NEW DIMENSION GROUP
Adult Psychiatric Intake Form

All information on this form is strictly confidential. Please complete all information on this form and bring it to the first visit. Thank you!

Name_____ Date of Birth _____ Referred by_____

What are the problem(s) you are seeking help for?

1._____
2._____
3._____

What are your treatment goals?

1._____
2._____
3._____

What, if anything, happened recently to make the problem(s) worse? _____
_____

Please circle each symptom that relates to you:

Depressed Mood	Trouble staying asleep	Easily distracted	Talkative
Unable to enjoy activities	Avoidance	Trouble staying on task	Excessive energy
Loss of interest	Feeling agitated	Increase risky behavior	Suspicious thoughts
Change in appetite	Feeling guilty	Decrease need for sleep	Hearing voices
Weight loss/gain	Feeling worthless	Impulsive	Seeing images
Crying spells	Feeling hopeless	Pain	Obsessive thoughts
Extreme fatigue	Excessive worry	Addicted to drugs/alcohol	Intrusive thoughts
Sleeping too much	Anxiety attacks	Flashbacks	Suicidal thoughts
Trouble getting to sleep	Poor concentration	Racing thoughts	

Yes **No**

____ ____ Have you ever been a patient of a psychiatrist?
If yes, what was your diagnosis and how long were you treated? _____
____ ____ Have you ever been in talk therapy/psychotherapy?
If yes, with whom, when and for how long? _____
____ ____ Have you ever attempted suicide?
____ ____ Have you ever been hospitalized for any psychiatric reason?
If yes, name the hospital(s), the date(s), and for what reason?

Date	Hospital Name	Reason for admission
_____	_____	_____
_____	_____	_____
_____	_____	_____

____ ____ Have you ever taken any psychiatric medication? If yes, which ones? (*See examples of medications on back*)

Medication Taken and Dosage	**Response/Side-Effects and Reason Discontinued**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Some examples of PSYCHIATRIC MEDICATIONS are:

Antidepressants				
Celexa (citalopram)	Prozac (fluoxetine)	Zoloft (sertraline)	Paxil (paroxetine)	Lexapro (escitalopram)
Luvox (fluvoxamine)	Effexor (venlafaxine)	Cymbalta (duloxetine)	Wellbutrin (bupropion)	Remeron (mirtazapine)
Pristiq (duloxetine)	Elavil (amitriptyline)	Anafranil (clomipramine)	Pamelor (nortrptyline)	Tofranil (imipramine)
Mood Stabilizers				
Depakote (valproate)	Lamictal (lamotrigine)	Tegretol (carbamazepine)	Topamax (topiramate)	Lithium
Antipsychotics/Mood Stabilizers				
Seroquel (quetiapine)	Zyprexa (olanzepine)	Geodon (ziprasidone)	Abilify (aripiprazole)	Haldol (haloperidol)
Prolixin (fluphenazine)	Clozaril (clozapine)	Risperdal (risperidone)	Fanapt (iloperidone)	Latuda (lurasidone)
Sedative/Hypnotics				
Ambien (zolpidem)	Lunesta (eszopiclone)	Sonata (zaleplon)	Rozerem (ramelteon)	Restoril (temazepam)
Antianxiety medications				
Xanax (alprazolam)	Ativan (lorazepam)	Klonopin (clonazepam)	Valium (diazepam)	Buspar (buspirone)
ADHD medications				
Adderall (amphetamine)	Concerta (methylphenidate)	Ritalin (methylphenidate)	Strattera (atomoxetine)	Vyvanse (lisdexamfetamine)
Others				
Provigil (modafinil)	Desyrel (trazodone)	Emsam (selegiline)	Savella (milnacipran)	Symbyax (fluoxetine/olanzapine)

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

Yes	No		Who? (mother/ father/ children/ siblings/ grandparents/ aunts/ uncles/ cousins)
____	____	Depression	_____
____	____	Bipolar or Manic-Depressive disorder	_____
____	____	Anxiety	_____
____	____	Schizophrenia	_____
____	____	Alcohol abuse	_____
____	____	Other substance abuse	_____
____	____	Suicide attempt	_____

Your Medical History:

Primary Care Provider Name _____ Address _____ Phone _____

How long have you been a patient with this provider? _____

Date of last appointment _____

Date and place of last physical exam:_____

Current Weight _____ Height _____

List all medical illness you now have, or have had in the past: (include high blood pressure, diabetes, heart disease, etc.)

