LAVERDURE
PSYCHIATRY

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INTAKE QUESTIONNAIRE FOR NEW PATIENTS

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal laws.

Date: _____ **Name:** _____

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

Home Address: _____ **City/State/Zip Code:** _____

Cell/Home/or and/Alternate Phone: _____

Emergency Contact Name: _____ **Phone Number:** _____

Relationship: _____

Marital Status: single married separate divorced remarried engage widowed cohabiting

Have you been married previously? ☐ **Yes** ☐ **No** **If yes, describe below (when, how long).**

_____

Sexual Orientation: ☐ **Heterosexual** ☐ **Homosexual** ☐ **Bisexual** ☐ **Other**

If applicable, please complete the following:

Partner's Name: _____ **Partner's Age:** _____

Partner's Occupation: _____

IF YOU HAVE CHILDREN, PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

_____

_____

_____

How long has this been going on? _____

What made you come in at this time?

_____

_____

What do you hope to gain from this evaluation and/or counseling?

_____

_____

If you had difficulties in the past, what have you done to cope? Was it helpful?

_____

_____

SYMPTOMS:

Please √ any symptoms or experiences that you have had **in the last 30 days.**

	Difficulty Falling Asleep		**Difficulty Staying Asleep**
	Difficulty Getting Out of Bed		**Not Feeling Rested In The Morning**

Average hrs. of sleep per night: _____

	Persistent Loss of Interest in Previously Enjoyed Activities		
	Withdrawing From Other People		**Spending Increased Time Alone**
	Depressed Mood		**Feeling Numb**
	Rapid Mood Changed		**Irritability**
	Anxiety		**Panic Attacks**
	Frequent Feelings of Guilt		**Avoiding People, Places, Activities, etc.**
	Difficulty Leaving Your Home		
	Fear of Certain Objects or Situations (i.e., flying, heights, bugs)		**Describe: _____**
	Repetitive Behaviors or Mental Acts (i.e., counting, checking doors, washing hands)		
	Outbursts of Anger		**Worthlessness**
	Hopelessness		**Sadness**
	Helplessness		**Fear**
	Feeling or acting like a different person		**Changes in eating/appetite**
	Eating More		**Eating Less**
	Voluntary Vomiting		**Use of Laxatives**
	Excessive Exercise to Avoid Weight Gain		**Binge Eating**
	Are you trying to lose weight? Circle one: Yes or No		**Weight Gain: _____lbs.** **Weight Loss: _____lbs.**
	Difficulty Catching Your Breath		**Increase Muscle Tension**
	Unusual Sweating		**Easily Started, Feeling "Jumpy"**
	Increased or Decreased Energy (circle one)		**Dizziness**
	Tremor		**Intrusive Memories**
	Frequent Worry		**Memory Changes**

	Racing Thoughts		**Nightmares**
	Difficulty Concentrating or Thinking		**Flashbacks**
	Thoughts About Harming or Killing Yourself or Others		
	Feeling as if you were outside yourself, detached, observing what you are doing.		
	Feeling puzzled as to what is real and unreal.		
	Persistent, repetitive, intrusive thoughts, impulses, or images.		
	Unusual visual experiences such as flashes of light, shadows.		
	Hear voices when no one else is present.		
	Feeling that your thoughts are controlled or placed in your mind.		
	Feeling that the television or the radio is communicating with you.		
	Difficulty Problem Solving		**Difficulty Meeting Role Expectations**
	Dependency on Others		**Manipulation of Others to Fulfill Your Own Devices**
	Inappropriate Expression of Anger		**Self-Mutilation/Cutting**
	Difficulty or Inability to Say "No" Others		**Ineffective Communication**
	Sense of Lack of Control		**Decreased Ability to Handle Stress**
	Abusive Relationship		**Difficulty Expression Emotions**
	Concerns About Your Sexuality		

Please describe any other symptoms or experiences you have had problems with:

_____

_____

PSYCHIATRIC AND MENTAL HEALTH HISTORY:

Have you seen a counselor, psychologist, psychiatrist, or other mental health professional before?

☐ **Yes** ☐ **No** **If so, who, where, and when:** _____

_____

_____

_____

PSYCHIATRIC MEDICATIONS

Are you currently taking psychiatric medication? ☐ **Yes** ☐ **No**

Read through the lists below and √ "PAST" if you have taken a medication in the past or √ "PRESENT" if you are currently taking a medication.

