FAIRVIEW COUNSELING CENTER

Psychiatric Intake Form

Date: ____________

New patient form: Please fill in this form as completely as you can.

Name: ____ **ID:** ________ **Age:** ______

Date of birth: ___/___/___ **Referred by:** ____

Person completing form: ____

Relationship to patient: ____

Fairview doctor ____________________________ **Fairview clinic** ______________________

Why are you seeking care at this clinic? What symptoms are bothering you?

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Please rate depression symptoms on attached PHQ-9.

Please rate mood symptoms on attached *Mood Disorder Questionnaire.*

Please rate anxiety symptoms on attached GAD7.

Do you have a fear of crowds or leaving home? Yes____ No____

Do you have problems with anxiety, worry, panic attacks, obsessive thoughts or compulsive behavior (checking, cleaning, counting, etc.)? If so please briefly describe: ______________________________

____

Do you have problems with flashbacks or nightmares following a traumatic event? Yes____ No____

Have you ever been diagnosed with ADHD (attention deficit disorder)? Yes____ No____
If so, were you prescribed medicine? Yes____ No____

Are your thoughts scattered or disjointed? Do you have paranoia or hallucinations? Yes____ No____
If so, please describe: ____

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Have you had problems with an eating disorder, gambling, or shoplifting? Yes____ No____

Psychiatric History:

List any mental health diagnoses: ____

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If you have been in the hospital overnight for mental health care, list the dates and location:

Hospital	Dates

Have you ever had Electroconvulsive Therapy (ECT)? Yes____ No____

If yes, when? ____

Have you ever been committed? Yes____ No____

If yes, when? Where?____

List trials of psychiatric medicines, date and doses (if known). Refer to the attached list of medicines.

Who is your current counselor or therapist? ____

What types of therapy have you had?

☐ Cognitive Behavioral Therapy (CBT) ☐ Dialectical Behavioral Therapy (DBT) ☐ other

Substance use: Do you currently use drugs, alcohol, or tobacco? Yes____ No____ If yes, which:

____

____

If you use, have you felt guilty about your drinking or drug use? Yes____ No____

In the past year, have you wanted or needed to cut down on your drinking or drug use? Yes____ No____

Dates of chemical dependency treatments (if any): ____

Medical History:

Surgery: ____

____

Have you had a serious head injury or seizures? Yes____ No____

Have you had allergies or bad reactions to medications? Yes____ No____

Do you have ongoing health problems or a history of serious medical problems? Please check the box; we will review:

☐ headaches ☐ allergies ☐ sinus problems ☐ heart problems ☐ high blood pressure
☐ asthma or bronchitis ☐ stomach problems ☐ breast or pelvic problems ☐ back pain or arthritis
☐ diabetes ☐ HIV/AIDS or hepatitis ☐ other

Do you exercise on a regular basis? Yes____ No____

What is your diet like? ____

Do you use any herbal or nutritional supplements? Yes____ No____ If so, please list: _________

____

Current medicines and doses (if known): ______________________________________

____

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Do any family members have mental illness or substance use problems? Yes____ No____
If so, please list: ____

Social History:

Where did you grow up? ____

How many brothers and sisters did you have? ________________________________

Were your parents married? Yes____ No____

Highest educational level completed: _____________________________________

Marital status and living situation: ______________________________________

Do you have children? Yes____ No____

Do you work outside the home? No____ Full time____ Part time____

What are the main stresses in your life now? ________________________________

Is there anything else that I need to know that may help with this initial interview? Yes____ No____

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______________________	____________	________
Patient Signature	*Date*	*Time*
______________________	____________	________
Parent/Legal Guardian Signature	*Date*	*Time*