370 Main Street,
Suite 200 Laurel,
MD 20708
Tel: (240) 755-1056

Outpatient Adult Psychiatry/Psychology Intake Form

This form must be filled out in its entirety before coming in for an appointment. Failure to do so may result in your appointment being rescheduled.

Note: You are able to enter your answers directly onto this form.

Name of person completing this section (if different than patient) and relationship to patient: Click here to enter text.

Patient Information

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

Age:_____ **Social Security Number**:_____ ☐Will provide at time of apt **Sex**: ☐Male ☐Female

Email: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Address: _____
Home Phone: _____**Cell Phone**: _____

Ethnicity: _____

Who were you referred to our clinic by: _____ **PCP:** _____

Emergency Contact Name _____
Phone _____
Relationship: _____

*****For all New Patients*****

I understand if I cancel my new patient appointment after the 48 hour cancellation policy or no show/miss my appointment my card will be charged the full amount of the appointment. ☐ **Yes** ☐ **No** **Type or initial name or sign:** _____

Pharmacy Information

Name of Preferred Pharmacy: _____

Pharmacy Address: _____

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Pharmacy Cross Streets:_____ & _____

Pharmacy City: _____

Pharmacy Phone: _____ Pharmacy Fax:_____

Patient Name: _____

Please answer the following Questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All the information you provide will be kept confidential.**

What problems are you having which prompted you to come to this clinic? (Be as thorough as possible)

_____
_____
_____
_____

What are you goals/expectations for treatment?

_____
_____
_____

Past Psychiatric Treatment

Have you ever been hospitalized for psychiatric reasons? ☐No ☐Yes

If Yes, when and where? _____

Have you ever had outpatient treatment by a psychiatrist? ☐No ☐Yes

If yes, when and by whom? _____

Which psychiatric medications have you taken in the past and what were the benefits and/or side affects you had from them? ☐None List: _____

Are you taking any psychiatric medications now? ☐No ☐Yes

Current Medication List – Please list all medications prescribed/otc/and supplements

Medication Name	Dose	Frequency

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Are you allergic to any medications? ☐ No ☐ Yes
List medications and allergic reactions: _____

Have you undergone any surgical procedures? ☐ No ☐ Yes
Please list procedures & dates of surgery: _____
Does your mind work overtime? ☐ No ☐ Yes
Do you have unexplained bursts of energy? ☐ No ☐ Yes Do you often worry or feel nervous? ☐ No ☐ Yes
Do you have physical symptoms from anxiety? ☐ No ☐ Yes Do you feel isolated? ☐ No ☐ Yes
Is anyone physically or emotionally abusing you? ☐ No ☐ Yes
How many hours do you get of sleep per night? ☐ 1-3 ☐ 4-6 ☐ 7-10
How many meals do you eat per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 +

Do you have problems with chronic physical pain? ☐ No ☐ Yes

Rate average pain level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have you ever suffered a severe head injury with loss of consciousness or concussion? ☐ No ☐ Yes
Describe:_____

What are things that bother you the most – describe.

☐Problems/losses within my family
☐Problems/loses among my friends community
☐educational problems
☐Occupational problems
☐Housing problems
☐Financial/economic problems
☐Can't get adequate health care
☐Problems with law, legal system
☐Discipline problems at work
☐Careless, high-risk behavior
☐ Other – explain _____

Past Medical History:

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☐Diabetes ☐Heart Disease ☐Blood pressure ☐Cancer
☐Asthma ☐Emphysema ☐Liver disease ☐Kidney disease
☐Depression ☐Anxiety ☐Ulcers ☐Heart Attack
☐Stroke ☐Heart Palpations ☐Heart Surgery ☐Pace maker implant
☐Cancer ☐Lung Disease ☐Asthma ☐Emphysema
☐Chronic cough ☐Bronchitis ☐Pneumonia ☐Tuberculosis
☐Shortness of breath ☐Seizures ☐Epilepsy ☐Fainting
☐ Vertigo/Dizziness ☐ Motor difficulties ☐ Serious head injuries ☐ Recurring headaches
☐ Arthritis ☐ Muscle cramps ☐ Muscle stiffness ☐ Weakness
☐ Tremors ☐ Numbness ☐ Difficulty walking ☐ Uncontrolled movements
☐ Kidney disease ☐ Thyroid disease ☐ Hormone problems ☐ Blood Disease

