AT Psychiatry, PLLC
CHANGE YOUR MIND!

Intake Form
Medical and Psychiatric History

Date: _____

Name: _____ **Last Name:** _____ **Marital Status:** _____

Age: _____ **Date of Birth:** _____ **Gender:** _____

What is your best contact phone number: _____

What is your e-mail address: _____

May we leave a message at this number? Yes ☐ No ☐

Please be aware that email is not a confidential means of communication. We cannot guarantee that email messages will be received or responded to in a timely fashion. E-mail is not an appropriate way to communicate confidential or urgent information. Your use of e-mail is at your own risk. We use e-mail for reminders. We use an electronic health record system called talkEHR™/talkPHR™. You may access your records and message us once you have an account. Please sign up at https://talkphr.com once you receive an e-mail invitation after your first visit.

What is your address: _____

Preferred Pharmacy (Name, location, phone #): _____

Primary Care Provider: _____

Please list the providers you are currently seeing including your therapist(s).

Name	Address	Specialty or condition being treated

What mental health issues do you want to focus on during this visit?

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<u>Current Medical and Psychiatric Problems</u> (e.g. depression, insomnia, diabetes, heart disease, hypertension, hypothyroidism, etc.):

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

<u>Past Medical and Psychiatric History</u> (e.g. any <u>major</u> past illnesses and hospitalizations for depression, suicidal thoughts or attempt, cancer, heart attack or stroke; include year if known):

	Date		Date

<u>Past Surgical History</u> (e.g. any major past surgeries such as cholecystectomy, appendectomy, hysterectomy, spinal fusion, coronary artery bypass graft, heart pacemaker insertion, etc.; include year if known):

	Date		Date

<u>Past Gynecologic/Obstetric History</u> (all past pregnancies):

Vaginal Births		Miscarriage / Still births	
Caesarian Sections		Pregnancy Terminations	

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Family History (have your parents, brothers or sisters, child, and grandparents had any of the following conditions):

	Yes	No	If yes, which relative
Heart attack			
Stroke			
High blood pressure			
High cholesterol			
Diabetes			
Thyroid disease			
Cancer (type if known)			
Kidney disease			
Liver disease			
Rheumatoid arthritis			
Dementia (e.g. Alzheimer's or Parkinson's disease)			
Depression			
Bipolar disorder (manic-depressive illness)			
Schizophrenia			
Alcoholism			
Drug abuse (e.g. cocaine, methamphetamines, heroin, etc.)			

Pharmaceuticals and Supplements:

Do you have medication allergies? ☐ Yes ☐ No If yes, please list:

Medication	Reaction	Medication	Reaction

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Please list all prescribed and over-the-counter medications you take regularly. ***Please include all supplements, vitamins or herbal products.***

Medicine/ Supplement and Dose	Frequency	Medicine / Supplement and Dose	Frequency
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Please outline your use of the following, past or present:

Product:	Current Use? Yes/No	Quantity Per Day	Quantity Per Week	Past Use? Yes/No	Do you or others have concerns about your usage?
Tobacco					
Alcohol					
Marijuana					
Recreational Drugs					
Caffeine					

Preventive Health:

Do you routinely wear a seat belt? ☐ Yes ☐ No

Do you see your Primary Care Provider regularly for vaccination, annual physicals, etc.? ☐ Yes ☐ No

Do you wear glasses or lenses? ☐ Yes ☐ No **When was your last eye exam?** _____

Do you wear dentures? ☐ Yes ☐ No **When was your last dental exam?** _____

Do you wear hearing aids? ☐ Yes ☐ No

Do you own any firearms? ☐ Yes ☐ No

Do you store your firearms in a safe or locked box? ☐ Yes ☐ No

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Review of Symptoms (Please check yes/no for the following symptoms; mark yes if you have had them in the past 2 weeks):