_____

_____

Past medical problems, non-psychiatric hospitalization or surgeries _____

_____

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ( ) **Yes** ( ) **No**

Are you planning to get pregnant in the near future? ( ) **Yes** ( ) **No**

Are you breast feeding? ( ) **Yes** ( ) **No**

Birth control method _____

How many times have you been pregnant? _____ How many live births? _____

Review of Systems: *Please circle if you are currently experiencing any of the following:*

Rashes	Glaucoma	Swelling	Muscle or joint pain
Hair or nail changes	Cataracts	Stomach aches	Leg cramping
Headaches	Sore throat	Nausea or vomiting	Seizures
Head injury	Breathing problems	Diarrhea or constipation	Dizziness
Vision or hearing problems	Chronic cough	Heart burn	Weakness
Ringing in ears	Wheezing	Urinary problems	Tremor
Glasses or contacts	Chest pain or discomfort	Moving or walking problems	Easy bruising

List ALL current prescription medications, dosages and how often you take them: (if none, write none)

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

List all Medication allergies: _____

Pharmacy: _____ Phone: _____

Social Information and Family Background:

Where were you born? _____ Where did you grow up? _____

What was your father's occupation? _____

What was your mother's occupation? _____

Yes No

____ ____ Are your parents living?
____ ____ Are they married?
____ ____ Did your parents' divorce?
If so, how old were you when they divorced? _____
____ ____ Do you have any brothers/sisters? If so, how many? _____
List your siblings and their ages: _____
_____
____ ____ Are you married?
____ ____ Have you been divorced? If yes, how many times? _____
____ ____ Do you have children? How many and their ages? _____
____ ____ Are you employed? If yes, what is your job? _____
____ ____ Have you ever been in military?
If yes, what branch and for how long? _____
____ ____ Do you have any history of being abused emotionally, sexually, physically or by neglect?
If yes, Please describe when, where and by whom. _____
_____

Who lives in the home with you currently? _____
_____

How far in school did you go? _____

What would you say is the most stressful thing in your life currently? _____
_____

Substance Use:

Yes No

____ ____ Do you drink alcohol?

If yes, how much do you drink? ____ Rarely ____Occasionally ____Frequently

- How many days per week do you drink any alcohol? _____
- What is the least number of drinks you will drink in a day? _____
- What is the most number of drinks you will drink in a day? _____

____ ____ Have you ever tried to cut back your drinking unsuccessfully?
____ ____ Do you get annoyed at friends/family telling you that you need to drink less?
____ ____ Do you ever feel guilty about your drinking?
____ ____ Do you ever use alcohol first thing in the morning?
____ ____ Do you think you may have a problem with alcohol or drug use?

Check if you have ever tried the following:

Yes	No		If yes, **how long** and **when did you last use**?
____	____	Marijuana	_____
____	____	Methamphetamine	_____
____	____	Heroin	_____
____	____	Cocaine	_____
____	____	LSD or Hallucinogens	_____
____	____	Stimulants (pills)	_____
____	____	Pain killers (not as prescribed)	_____
____	____	Methadone	_____
____	____	Tranquilizer/sleeping pills	_____

____ ____ Have you ever been treated for alcohol or drug use or abuse?
____ ____ Have you ever been through detox or rehab?
If yes, for which substances? _____
If yes, where were you treated and when? _____
_____

____ ____ How you ever smoked cigarettes?
____ ____ Currently? If so, how many packs per day on average? _____How many years? _____
____ ____ In the past? If so, how many years did you smoke? _____When did you quit? _____
____ ____ Do you use a pipe, cigars, or chewing tobacco?

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Yes No

____ ____ Have you ever been arrested? If yes, for what reason(s) _____
____ ____ Do you have any pending legal problems? If yes, list problems _____
____ ____ Are you currently on Probation or Parole? If yes, ending Date: _____
____ ____ Are you involved in any lawsuits?
____ ____ Any upcoming Court dates?

Is there anything else that you would like New Dimension Group to know?

_____
_____
_____
_____

Signature_____ Date_____

Emergency Contact _____ Telephone # _____

Reviewed by _____ Date _____
(Office use)

If you use caffeine, tobacco, alcohol or drugs, please complete following information

TYPE OF DRUG	AGE OF 1ST USE	WHAT AGE DID YOU START USING IT REGULARLY	AVERAGE NUMBER OF DAYS USED EACH WEEK	ABOUT HOW MUCH WOULD YOU USE EACH DAY	NUMBER OF DAYS USED IN PAST 30 DAYS	LAST DATE YOU USED
Coffee Cola Caffeine pills						
Cigarettes						
Beer Wine Liquor						
Marijuana						
Crack cocaine Cocaine powder						
Heroin: Snort Shoot						
Methadone						
Pain Medication Type:						
Tylenol #3 or 4						
Muscle Relaxers Soma Flexeril Other: _____						
Valium, Librium Other: _____						
Glue Poppers Aerosols						
PCP LSD Mescaline						
Meth-amphetamine						
Phenobarbital Sleeping pills						
Steroids						
Other:						