Adult Intake Form

Quality Life Group Psychiatric and Psychological Services

Adult Patient Information

Name: _____, Sex: _____, Age: _____

Ethnicity _____, Race _____

Date of Birth: _____, Email address: _____

Address: _____, City: _____

State: ____, County,_____, Zip:_____

Telephone numbers:
Home: ( ) _____,Work: ( )_____

Cell: ( ) _____

Referral by: _____

Person to notify in case of emergency: _____

Emergency Contact Telephone Number: ( ) _____

School/ Employer: _____

Marital Status: _____

Insurance Company Information
Name of Insurer: _____

Member Number: _____

Authorization Number: _____

Insurer's Telephone Number: ( ) _____; ( ) _____

Insurer's email: _____

Coordination of Care:
Primary Care Doctor _____; Phone number _____
Email _____; Telephone number _____
Street _____; City _____; State _____
Zip _____

Therapist/Psychologist _____; Phone number _____
Email _____; Telephone number _____
Street _____; City _____; State _____
Zip _____

I agree to release my diagnosis and treatment recommendation information to my insurance company for billing and coordination of care: yes ____no_____

I agree to release my diagnosis and treatment recommendation information to my primary care provider for coordination of care: yes ___ no ____

I agree to release diagnosis and treatment recommendation information to my therapist/psychologist for coordination of care: yes____, no ____

I would like help with the following problem/ symptoms.

_____
_____
_____

My Psychiatric Diagnoses are:

_____
_____
_____

Medical History

Please indicate if you suffer from any of the following conditions, circle current, past or both and circle a number, 1 through 5 to indicate severity. 1 is mild, 3 is moderate, 5 is severe.

Infectious diseases	Current / Past	1 2 3 4 5
Allergies	Current / Past	1 2 3 4 5
Asthma/lung disease	Current / Past	1 2 3 4 5
Diabetes	Current / Past	1 2 3 4 5
Thyroid disease	Current / Past	1 2 3 4 5
Myocardial infarction	Current / Past	1 2 3 4 5
Hypertension	Current / Past	1 2 3 4 5
Liver disease	Current / Past	1 2 3 4 5
Cancer	Current / Past	1 2 3 4 5
Stroke	Current / Past	1 2 3 4 5
Head injury	Current / Past	1 2 3 4 5
Seizures	Current / Past	1 2 3 4 5
Suffocation/ drowning	Current / Past	1 2 3 4 5
Loss of consciousness	Current / Past	1 2 3 4 5
Headaches	Current / Past	1 2 3 4 5
Memory loss	Current / Past	1 2 3 4 5
Neurological disorder	Current / Past	1 2 3 4 5
Easy Bleeding/bruising	Current / Past	1 2 3 4 5
Sexual dysfunction	Current / Past	1 2 3 4 5
Pregnancy	Current / Past	1 2 3 4 5
Menopause	Current / Past	1 2 3 4 5
Kidney disease	Current / Past	1 2 3 4 5
Chronic pain	Current / Past	1 2 3 4 5
Excessive menstrual bleeding or pain	Current / Past	1 2 3 4 5
Gynecological condition/procedure	Current / Past	1 2 3 4 5
Skin Condition	Current / Past	1 2 3 4 5
Surgical Procedures	Current / Past	1 2 3 4 5

Medication Allergies:

_____

_____

Please list all medications you are currently taking for medical illness:

_____

_____

Family Psychiatric History

Please indicate the blood relationship of your family members with a psychiatric condition as follows:
1st degree relative – biological child or parent; 2nd degree- biological grandparent, cousin, uncle, aunt, niece, nephew

Psychiatric care	Maternal / Paternal	1st degree/ 2nd degree
Anxiety disorder	Maternal / Paternal	1st degree/ 2nd degree
Depressive disorder	Maternal / Paternal	1st degree/ 2nd degree
Manic depression or Bipolar disorder	Maternal / Paternal	1st degree/ 2nd degree
Schizophrenia	Maternal / Paternal	1st degree/ 2nd degree
Psychotic disorder	Maternal / Paternal	1st degree/ 2nd degree
Attention deficit/ hyperactivity disorder	Maternal / Paternal	1st degree/ 2nd degree
Learning disorders	Maternal / Paternal	1st degree/ 2nd degree
Mental retardation	Maternal / Paternal	1st degree/ 2nd degree
Autistic disorder	Maternal / Paternal	1st degree/ 2nd degree
Substance abuse	Maternal / Paternal	1st degree/ 2nd degree
Psychiatric hospitalization	Maternal / Paternal	1st degree/ 2nd degree
Eating Disorder	Maternal / Paternal	1st degree/ 2nd degree
Narcolepsy	Maternal / Paternal	1st degree/ 2nd degree
Sleep disturbance	Maternal / Paternal	1st degree/ 2nd degree
Homicide attempt	Maternal / Paternal	1st degree/ 2nd degree
Suicide attempt	Maternal / Paternal	1st degree/ 2nd degree

Social History of Client:

Highest degree of education obtained:

_____

_____

With whom do you live?