GENERAL	Yes	No	GASTROINTESTINAL	Yes	No
Fever			Diarrhea/constipation		
Sweats at night			Indigestion/heartburn		
Hot flashes			Nausea/vomiting		
Temperature intolerance			Blood in stool		
Excessive thirst			**GENITOURINARY**		
Fatigue			Pain or burning on urination		
Sleep difficulties			Frequent urination		
Daytime sleepiness			Waking to urinate more than once at night		
Unplanned weight change			Excessive urination		
SKIN			Difficulty emptying bladder		
Rash			Urinary incontinence		
New or changing moles			Decreased sexual desire		
EYES			Pain with intercourse		
Pain			Sexually Transmitted Diseases		
Redness			Fertility issues		
Vision change			**Men:**		
EAR, NOSE, THROAT			Erectile dysfunction		
Hearing loss			**Women:**		
Ringing in ears			Heavy vaginal discharge		
Dizziness or vertigo			Heavy menstrual bleeding		
Bleeding gums			Painful menstrual periods		
Nosebleeds			Irregular menstrual bleeding		
BREAST			**MUSCULOSKELETAL**		
Breast pain			Generalized or all-over pain		
Masses and or lumps			Joint pain		
Nipple discharge			Stiffness		
Skin changes			Joint swelling		

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CARDIOVASCULAR			Joint redness		
Chest pain			Back or neck pain		
Heart murmur			**NEUROLOGICAL**		
Irregular heart beat (palpitations)			Abnormal gait (Trouble Walking) or falls		
Leg swelling or edema			Headache severe and/or frequent		
PULMONARY			Seizures		
Wheezing or shortness of breath			Muscle weakness or stroke		
Chronic cough			Fainting or loss of consciousness		
HEMATOPOIETIC			Localized numbness or tingling		
Swollen lymph glands			**PSYCHOLOGICAL**		
Blood clots			Anxiety		
Excessive bleeding			Depression		
Anemia			Memory loss		
			Mood swings / irritability		

Trauma History:

Have you ever been the victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster)? ☐ Yes ☐ No

If yes, is this an active issue in your life that you would like to address while you are here? ☐ Yes ☐ No

Do you consider your current home to be safe? ☐ Yes ☐ No

Movement, Exercise and Rest:

What forms of exercise and movement do you enjoy (e.g. walking, jogging, climbing stairs, bicycling, etc.)? Please describe your usual physical activity.

Activity	How often	How long each time

How many hours of sleep do you usually get each night? _____

Describe any issues you have with sleep: _____

_____

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Nutrition (please list any food allergies or sensitivities):

Foods	Reaction	Foods	Reaction

Please list everything you ate in the last 24 hours:

Morning:
Afternoon:
Evening:
Snacks:

Do you currently or have you ever had a problem with weight or eating? ☐ Yes ☐ No If yes, please describe:

_____

Have you ever had any binge eating or purging? ☐ Yes ☐ No

Have you ever used laxatives daily for more than 3 days? ☐ Yes ☐ No

Personal and Professional History:

Current or past occupations: _____

☐ Retired ☐ Working at home ☐ Care-taking ☐ Disabled ☐ Unemployed

Do you anticipate any work changes in the near future? Retirement, etc. _____

Do you have a Racial/Culture heritage that is important to you? _____

Do you have any current or ongoing legal problems? _____

Relationships:

Relationship status: _____ if married or partnered, what is your relationship length? _____

What are your living arrangements? _____ Number of children and ages: _____

Are you sexually active? ☐ Yes ☐ No Are you happy with your sexual life? _____

Which relationship(s) fulfill and/or empower you? _____

Who or what drains your energy? _____

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Spirituality:

What things or activities bring you your greatest joy and meaning? What inspires you?

_____

_____

What things create the greatest challenges for you? _____

_____

What makes you feel connected to the larger world? Describe your spiritual or religious practices if any (e.g. meditation, prayer, time in nature, worship attendance, etc.) _____

_____

If time and money were not an issue, describe the things you long to do in your life._____

_____

Mind-Body Connection:

Rate the amount of stress in your life:

☐ None ☐ A Little Bit ☐ Moderate ☐ Quite a Lot ☐ Extreme

How well do you manage stress?

☐ Not at All ☐ A Little Bit ☐ Moderate ☐ Quite well ☐ Excellent

What are the main sources of stress in life? (Personal, professional, financial etc.) _____

_____

What are your methods of coping with the stress in your life? _____

_____

Is there anything else that would be helpful for us to know about you? _____

_____

_____

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