PSYCHIATRIC CONSULTANTS OF WICHITA

Mental Health Intake Form
Please complete all information on this form and bring it with you to your appointment.

Name_____ Date of Birth_____ Date_____

Allergies_____ Current Weight _____ Height _____

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

_____

What are your treatment goals? _____

_____

Current or Previous Therapist/Counselor: _____ Phone Number: _____
May we contact this provider? _____ Yes _____No

Previous Mental Health Provider: _____ Phone Number: _____
May we contact this provider? _____ Yes _____No

Primary Care Physician: _____ Phone Number: _____
May we contact this provider? _____ Yes _____No

Current Symptoms Checklist: (check any symptoms present, circle major symptoms)

( ) Depressed mood	( ) Increase risky behavior	( ) Suspiciousness	( ) Decreased libido
( ) Racing thoughts	( ) Avoidance	( ) Change in appetite	( ) _____
( ) Excessive worry	( ) Loss of interest	( ) Excessive energy	( ) _____
( ) Unable to enjoy activities	( ) Increased libido	( ) Excessive guilt	
( ) Impulsivity	( ) Hallucinations	( ) Increased irritability	
( ) Anxiety attacks	( ) Concentration/forgetfulness	( ) Fatigue	
( ) Sleep pattern disturbance	( ) Decrease need for sleep	( ) Crying spells	

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

Exercise:
Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise? _____ Amount of time? _____ Type? _____

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

List ALL current medications and how often you take them: (if none, write none)
(Include all prescription, over-the-counter medications and supplements. Continue on back if needed)

Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

Personal and Family Medical History

	You	Family	Who
Thyroid Disease -------	( )	( )	_____
Anemia----------	( )	( )	_____
Liver Disease ----------	( )	( )	_____
Kidney Disease --------	( )	( )	_____
Diabetes ----------	( )	( )	_____
Cancer (type) ----------	( )	( )	_____
Fibromyalgia ----------	( )	( )	_____
Heart Disease ---------	( )	( )	_____
Epilepsy or seizures ----------	( )	( )	_____

	You	Family	Who
Chronic Pain ----------	( )	( )	_____
High Blood Pressure _____	( )	( )	_____
Head trauma ----------	( )	( )	_____
Asthma/respiratory problems -	( )	( )	_____
Stomach/intestinal problems -	( )	( )	_____
Other ----------	( )	( )	_____

Past Surgeries: _____

Do you have any metal implants? _____

Is there any additional personal or family medical history? _____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ Results: ( ) normal ( ) abnormal or ( ) unknown

Past Psychiatric History:
Outpatient treatment ( ) Yes ( ) No
Reason Dates Treated By Whom

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No
Reason Date Hospitalized Where

_____

_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for: If yes, please indicate who.

Bipolar disorder	( ) Yes ( ) No	_____	Schizophrenia	( ) Yes ( ) No	_____
Depression	( ) Yes ( ) No	_____	Post-traumatic stress	( ) Yes ( ) No	_____
Anxiety	( ) Yes ( ) No	_____	Alcohol abuse	( ) Yes ( ) No	_____
Anger	( ) Yes ( ) No	_____	Other substance abuse	( ) Yes ( ) No	_____
Suicide	( ) Yes ( ) No	_____	Violence	( ) Yes ( ) No	_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No

If yes, who was treated, what medications did they take, and how effective was the treatment? _____

_____

Family Background and Childhood History:

Who did you live with growing up? _____ Where did you grow up? _____

Did your parents' divorce? ( ) Yes ( ) No. How old were you? _____ Who did you live with? _____

Trauma History:

Have you ever been abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No By whom: _____

Do you have a history of PTSD, hx of traumatic event? ( ) Yes ( ) No, explain: _____

Educational History:

Did you graduate High School? _____ Did you attend college? _____ Did you graduate College? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

What is/was your occupation? _____ How long? _____

Have you ever served in the military? _____ Branch and when? _____ Discharged? ( ) Yes ( ) No ( ) Honorable

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed. How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation? _____ ( ) Prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____ How long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

Legal History:

Have you ever been arrested? _____ Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No. Do you find your involvement ( ) more helpful ( ) stressful

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____ the most? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs in the morning to steady your nerves or get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No If yes, which ones and for how long? _____

Check if you have ever tried the following:

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

Other _____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do Remember).