ANTIDEPRESSANTS	PAST	PRESENT	MOOD STABILIZERS	PAST	PRESENT
imipramine			**lithium carbonate/Eskalith**		
desipramine/Norpramin			**carbamazepine/Tegretol, Equetro**		
amitriptyline/Elavil			**divalproex/Depakene/Depakote**		
Nortriptyline/Pamelor			**lamotrigine/Lamictal**		
clomipramine/Anafranil			**oxcarbazepine/Trileptal**		
trazodone/Desyrel			**levetiracetam/Keppra**		
nefazodone			**ANTI-ANXIETY**	**PAST**	**PRESENT**
fluoxetine/Prozac			**diazepam/Valium**		
bupropion/Wellbutrin/Zyban			**chlordiazepoxide/Librium**		

sertraline/Zoloft			**oxazepam/Serax**		
paroxetine/Paxil			**clonazepam/Klonopin**		
venlafaxine/Effexor			**lorazepam/Ativan**		
desvenlafaxine/Pristiq			**alprazolam/Xanax**		
fluvoxamine/Luvox			**buspirone/BuSpar**		
levomilnacipran/Fetzima			**gabapentin/Neurontin**		
citalopram/Celexa			**hydroxyzine/Atarax/Vistaril**		
escitalopram/Lexapro			**propranolol/Inderal**		
duloxetine/Cymbalta			**atenolol/Tenormin**		
vilazodone/Viibryd			**guanfacine/Tenex/Intuniv**		
vortioxetine/Trintellix			**clonidine/Catapress/Kapvay**		
milnacipran/Savella			**prazosin/Minipress**		
			pregabalin/Lyrica		

MAO INHIBITORS			**ADD/ADHD**	**PAST**	**PRESENT**
phenelzine/Nardil			**Amphetamines:** Adderall, Vyvanse, Mydayis, Dexedrine		
tranylcypromine/Parnate			**Methylphenidates:** Ritalin, Focalin, Concerta, Methylin, Daytrana, Quillivant		
selegiline/Emsam			**Other:** Strattera, Intuniv, Clonidine, Viloxazine		

ANTIPSYCHOTICS & BIOPOLAR	**PAST**	**PRESENT**	**OVER THE COUNTER**	**PAST**	**PRESENT**
chlorpromazine/Thorazine			**St. John's Wort**		
thioridazine/Mellaril			**SAMe**		
clozapine/Clozaril			**Omega-3 Fatty Acids**		
quetiapine/Seroquel			**L-methylfolate (Enlyte, Deplin)**		
perphenazine/Trilafon			**N-acetylcysteine (NAC)**		
loxapine/Loxitane			**Lithium Orotate**		
trifluoperazine/Stelazine			**5-HTP**		
fluphenazine/Prolixin			**L-Tyrosine**		
thiothixene/Navane			**Vitamin B12**		
haloperidol/Haldol			**L-Tryptophan**		
risperidone/Risperdal			**Other:**		
olanzapine/Zyprexa			**HYPNOTICS/SLEEP AIDS**	**PAST**	**PRESENT**
ziprasidone/Geodon			**temazepam/Restoril**		
iloperidone/Fanapt			**triazolam/Halcion**		
asenapine/Saphris			**zolpidem/Ambien**		
lurasidone/Latuda			**zolpidem/Intermezzo**		
aripiprazole/Abilify			**zaleplon/Sonata**		
brexpiprazole/Rexulti			**eszopiclone/Lunesta**		
cariprazine/Vraylar			**ramelteon/Rozerem**		
lumateperone/Caplyta			**diphenhydramine/Benadryl**		
Long Acting Injectables:			**doxepin/Silenor**		
			suvorexant/Belsomra		

List any other "over the counter" medications or other prescriptions that are not listed above.

_____

_____

_____

Have you been hospitalized for psychiatric medications? ☐ **Yes** ☐ **No** **If yes, describe below.**

_____

_____

_____

Have you ever attempted suicide? ☐ **Yes** ☐ **No** **If yes, describe below.**

_____

_____

SUICIDAL QUESTIONS

Directions: Answer the following question.

