House Psychiatric Clinic - Adult New Patient Intake

Patient Name

Date of Birth:

What is your age?

Please check if you are experiencing or have experienced any of the following mood symptoms:

- [ ] Depressed or sad mood.
- [ ] Feeling less joy in life or less interest in life.
- [ ] Thoughts of death or suicidal thinking/attempt.
- [ ] Energy changes (fatigue or too much energy).
- [ ] Weight/Appetite changes (gain or loss).
- [ ] Concentration or memory problems.
- [ ] Decreased sexual desire.
- [ ] Too much sleep or too little sleep.
- [ ] Feeling worthless or too much guilt.
- [ ] Feeling great about yourself.
- [ ] Feeling rested after 3-4 hours of sleep for many nights and not feeling tired.
- [ ] More talkative than usual or a pressure to keep talking.
- [ ] Increased irritability.
- [ ] Increased sexual activity or promiscuity.
- [ ] Reckless behavior that is not typical for you.
- [ ] Feeling powerful.
- [ ] Having thoughts of harming someone else.
- [ ] None of the above mood symptoms apply.

Please check if you are experiencing or have experienced any of the following anxiety symptoms:

- [ ] Worry that is difficult to stop.
- [ ] Anxiety or panic attack.
- [ ] Felt anxiety was making you "crazy".
- [ ] Pounding or racing heart beat or pulse.
- [ ] Trembling or shaking.
- [ ] Fear of losing control.
- [ ] Fear of death or dying.
- [ ] Worried about anxiety so much that it stopped you from leaving your home or going out.
- [ ] Uncomfortable in social situations.
- [ ] Thoughts in your mind that are hard to stop (obsessing).
- [ ] Checking constantly.
- [ ] Counting in your head.
- [ ] Repetitive hand washing, tapping, showering or some other activity that you felt you could not stop.
- [ ] None of the above apply.

Please check if you are experiencing or have experienced any of the following stress/trauma symptoms:

- [ ] Distressing memories of past events.
- [ ] Attempts to forget or block out old memories.
- [ ] Distressing dreams.
- [ ] Painful or hard life experiences.
- [ ] Has anybody ever physically, sexually or emotionally hurt you?
- [ ] Feeling out of body.
- [ ] Feeling that things are not real.
- [ ] Losing big chunks of time.
- [ ] None of the above apply.

Please check if you are experiencing or have experienced any of the following thought symptoms:

- [ ] Heard voices that others say might not be there.
- [ ] Seen images that others say might not be there.
- [ ] Strange smell that others don't smell.
- [ ] Strange tastes that do not make sense.
- [ ] Felt sensations on body that do not make sense.
- [ ] Felt people are out to get you, harm you or are following you.
- [ ] Felt people are talking about you.
- [ ] Receiving unspoken messages from others.
- [ ] None of the above apply.

Please check if you are experiencing or have experienced any of the following eating/body symptoms:

- [ ] I am very concerned about my weight.
- [ ] I restrict my diet.
- [ ] I make myself vomit or use laxatives to control my weight.
- [ ] I spend hours every day working out to control my weight.
- [ ] I spend a lot of time thinking about my weight/body.
- [ ] I sometimes binge on food.
- [ ] None of the above apply.

Please check if any of the following traits describe you:

- [ ] I am very fearful of being alone or being abandoned.
- [ ] I feel like I am on an emotional roller coaster at times.
- [ ] I tend to build people up and then be disappointed in them.
- [ ] I can change my personality to fit the situation. Sometimes I am not sure who I am.
- [ ] I can be impulsive in ways that are harmful (sex, spending, driving, eating)
- [ ] I tend to feel empty inside.
- [ ] I can get angry and have a temper.
- [ ] People sometimes call me arrogant.
- [ ] I find it difficult to understand what other people are feeling.
- [ ] I am very concerned about power.
- [ ] I am special and sometimes people don't realize that.
- [ ] I find it difficult to follow social norms (what people expect).
- [ ] I find it difficult to plan ahead.
- [ ] I sometimes get into physical fights.
- [ ] It is difficult for me to show remorse.
- [ ] I am superstitious.
- [ ] I have a sixth sense.
- [ ] I prefer solitary activities.
- [ ] Neither desire nor enjoy close relationships.
- [ ] I have limited but intense interest in only a few activities
- [ ] I have difficulty making everyday decisions.
- [ ] I have a hard time initiating projects on my own.
- [ ] I tend to be preoccupied with details and rules.
- [ ] I tend to be a perfectionist.
- [ ] Right is always right and wrong is always wrong!
- [ ] None of these traits apply to me.