☐Other _____

Alcohol drug and tobacco use ☐ Check if none

Alcohol ☐ current use: date of last use _____

Problems related to use? ☐ No ☐ Yes

Legal, financial, health, relationship) List:_____

Treatment required? ☐No ☐ Yes Describe: _____

Illicit drug and/or prescription drug abuse (continued on next page)

Substance	Date of last use	Problems related to use	Treatment required
Benzodiazepines (valium, Xanax, Ativan)		☐ Yes ☐ No	☐ Yes ☐ No
Caffeine		☐ Yes ☐ No	☐ Yes ☐ No
Marijuana		☐ Yes ☐ No	☐ Yes ☐ No
Cocaine		☐ Yes ☐ No	☐ Yes ☐ No
Designer drugs (Club drugs: G,X)		☐ Yes ☐ No	☐ Yes ☐ No
Hallucinogens (LSD, Mushrooms)		☐ Yes ☐ No	☐ Yes ☐No
Inhalants (gasoline, glue, aerosol)		☐ Yes ☐ No	☐ Yes ☐ No
Methamphetamines (Speed, ice, Ritalin)		☐ Yes ☐ No	☐ Yes ☐ No

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Opiates/Methadone (Vicodin, OxyContin, heroin)		☐ Yes ☐ No	☐ Yes ☐ No
Other		☐ Yes ☐ No	☐ Yes ☐ No

Social History

Where were you born? _____

Where did you grow up? _____

Did your parents stay together while you were growing up? ☐Yes ☐No

How old were you when they separated? _____

Father's occupation while you were growing up: _____

Mother's occupation while you were growing up: _____

Where there any complications at your birth (Premature birth, major medical problems?) ☐No ☐ Yes

Describe: _____

Are you/were you a victim of any form of physical/sexual/emotional abuse?

Physical abuse: ☐ No ☐ Yes Age of occurrence: _____

Sexual abuse: ☐ No ☐ Yes Age of occurrence: _____

Emotional abuse: ☐ No ☐ Yes Age of occurrence: _____

Did you graduate from high school? ☐ No ☐ Yes Last grade attended: _____

What type of jobs have you had in the past? _____

Are you currently employed? ☐ No ☐ Yes If yes, where: _____

Are you currently involved in a romantic relationship? ☐No ☐ Yes

Spouse's/partner's first name: _____

How long have you been together? _____

How would you describe your relationship? _____

What is your spouse's/partner's occupation? _____

Have you been involved in any previous significant intimate/romantic relationships? ☐ No ☐ Yes Describe:

_____

What are some things you enjoy doing (hobbies, sports, past times)? _____

Have you ever been convicted of any crimes, incarcerated in prison, or placed on probation? ☐No

☐Yes Describe: _____

Family History

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Is there any history of mental illness or substance abuse among your blood relatives?
☐No ☐Yes
If yes, describe – Father's side: _____ Mother's
side: _____

Social Supports

Is there anyone your trust or confide in during times of trouble? ☐ No ☐ Yes Name
supports: _____

Do you have any religious ties or involvement in a church? ☐ No ☐ Yes Describe:
_____

Current living situation

Do you live in a: ☐ House ☐ Apartment ☐ Manufactured Home ☐ other
☐ Own or ☐ Rent
Do you live alone? ☐ Yes ☐ No If not, who else lives with you: _____
Do you have planes to move in the near future? ☐ Yes ☐ No Where: _____
Do you have any pets? ☐ Yes ☐ No List: _____

How many children do you have

_____ Boys _____ Girls

How many siblings do you have

_____ Brothers _____ Sisters

Advanced Directives

Do you have a psychiatric advanced directive? ☐ Yes ☐ No

Reviewed by:_____

Date:_____ Patient Name: _____

Patient Signature_____