

Psychology Associates of Brevard

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INITIAL INTAKE SYMPTOM INVENTORY

Today's Date: _____ Date of Birth: _____ Referred By: _____

Patient's Name: _____ Age: _____

Email Address: _____

Person Completing This Form: _____

Reason for Appointment (In a brief statement, please indicate your concerns, if you are not the patient, please indicate your concerns for the patient):

Check any symptoms below experienced in the last 2 weeks, including today:

Heart palpitations Frequent sweats Feeling scared/afraid Sleep disturbance Intrusive thoughts/"It feels like I can't turn off my brain"
 Stomach pain/discomfort Body aches Jumpy/Easily startled Exposed to traumatic event (e.g: abuse, assault)

Difficulty following directions Misses appointments/assignments Acts before thinking
 Restless/fidgety Easily bored Difficulty completing tasks Repeats self frequently Forgets conversations Difficult organizing thoughts Loss of previous abilities Deliberately annoys others Argues with authority Disregards the rights of others Fights Physically aggressive Verbally aggressive (e.g. insults, put downs)

Few friends Difficult getting along with others Only interested in a few specific areas

Rigid/Inflexible behavior Low frustration tolerance Tantrums/meltdowns Seems immature

Difficulty with fine motor tasks (e.g. tying shoes) Insists on following nonfunctional routines

Eating things that are not food Aversions to certain textures Poor eye contact

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Crying spell Excessive drug or alcohol use Irritability Low energy Loss of appetite Loss of interest in hobbies Sleeping all day Feeling sad Talking about death/dying Low energy

Days of weeks with seemingly endless energy Days or weeks with decreased need for sleep Sudden increase in risky/dangerous behavior More talkative than usual Ideas come into mind faster than can be spoken Inflated self-esteem/grandiosity

Sees or hears things that are not there Withdrawing Acts in strange or bizarre ways Speech at time does not make sense Neglect of self-care Binge eating Purging behavior (e.g. self-induced vomiting, misuse of laxatives) Expresses unhappiness with assigned gender

Please indicate how the symptoms you have checked have affected the patient:

- Mild (Can get through the day and meet responsibilities with little or no difficulty)
- Moderate (Occasionally difficult to complete daily tasks because of these symptoms)
- Severe (Symptoms interfere frequently or always with meeting daily responsibilities)

Approximately how long have these symptoms been present: _____

Have the symptoms become worse, stayed the same, or improved since they started?

What medications is the patient taking for depression, anxiety, ADHD, or other mental health conditions? Please list below:

Medication Name	Dosage	Frequency	Prescribing Physician