Psychiatric Evaluation Intake Form

CAIRN CENTER

1. Patient Contact Information

Patient Name_____ Preferred Name _____
Last First MI

Address_____

Best contact phone number: _____Email address: _____

Primary Care Physician _____Tel _____Fax_____

Pharmacy _____ Phone #_____

2. Date of Birth ☐☐/☐☐/☐☐☐☐ **3. Age** ☐☐
M M D D Y Y Y Y **Years**

4. Race/Ethnicity (Check one or more):

☐ American Indian/ Alaskan Native ☐Asian ☐ AfricanAmerican ☐ Hispanic ☐ Caucasian ☐ Other_____

5. Current marital status (Check one):

☐ Single,never married ☐ Married,living together ☐ Separated ☐ Widowed ☐ Cohabiting with partner ☐ Divorced
☐ Married,not living together

6. If you are married or cohabitating with partner, how long has this been? ☐☐ ☐☐
Years Months

7. Total number of marriages? ☐☐ **How many children do you have?** ☐☐

8. Spouse's/Partner's Name_____

9. Who else lives with you? _____

10. How many years of formal education have you completed? ☐☐
Years

11. Highest degree obtained: (Check only one)

☐ High school graduate ☐ G.E.D. ☐ 4 year college degree ☐ M.B.A./M.A./M.S./M.P.H. ☐ M.D.
☐ Junior college degree or technical school diploma ☐ J.D./LL.B. ☐ Ph.D ☐ Other_____

12. What best describes your current employment status? (Check one from each category a, b, & c)

a. Employment Status	**b. Student Status**	**c. Volunteer Status**
☐ Unemployed, not looking for employment	☐ Part-time	☐ Volunteer Part-time
☐ Unemployed, looking for employment	☐ Full-time	☐ Volunteer Full-time
☐ Full-time employed ☐ Part-time employed	☐ Not a student	☐ No Volunteer Work
☐ Retired ☐ Self-employed		
☐ On welfare ☐ Social security disability		

14. What is your occupation? _____

15. Current Residence

☐ Own my house/ condo ☐ Retirement Complex/Senior Housing ☐ RENTING ☐ Apartment /Condominium

16. What is your spouse's occupation? _____

Are you currently seeing a therapist? (Name/contact #)_____

Have you ever seen a psychiatrist/psychotherapist before? If yes, please list:_____

Previous history: Have you ever been treated for any of the following (check all that apply):

____ Depression _____ADHD ____ Bipolar (Manic / Depressive) Disorder
____ Anxiety _____OCD ____ Schizophrenia
____ Panic Attacks _____PTSD ____ Alcohol Problems (including AA)
____Anorexia/ Bulimia _____Binge-eating ____ Drug Problems _____ECT treatment

Please list in chronological order all prior psychiatric hospitalizations (if any) below: None

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below: Never

Approximate date of attempt	How did you attempt (method)?

Please List *all* current medications below(include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort etc)

Name of Medication	Dosage(Mg)	How many times a day?	On this for how long?	Side effects (if any)	Prescribing physician

Please review the following list of medications. If you have taken any of these medications please fill out the specific boxes related to that medication.

