Matthews-Vu Medical Group

Psychiatric Intake Form

Date: _____ Name: _____ Age: _____

What issue(s) bring(s) you to the clinic?

_____

_____

_____

_____

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

Matthews-Vu
Healthcare for Children and Adults

Past Psychiatric Care

Have you been ever diagnosed with a mental health condition by a medical provider (e.g. Depression, bipolar, schizophrenia, ADHD)? If so, please list.

_____

_____

Have you ever been seen by a psychiatrist or therapist/counselor? 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? 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? Circle all that apply and list any good or bad effects of the medications.

Medication	Good/Bad effects	Medication	Good/Bad effects	Medication	Good/Bad effects
Abilify		Haldol		Serax	
Ambien		Klonopin		Seroquel	
Adderall		Invega		Sonata	
Antabuse		Lamictal		Strattera	
Atarax		Latuda		Suboxone/ Subutex	

Ativan		Lexapro		Tegretol	
Buspar		Librium		Thorazine	
Campral		Lithium		Topamax	
Celexa		Lunesta		Trazodone	
Clonidine		Mellaril		Trileptal	
Clozaril		Methadone		Valium	
Cogentin		Norpramin		Viibryd	
Concerta		Pamelor		Vistaril	
Cymbalta		Paxil		Vivitrol	
Dalmane		Pristiq		Vraylar	
Depakote		Remeron		Wellbutrin	
Dexedrine		Restoril		Xanax	
Effexor		Rexulti		Zoloft	
Elavil		Risperdal		Zyprexa	
Fanapt		Ritalin			
Geodon		Saphris			

Any other psychiatric medications you have taken?

_____

Past Medical Care

Do you have a primary care doctor? Name _____ Last seen? _____

Have you ever been diagnosed with (please circle)?

Seizures TBI/head injury Migraine Hypothyroidism Endometriosis

Polycystic Ovarian Syndrome

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 prescribed it

Describe any allergies you have (e.g. to medications, foods).

_____

_____

Are you currently having or have you recently had any of these physical symptoms (please circle)?

Fevers	Headache	Constipation	Hot/Cold flashes	Chills
Chest pain	Acid Reflux	Joint Pains	Night Sweats	Shortness of breath
Decreased Sex Drive	Problems reaching orgasm	Unexplained weight loss	Heart Palpitations	Muscle pains or tension
Easy bruising or bleeding	Weakness in arms/legs	Cough	Sore Throat	Rashes
Pain or difficulty urinating	Numbness in arms/legs	Dental problems	Episodes of passing out	Nausea or vomiting
Changes in vision	Problems walking	Diarrhea	Changes in hearing	

For Women-

Last menstrual period? _____ Usually regular? Yes/No

Do you use any birth control? Yes/No If yes, please list: _____

Have 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 used the following substances?

Substance	Last time used?	Approx 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 or K2/ “spice”			
Cocaine			
Opiates (e.g. Heroin, morphine, Percocept, oxycodone, Tylenol #3, Dilaudid/hydromorphone)			

Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)			
PCP or LSD			
Mushroom			
Other			

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? _____

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? _____

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? _____

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

_____

Have you tried to hurt yourself in the past? 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? If so, please explain.

_____

_____

_____

Do you own any guns or knives?_____

Thank you for taking the time to complete this questionnaire. I look forward to meeting you.