INTAKE FORM

SOUTHWEST GENERAL MEDICAL GROUP, INC. BEHAVIORAL HEALTH

Name: _____ **Date:** _____ **Date of Birth:** _____

What is the main reason you are seeking services? _____

_____

How were you referred? _____

Name of Medical Provider: _____

Name of prior psychiatrists or psychiatric nurse practitioners: _____

Name of previous psychotherapist: _____

Dates of previous treatment: _____

Psychiatric History:

Have you been diagnosed with any psychiatric disorder(s) previously? If so, please specify: _____

_____

Have you ever been hospitalized for any psychiatric reason: **Yes or No** (circle one)

Reason & Dates: _____

Name of hospital: _____

Do you have a history of any of the following?

Attempted suicide? **Yes or No** (circle one). If so, dates: _____ Method: _____

Nearly attempted suicide? **Yes or No** (circle one). Dates: _____Method:_____

Violence against others (e.g. threats, fights)? **Yes or No** Date(s):_____

Self-harm (e.g. cutting or burning yourself)? **Yes or No** Date(s): _____

Eating Disorder? **Yes or No** Date(s)_____

Name: _____ **Date of Birth:**_____

Medical History:

What was the date of your last physical exam? _____

Do you have now or have you ever had the following medical problems?

PROBLEM	NOW OR PAST?	DETAILS
High Blood Pressure		
Heart Disease or Arrhythmia		
Asthma		
COPD or Emphysema		
Cancer		
Diabetes		
Obesity		
Chronic pain		
Thyroid disorder		
Autoimmune Disorder		
Vision problem		
Hearing problem		
Stomach, esophagus, or intestinal		
Liver Disease		
Skin problem		
Sexual or reproductive problem		
Seizure Disorder		
Stroke		
Dementia		
Head Injury		
Sleep Apnea		

Name: _____ **Date of Birth:**_____

Medical History continued:

Have you ever stayed in a hospital other than a psychiatric hospitalization? **Yes or No** (circle one)

Date:_____ Reason:_____

Have you ever had surgery? **Yes or No** (circle one) Date: _____

Reason:_____

Please list all allergies to medications, food, or the environment: _____

_____

Please list all of your current medications, including over the counter medications, vitamins, supplements:

Name of medication Dose How often do you take it? When was it started? Prescriber

_____

_____

_____

_____

_____

_____

Alcohol and Drug History:

Has anyone ever thought that you might have a problem with alcohol? **Yes or No** (circle one)

Has anyone ever thought that you might have a problem with prescribed drugs? **Yes or No** (circle one)

Has anyone ever thought that you might have a problem with illegal drugs? **Yes or No** (circle one)

Do you use tobacco products? **Yes or No** (circle one)

If so, are you interested in quitting tobacco or nicotine use? **Yes or No** (circle one)

Have you ever received treatment for addiction? **Yes or No** (circle one)

Name: _____ Date of Birth:_____

HOW MUCH DO YOU USE OF THE FOLLOWING SUBSTANCES?		
TYPE	**ROUTE (e.g. oral)**	**AMOUNT (e.g. mg) per Day/Week/Month**
Alcohol		
Tobacco or nicotine or other		
Marijuana (all forms)		
Caffeine		
Pain pills (opiates)		
Sleep pills (e.g. Ambien)		
Benzodiazepines (e.g. xanax, klonopin, valium)		
ADHD meds (e.g. Ritalin, Adderall)		
Cocaine		
Methamphetamines		
Heroin		
Other		

Name: _____ **Date of Birth:**_____

Family history:

Have any of your biological relatives had the following problems? (Check all that apply)

Problem:	Mother	Father	Brother	Sister	Child	Grandma	Grandpa	Aunt/Uncle	Cousin
Depression									
Anxiety									
Bipolar Disorder									
Schizophrenia									
Suicide									
Alcohol or Drug Addiction									
Other psychiatric problem									

Name: _____ **Date of Birth:**_____

Social History:

With whom do you live? _____

What is your marital status? _____ Have you been married previously?_____

How many, if any, children do you have?_____ Their ages?_____

What is your highest level of education?_____

Currently employed? _____ Occupation?_____

Do you have any current legal problems? **Yes or No** (circle one) Details:_____

_____

Have you been charged with any crimes in the past? **Yes or No** (circle one) Details: _____

_____

Have you spent any time in jail or in prison? **Yes or No** (circle one) Details: _____

_____

Have you ever or are you currently on Parole or Probation? **Yes or No** (circle one) Details: _____

_____

Please list any current stressors (e.g. going through divorce, recent move, or started new job)

_____

_____

Do you have guns in your home? **Yes or No** (circle one) _____

_____