Please list your PCP/Family Doctor/OB-Gyn?

Name_____ Last Seen?_____

What medical illnesses do you have?

_____

What surgeries have you had?

_____

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

Medication	Dosage	# times per day	For what condition	Who prescribes it

Do you have any Allergies? Yes/No, (to medications, foods): _____

Are you currently having or have you recently had any of these physical symptoms? Yes/No, Please circle.

Fevers	Headache	Constipation	Hot/cold flashes
Chills	Chest pain	Acid reflux	Decreased sex drive
Night sweats	Shortness of breath	Joint pains	Problems reaching orgasm
Unexplained weight loss/gain	Heart palpitations	Muscle pains or tension	Easy bruising or bleeding
Weakness in arms/legs	Cough	Pain or difficulty urinating	Rashes
Numbness in arms/legs	Sore throat	Dental problems	
Episodes of passing out	Nausea or vomiting	Changes in vision	
Problems walking	Diarrhea	Changes in hearing	

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? _____
Miscarriages? Yes/no
Elective abortions? Yes/no
Any depression or unreal thoughts around pregnancies? Yes/no

Substance Use History

How often have you used the following substances?

	Last time used?	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			
Cocaine			
Opiates (e.g. Heroin, morphine, Percocet,			

oxycodone, Tylenol #3, Dilaudid/hydromorphone)			
Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)			
PCP or LSD			
Mushrooms			
Others			

Family History

Please list blood relatives who have been diagnosed with the following conditions.
Alcoholism_____
Anxiety disorders _____
Bipolar disorder _____
Cancer_____
Depression_____
Diabetes_____
Drug abuse _____
Heart disease/high blood pressure/arrhythmias _____
Osteoporosis_____
Seizures_____
Schizophrenia_____
Strokes_____
Suicides_____
Thyroid disease _____

Social History

Where do you live? _____
Who lives with you? _____

How far did you go in school/highest level of education? _____

What is your current job/occupation? _____
What jobs have you had in the past?

_____

_____

Are you married? Yes/no If so, for 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 any religious beliefs? Yes/ No
How important are your religious/spiritual beliefs to your life?_____

Have you had any legal issues (arrests, charges, time in jail)? If so, please describe.

_____
_____
_____

Have you ever been the victim of a violent crime? Yes/No
Have you ever been a victim of physical abuse? Emotional? Sexual abuse or rape? If so, please explain.

_____
_____
_____
_____

Safety

Do currently have thoughts of hurting yourself? Yes/No, Please explain.

_____

Have you tried to hurt yourself in the past? Yes/No, If so, please explain.

_____
_____
_____

Do you currently have thoughts of hurting anyone else? Yes/no Please explain.

_____

Have you tried to hurt anyone in the past? Yes/No, If so, please explain.

_____
_____
_____

Do you own any guns or knives? _____