Generic Name	Brand Name	Dose Taken	Dates Taken	Outcome (side effects, reason for stopping)
SSRI's				
Fluoxetine	Prozac			
Citalopram	Celexa			
Fluvoxamine	Luvox			
Paroxetine	Paxil			
Paroxetine CR	Paxil CR			
Sertraline	Zoloft			
Escitalopram	Lexapro			
SNRI's				
Venlafaxine	Effexor			
Desvenlafaxine	Pristiq			
Duloxetine	Cymbalta			
Levomilnacipran	Fetzima			
Other Antidepressants				
Bupropion	Wellbutrin			
Mirtazapine	Remeron			
Nefazodone	Serzone			
Trazodone	Desyrel			
Amoxapine				
Vilazodone HCL	Viibryd			
TCA/Tetracyclic				
Amitriptyline	Elavil, Endep			
Imipramine	Tofranil			
Desipramine	Norpramin			
Trimipramine	Pertofrane			
Clomipramine	Surmontil			
Maprotiline	Anafranil			
Doxepin	Ludiomil			
Nortriptyline	Sinequan			
Protriptyline	Pamelor, Aventyl Vivactil			
MAOI				
Phenelzine	Nardil			
Selegiline	Eldepryl			
Selegiline Transdermal Patch	Emsam			
Tranylcypromine	Parnate			
Isocarboxazid	Marplan			

Generic Name	Brand Name	Dose Taken	Dates Taken	Outcome (side effects, reason for stopping)
Antipsychotics				
Risperidone	Risperdal			
Olanzapine	Zyprexa			
Quetiapine	Seroquel			
Ziprazadone	Geodon			
Aripeprazole	Abilify			
Paliperadone	Invega			
Lurasidone	Latuda			
Clozapine	Clozaril			
Iloperidone	Fanapt			
Asenapine	Saphris			
Brexpiprazole	Rexulti			
Cariprazine	Vraylar			
Mood Stabilizers				
Lithium Carbonate	Lithobid, Eskalith			
Divaloprox Sodium	Depakote			
Lamotrigine	Lamictal			
Carbamazepine	Tegretol			
Oxcarbazepine	Trileptal			
Toprimate	Topamax			
Gabapentin	Neurontin			
Pregabelin	Lyrica			
Anti-anxiety				
Alprazolam	Xanax			
Lorazepam	Ativan			
Clonazepam	Klonopin			
Diazepam	Valium			
clorazepate	Tranxene			
Buspirone	Buspar			
Hydroxyzine	Vistaril			
Sedative/Hypnotics				
Zolpidem	Ambien			
Eszopiclone	Lunesta			
Zaleplon	Sonata			
Ramelteon	Rozerem			
Mirtazapine	Restoril			
Trazodone	Desyrel			
Suvorexant	Belsomra			

Psychostimulants (ADHD Medications)				
Methylphenindate	Ritalin	_____	_____	_____
	Ritalin LA	_____	_____	_____
	Concerta	_____	_____	_____
	Focalin	_____	_____	_____
	Focalin XR	_____	_____	_____
	Daytrana	_____	_____	_____
	Cotempla	_____	_____	_____
Amphetamine	Adderall	_____	_____	_____
	Adderall XR	_____	_____	_____
	Vyvanse	_____	_____	_____
	Mydayis	_____	_____	_____
	Adzenys XR-ODT	_____	_____	_____
	Dyanavel XR	_____	_____	_____
		_____	_____	_____
Modafinil	Provigil, Nuvigil	_____	_____	_____
Atomoxetine	Strattera	_____	_____	_____

Is there anything else that you would like us to know? _____

_____

_____

Patient or Guardian Signature _____ Date_____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Recommendations: _____

Follow-up in: _____ Weeks

Medications: _____

_____

Reviewed by _____Date _____

Reviewed by _____Date _____