AFFINIITAS PSYCHIATRIC CARE

Psychiatric Services Intake
Provider: Rebecca Elbert, CNS

Section 1: Client/Family Mental Health History

Presenting Complaint: _____

History of psychiatric illness: (Circle answers)

Have you ever had counseling or therapy? Yes / No

If yes: Age _____ Location: _____

Have you been prescribed medication for mental health in the past? Yes / No

If yes: Age _____ Location: _____

By: Primary Care Provider OR Psychiatric Provider

Have you had any In Patient Psychiatric admission: Yes / No

If yes: Age _____ Location: _____ If more than one admission:

Age _____ Location: _____

Age _____ Location: _____

Have you ever been admitted to:

PHP (Partial Hospital Program) Yes / No When _____ Where _____

IOP (Intensive Outpatient Program) Yes / No When _____ Where _____

Past Psychiatric History:

Illness	You	Relative	Relationship to you
Depression			
Bipolar D/O			
Anxiety			
ADHD			
PTSD			
Eating Disorder			
Schizophrenia			
Autism Spec. D/O			
Self-Injurious Behavior			
Suicide / Age			

* If you have had a suicide attempt: Hospital Admission: Y / N Where/When _____

Have you had more than one attempt: Yes/No How many: _____

Do you have a history of: Violent Behavior Yes / No

Do you have guns where you live: Yes / No

History of Closed Head Trauma/loss of Consciousness: Y / N Year_____ Age _____

Explain: _____

History of Abuse: Yes / No Age of first abuse: _____

Verbal Yes / No By Whom: _____

Physical Yes / No By Whom: _____

Emotional Yes / No By Whom: _____

Sexual: Yes / No Family Member Friend Stranger

CURRENT MEDICATIONS:

Medication	Dose	Time(s) taken

Pharmacy: _____ Allergies: _____

Primary Care Provider: _____@ _____ Clinic Last Visit: _____

Section 2: Review of Systems:

1. How are you feeling today? _____
   _____
2. Eyes: blurry vision double vision eye discharge red eyes _____
3. ENT: ear pain / discharge nasal discharge / congestion throat pain / hoarseness
4. Cardiovascular: chest pain - at rest OR with exertion / palpitations / swollen ankles
5. Pulmonary: shortness of breath / cough / wheezing / snoring or stop breathing
6. Gastrointestinal: heart burn / abdominal pain / difficulty swallowing / nausea / vomiting
7. Genitourinary: blood in urine / burning with urination / nighttime urination x ____
8. Musculoskeletal: **Painful:** joints / muscles / back **Achy:** joints / muscles
9. Skin / hair: hair loss / rashes / sores that don't heal / itching
10. Neurologic: numbness / tingling / weakness / dizziness / H/A / balance / seizures
11. Endocrine: fatigue / weight loss / weight gain

Is PAIN a concern you have? Y / N 0-10 Worst ____ Least ___ Average ____ Today _____

Developmental History: Are you the child of a normal pregnancy, delivery, development? Yes No
If NO explain:

_____

_____

Section 3: Substance Use History :

	Alcohol	Drugs
Have you ever felt that you ought to cut down on your drinking or drug use?	Yes / No	Yes / No
Have people annoyed you by criticizing your drinking or drug use?	Yes / No	Yes / No
Have you ever felt guilty about your drinking or drug use?	Yes / No	Yes / No
Have you ever had a drink or used drugs first thing in the morning to get going?	Yes / No	Yes / No

Drug	Age first used	Last used	Frequency and amonut
Alcohol			
Cigs / Chew / Cigars / Vape (Circle)			
THC			
Ecstasy / Cocaine / Meth (Circle)			
Opioids / Heroine (Circle)			
Prescription Drugs			
OTHER:			

Chemical Dependency Treatment: Yes No

Treatment Center	Drug(s)	Date	Sobriety Date

Family History of Substance Use Disorder:

Substance	Family Member	Any Treatment / Sober Yes or No

Section 4: Medical History

ILLNESS	You	Family Member	Treatments (Meds / Surgery)
Hypertension/ Heart Disease/Stroke			
Cardiac Arrhythmia/ Sudden death			
Diabetes Type I or Type II			
Kidney Disease			
Seizure			
Bleeding Tendency			
Dementia			
Cancer (Type)			
Cancer (Type)			
Thyroid Problems			

Surgeries: (Circle) Tonsils / Adenoids / Appendix / Gall Bladder / Gastric Bypass Year _____

Section 5: Social History

Racial origin: Caucasian / African American / Hispanic / Native American

Asian/Pacific Islander / Bi/multi-racial

Where were you born: _____

Where were you raised: _____

How many times did you move before you were 18? _____

Siblings: Brothers _____ Sisters: _____ Eldest? Yes / No Youngest Yes / No

How would you describe your growing up years? _____

High School Graduate? Yes / No Year _____

What school hard or easy for you? _____ Did you have an IEP? Yes / No

Post Secondary Schooling 2 years 4 or more years

Degree earned: _____ College: _____

Married / Single / Divorced / Widowed

Children: _____

Heterosexual / Homosexual / Bisexual / Transgender / Questioning

Current residence: Home/Own Home/Rent Apartment Other: _____

Who lives in the home? _____

Employment: PT / FT / Disabled / Retired

Employer: _____

Are you financially secure? Yes / No

If No, amount of debt: _____

Support system: Spouse/ Significant Other / Parents / Supportive friends – How many _____

Hobbies/What do you do for fun/relaxation: _____

Religious: Yes / No Denomination: _____ Regular attendance: Yes / No

Spiritual: Yes / No If yes do you find this beneficial for you mental health: Yes / No

Military History: Active Duty / Reserves / Guard

Army / Navy / Air Force / Marines / Coast Guard Military Specialty: _____

Deployed: Yes / No When/Where: _____

In a combat zone: Yes / No How long? _____