Please complete the following:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have troubles finishing the final details of a project.	○	○	○	○	○
I have difficulty organizing tasks.	○	○	○	○	○
I have difficulty remembering appointments or obligations.	○	○	○	○	○
I delay starting tasks that require a lot of thought or mental energy.	○	○	○	○	○
I fidget or squirm when I have to sit for a long period of time.	○	○	○	○	○
I feel overly active, like being driven by a motor.	○	○	○	○	○
I make careless mistakes.	○	○	○	○	○
I have difficulty paying attention when doing boring or repetitive work.	○	○	○	○	○
I have difficulty concentrating on what people are saying, even if speaking to me directly.	○	○	○	○	○
I often misplace or have difficulty finding things at work and home.	○	○	○	○	○
I am often distracted by activity and noise around me.	○	○	○	○	○
I often leave my seat in situations in which I am expected to remain seated.	○	○	○	○	○
I often feel restless or fidgety.	○	○	○	○	○

Please continue to complete the following:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I have difficulty unwinding or relaxing.	○	○	○	○	○
I often find myself talking too much in social situations.	○	○	○	○	○
In a conversation, I find myself finishing other people's sentences before they can finish them themselves.	○	○	○	○	○
I have difficulty waiting my turn.	○	○	○	○	○
I often interrupt others when they are busy.	○	○	○	○	○

Please list any psychiatrists you have seen.

Please list any psychiatric medications you are currently taking.

Please list any past psychiatric medications you have taken, and the reason you stopped.

Please list any therapists you have seen.

Please list your current primary care physician.

Please list any OTHER current medications and doses.

Are you allergic to any medications

- ◯ Yes
- ◯ No known drug allergies.

If you answered yes, please name the medications and provide the reaction.

Have you ever been hospitalized for a psychiatric condition? If so, where & when?

Have you ever been treated for substance abuse? If so, where & when?

Have you ever attempted to take your own life? If so, when and how did you try?

Do you have any past or current legal issues? Please check all that apply.

- ☐ Marital
- ☐ Custody
- ☐ Criminal
- ☐ Traffic
- ☐ Other
- ☐ None

Do you have a worker's compensation claim? If so, what is the injury?

Have you ever had any problems with:

- ☐ None, I am in good health.
- ☐ Asthma/Respiratory Illness
- ☐ Allergies
- ☐ Arthritis
- ☐ Anemia
- ☐ High blood pressure
- ☐ Head injury
- ☐ Diabetes
- ☐ Cholesterol
- ☐ Cancer
- ☐ Seizures/Epilepsy
- ☐ HIV
- ☐ Heart disease
- ☐ Neurological problems
- ☐ Balance problems
- ☐ Thyroid problems
- ☐ Vision problems
- ☐ Liver disease
- ☐ TB
- ☐ Stomach/GI problems
- ☐ Fibromyalgia
- ☐ Other

FAMILY HISTORY:

Please list any medical/psychiatric problems that run in your family. Please give the relationship as well.

	Mother	Father	Sibling	Grandparent	Significant other
Alcohol abuse/ dependence	○	○	○	○	○
Drug abuse/ dependence	○	○	○	○	○
Life-threatening disease	○	○	○	○	○
Suicide attempt	○	○	○	○	○
Mood disorder	○	○	○	○	○
Death	○	○	○	○	○
Domestic violence	○	○	○	○	○
Emotional abuse	○	○	○	○	○
Divorce	○	○	○	○	○
Physical/sexual abuse	○	○	○	○	○
Seizure disorder	○	○	○	○	○
Other	○	○	○	○	○

Living arrangement (With whom do you currently live?)

Relationship status.

- ☐ Single
- ☐ Relationship
- ☐ Domestic partner
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Do you work outside of the home? If so, what kind of work do you do?

Do you attend church?

- ◯ Yes
- ◯ No

If you answered yes, how active are you?

What do you do for recreation or exercise?

Do you use or have you ever used any of the following substances? Please check all that apply. If you check yes, please write in whether your use of this substance is past or current.