_____

_____

Type of employment:

_____

_____

Sexual Orientation:

_____

Number of Children:

_____

Legal problems/ circumstances:

_____

Main source of stress:

_____

_____

Negative experiences – physical or sexual abuse, domestic violence, trauma, loss:

_____

_____

Personal strengths/ weaknesses:

_____

_____

Personal goals/aspirations/ hopes/ dreams:

Spiritual/religious orientation/cultural issues

_____

_____

Psychiatric History of Client

Please indicate any psychiatric/ psychological care you have received, your approximate age at that time and your satisfaction with the treatment:

_____
_____
_____
_____
_____
_____

List all psychiatric medications prescribed; the reason prescribed; the duration; and effect by completing the following table.

Name of medication	Reason prescribed	Date started	Date ended/ reason for stopping	Helpful? Yes/No Side effects?

Psychiatric History Continued:

Please indicate if the following is current, past or both.
Please indicate the frequency using the following scale:
Almost Never (1); Sometimes (3); Almost Always (5)

Depression Symptoms	**When**	**Frequency**
Depressed mood	Current / Past	1 2 3 4 5
Loss of pleasure	Current / Past	1 2 3 4 5
Loneliness	Current / Past	1 2 3 4 5
Decreased appetite	Current / Past	1 2 3 4 5
Increased appetite	Current / Past	1 2 3 4 5
Poor concentration	Current / Past	1 2 3 4 5
Crying spells	Current / Past	1 2 3 4 5
Suicide thoughts	Current / Past	1 2 3 4 5
Homicide thoughts	Current / Past	1 2 3 4 5
Isolation	Current / Past	1 2 3 4 5
Irritability	Current / Past	1 2 3 4 5
Weight loss	Current / Past	1 2 3 4 5
Weight gain	Current / Past	1 2 3 4 5
Anger	Current / Past	1 2 3 4 5

Mania Symptoms	**When**	**Frequency**
Increased energy	Current / Past	1 2 3 4 5
Racing thoughts	Current / Past	1 2 3 4 5
Rapid speech	Current / Past	1 2 3 4 5
Less than four hours sleep per night	Current / Past	1 2 3 4 5
Euphoria	Current / Past	1 2 3 4 5
Invincibility	Current / Past	1 2 3 4 5
Irritability	Current / Past	1 2 3 4 5
Anger	Current / Past	1 2 3 4 5
Violent outburst	Current / Past	1 2 3 4 5
Sexual impulsivity	Current / Past	1 2 3 4 5
Financial impulsivity	Current / Past	1 2 3 4 5
Mood swings	Current / Past	1 2 3 4 5

Anxiety Symptoms	**When**	**Frequency**
Excessive worrying	Current / Past	1 2 3 4 5
Muscle stiffness	Current / Past	1 2 3 4 5
Panic attacks	Current / Past	1 2 3 4 5
Avoiding things	Current / Past	1 2 3 4 5
Unwanted fears	Current / Past	1 2 3 4 5
Unwanted rituals	Current / Past	1 2 3 4 5
Unwanted habits	Current / Past	1 2 3 4 5
Procrastination	Current / Past	1 2 3 4 5

Psychosis Symptoms	**When**	**Frequency**
Hearing voices	Current / Past	1 2 3 4 5
Seeing things	Current / Past	1 2 3 4 5
Paranoia	Current / Past	1 2 3 4 5
Special powers	Current / Past	1 2 3 4 5
TV, Radio, News talks to you or about you personally	Current / Past	1 2 3 4 5

ADHD Symptoms	**When**	**Frequency**
Overly active	Current / Past	1 2 3 4 5
Constantly in motion	Current / Past	1 2 3 4 5
Constantly talking	Current / Past	1 2 3 4 5
Constantly interrupting	Current / Past	1 2 3 4 5
Annoying to peers	Current / Past	1 2 3 4 5
Annoying to adults	Current / Past	1 2 3 4 5
Constantly distracted	Current / Past	1 2 3 4 5
Forgetful	Current / Past	1 2 3 4 5
Inattentive	Current / Past	1 2 3 4 5