Brand Name	**Generic Name**	**√ if yes**	**How long did you take it?**	**What Dosage did you take? Mg/d**	**Did it help? √ if yes**	**How often In a day?** Write **1, 2** or **3** times a day	**Any Side effects**
Selective Serotonin Reuptake Inhibitors(SSRIs)							
Luvox	Fluvoxamine						
Paxil	Paroxetine						
Paxil CR	Paroxetine						
Celexa	Citalopram						
Lexapro	Escitalopram						
Zoloft	Sertaline						
Prozac	Fluoxetine						
Serotonin-Norepinephrine Reuptake Inhibitors(SNRIs)							
Effexor	Venlafaxine						
EffexorXR	Venlafaxine						
Pristiq	desvenlafaxin						
Cymbalta	Duloxetine						
Other Antidepressants							
Desyrel	Trazadone						
Serzone	Nefazodine						
Wellbutrin XL / SR	Bupropion XL/ SR						
Remeron	Mirtazapine						
Viibryd	vilazodone						
Tricyclic Antidepressants							
Adapin	Doxepin						
Anafranil	Clomipramine						
Asendin	Amoxapine						
Elavil	Amitriptyline						
Ludiomil	Maprotiline						
Norpramin	Desipramine						
Pamelor	Nortriptyline						
Sinequan	Doxepin						
Surmontil	Trimipramine						
Tofranil	Imipramine						
Vivactil	Protriptyline						
Other Psychotropics (Have you taken any of these?)							
Abilify	Buprenorphin	Dexedrine	Ambien	Klonopin	Emsam	Provigil	Thorazine
Risperidal	Campral	Adderall	Buspar	Ativan	Nardil	Depakote	Dalmane
Invega	Antabuse	Vyvanse	Restoril	Xanax	Parnate	Lithium	Orap
Geodon	Suboxone	Strattera	Sonata	hydroxyzine	Halcion	Lamictal	Navane
Zyprexa	Naltrexone	Concerta	Buspar	Valium	Niravam	Phentermine	Trilafon
Seroquel	Ambien CR	Dexedrine	Halcion	vistaril	Tranxene	Tegretol	Mobane
Symbyax	Valproic Acid	Focalin	Atarax	Methadone	Cylert	Topamax	Stelazine
Clozapine	Adderall XR	Ritalin	Librium	Synthoid	Viibryd	Mellaril	Haldol
Rozerem	Metadate	Daytrana	Lunesta	Meridia	Saphris	Loxitane	Prolixin

Family History :Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate indicate paternal or maternal)

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression								
Anxiety								
Panic Attacks								
Post traumatic stress								
Bipolar/Manicdepression								
Schizophrenia								
Alcohol Problems								
Drug problems								
ADHD								
Suicide attempts								
Psychiatric hospital stay								

Medical History: Do you have, or have you ever had any of the following (please check all that apply)? **Please write in your medical problem in each category**

	Mark √		Mark √		Mark √
High Blood Pressure		Gastrointestinal Problems (ulcers, pancreatits, irritable bowel, colitis)		Viral Illness (herpes, Epstein-Barr, chronic hepatitis)	
Lung Disease		Arthritis or Rheumatoid Problems		Cancer	
Diabetes		Liver Damage or Hepatitis		Genital Problems	
Heart Disease		Other Endocrine/Hormone Problems		Eating Disorder	
Thyroid Disease		Neurological Problems (stroke, brain tumor, nerve damage)		Eye Problems	
Anemia		Gynecological / hysterectomy		Chronic pain	
Asthma		Urinary Tract or Kidney Problems		Fibromyalgia	
Skin Disease		Migraine or Cluster Headaches		HIV Positive or AIDS	
Seizures		Ear/Nose/Throat Problems		Head Injury	
Other medical issues		High Cholesterol		Sleep apnea	

Regarding alcohol, when was your last drink?_____
In the past 30 days, about how many of those days have you had at least one alcoholic drink?_____
What is the maximum number of drinks you have had in one day in the past month?_____drinks
DUI_____DWI_____Public Intoxication_____Seizures_____DT's_____

Please check the appropriate boxes that apply to you for the following substances:

	Never Used	Age first used	Last used on this approx date	Age peak use	Hx abuse?	Current use and frequency
Cocaine						
Amphetamine Or Speed						
Marijuana						
Diet Pills						
Hallucinogens (LSD,mushrooms, Mescaline)						
Ecstasy						
Diuretics						
Tranquilizers						
Pain Pills						
Inhalants						
Sleeping Pills						
Laxatives						
Cigarettes,cigars, Or tobacco						
PCP or Angel Dust						
IV Drug use						
Heroin						
GHB						
Anabolic Steroids						
Caffeine(coffee, Tea,cola's,iced tea						
Benzodiazepines (xanax,valium,ativan Restoril, Librium)						
Other:						

List all prior surgeries and hospitalizations for medical illnesses

_____
_____
_____

Are you allergic to any medication or food? If so, please list below

_____
_____

Last menstrual period (if applicable) _____
Contraceptive method: _____

Emergency contact: _____**Phone #**_____