- ☐ None
- ☐ Nicotine
- ☐ Tobacco
- ☐ Alcohol
- ☐ Marijuana
- ☐ Cocaine
- ☐ Ecstasy
- ☐ Heroin
- ☐ Methamphetamine
- ☐ Prescription drugs
- ☐ Other (please specify):

Have you ever felt you needed to cut down on your use of alcohol or drugs?

- ◯ Yes
- ◯ No

Do you ever feel guilty about alcohol/drug use?

- ◯ Yes
- ◯ No

Have people annoyed you by criticizing your use of alcohol or drugs?

- ◯ Yes
- ◯ No

Have you ever felt you needed a drink/drug first thing in the morning?

- ◯ Yes
- ◯ No

Have you ever experienced abuse, neglect or molestation at any time during your life?

- ☐ Yes
- ☐ No
- ☐ I'm not sure

REVIEW OF SYSTEMS:

Please check if you are experiencing any of the following general symptoms.

- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever or chills
- ☐ N/A None

Please check if you are experiencing any of the following skin symptoms.

- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color Changes
- ☐ Hair or nail changes
- ☐ N/A None

Please check if you are experiencing any of the following head symptoms.

- ☐ Headache
- ☐ Head injury
- ☐ N/A None

Please check if you are experiencing any of the following hearing symptoms.

- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage
- ☐ N/A None

Please check if you are experiencing any of the following eye symptoms

- [ ] Vision issues/problems
- [ ] Glasses or contacts
- [ ] Pain
- [ ] Redness
- [ ] Blurry or double vision
- [ ] Flashing lights
- [ ] Specks
- [ ] Glaucoma
- [ ] Cataracts
- [ ] N/A None

Please check if you are experiencing any of the following nose symptoms.

- [ ] Stuffiness
- [ ] Discharge
- [ ] Itching
- [ ] Hay Fever
- [ ] Nosebleeds
- [ ] Sinus pain
- [ ] N/A None

Please check if you are experiencing any of the following throat symptoms.

- [ ] Teeth issues
- [ ] Gum issues
- [ ] Dentures
- [ ] Sore Throat
- [ ] Dry mouth
- [ ] Hoarseness
- [ ] Thrush
- [ ] N/A None

Please check if you are experiencing any of the following neck symptoms.

- [ ] Lumps
- [ ] Swollen glands
- [ ] Pain
- [ ] Stiffness
- [ ] N/A None

Please check if you are experiencing any of the following breast symptoms.

- [ ] Lumps
- [ ] Pain
- [ ] Discharge
- [ ] Breast feeding
- [ ] N/A None

Please check if you are experiencing any of the following breathing symptoms.

- [ ] Cough
- [ ] Sputum
- [ ] Coughing up blood
- [ ] Shortness of breath
- [ ] Wheezing
- [ ] Painful breathing
- [ ] N/A None

Please check if you are experiencing any of the following heart symptoms.

- [ ] Chest pain
- [ ] Palpitations
- [ ] Difficulty breathing lying down
- [ ] Swelling
- [ ] Calf pain with walking
- [ ] Leg cramping
- [ ] N/A None

Please check if you are experiencing any of the following bowel or bladder issues.

- [ ] Swallowing problems
- [ ] Heartburn
- [ ] Nausea
- [ ] Diarrhea
- [ ] Constipation
- [ ] Blood in stool
- [ ] Increase in urinary frequency or urgency
- [ ] Burning or pain with urination
- [ ] Blood in urine
- [ ] Incontinence
- [ ] N/A None

Please check if you are experiencing any of the following genital issues.

- [ ] Pain with sex
- [ ] STDs
- [ ] Erectile dysfunction
- [ ] Discharge
- [ ] Loss of sexual desire
- [ ] N/A None

Please check if you are experiencing any of the following neurological symptoms.

- [ ] Dizziness
- [ ] Fainting
- [ ] Seizures
- [ ] Weakness
- [ ] Numbness
- [ ] Tingling
- [ ] Tremor
- [ ] N/A None

Please check if you are experiencing any of the following blood issues.

- [ ] Bruise easily
- [ ] Bleed easily
- [ ] N/A None

Please check if you are experiencing any of the following endocrine issues.

- [ ] Heat or cold intolerance
- [ ] Sweating
- [ ] Frequent urination
- [ ] Increased thirst
- [ ] N/A None