1. **In your lifetime, have you ever attempted to kill yourself?**
   ☐ **Yes** ☐ **No**
2. **If yes, when did this happen?**

☐ **Within Past 24 hrs. (including today)** ☐ **Within Last Month (excludes today)**

☐ **More Than 6 Months Ago** ☐ **Patient Refused to Answer**

3. **Do you have a history of self-harm?** ☐ **Yes** ☐ **No**
4. **When did it start, and last time it occurred?** _____

MEDICAL HISTORY:

Primary Care Provider (name, & where your provider is located): _____
Last Seen: _____
Allergies (list below with reactions, if none please write NONE):

_____

_____

Are you currently under treatment for any medical conditions? ☐ **Yes** ☐ **No** **If yes, list below.**

_____

_____

List any prior illnesses, operations, and accidents (including any head injuries, concussions. Any assaults to the head by possible mean of physical altercation, domestic violence, or near drownings).

_____

_____

_____

History of CAT scans or MRIs of the head or brain? When and where and what for?

_____

_____

_____

PAST PSYCHOSOCIAL FAMILY HISTORY:

Father

Age: _____

Living? ☐ **Yes** ☐ **No**

Deceased? ☐ **Yes** ☐ **No** **If yes, HIS age at time of his death. _____**

If yes, YOUR age at the time of his death. _____

Your health at the time of his death? _____

Frequency of contact with him? _____

Are you and/or been close to him? ☐ **Yes** ☐ **No**

Medical History:

_____

_____

Mental Health History (include alcohol/drug use):

_____

_____

Mother

Age: _____

Living? ☐ **Yes** ☐ **No**

Deceased? ☐ **Yes** ☐ **No** **If yes, HER age at the time of her death. _____**

If yes, YOUR age at the time of her death. _____

Your health at the time of her death? _____

Frequency of contact with her? _____

Are you and/or have been close to her? ☐ **Yes** ☐ **No**

Medical History:

_____

_____

Mental Health History (include alcohol/drug use):

_____

_____

Children

Frequency of contact with them? _____

Are you and/or have been close to them? ☐ **Yes** ☐ **No**

Medical History:

_____

_____

Mental Health History (include alcohol/drug use):

_____

_____

List ALL of your brother and sisters. (include name, sex, age, whereabouts, & are you close with them)?

_____

_____

_____

_____

During your childhood, did you live any significant period of time with anyone other than your natural parents? If yes, please give the person's name and relationship to you with their names, and relation with you.

☐ **Yes** ☐ **No** **If yes, describe below.**

_____

_____

_____

BIRTH & DEVELOPMENTAL HISTORY:

Place of Birth: _____

How did you come into the world?

☐ **Full Term** ☐ **Vaginal** ☐ **Premature** ☐ **C-Section**

Any interterminal exposure to:

☐ **Drugs** ☐ **Alcohol** ☐ **Nicotine** ☐ **Traumatic Birth**

☐ **Other: _____**

Adopted? ☐ **Yes** ☐ **No**

Age of Adoption: _____

Foster Care? _____

 # Of Moves in Lifetime: _____

Did your parents ever divorce or remarry? _____

Met milestone on time? ☐ **Yes** ☐ **No**

Childhood Illnesses? _____

Speech Therapy? ☐ **Yes** ☐ **No**

Occupational Therapy? ☐ **Yes** ☐ **No**

Individual Educational Plan (IEP)? ☐ **Yes** ☐ **No**

Age of First Sexual Encounter: _____ Was it consensual? ☐ **Yes** ☐ **No**

Education

Highest grade ever completed? _____

Degree obtained, if applicable: _____

Did you have any disciplinary problems in school? ☐ **Yes** ☐ **No** **If yes, describe below:**

_____

_____

What kind of grades did you get in school? _____

MILITARY HISTORY:

Have you served in the military? ☐ **Yes** ☐ **No** **If yes, describe below:**

_____

What type of discharge did you get? _____

VOCATIONAL HISTORY:

When did you begin working? ☐ **Teenage Years** ☐ **20's**

If so, did you work? **Regularly** **Work on and off**

Disabled? ☐ **Yes** ☐ **No** **When? _____** **How much per month? _____**

What qualified you for disability? _____

Patient Living (Sponsor): **Medicaid** **Medicare** **Food Bank** **Food Stamp** **TANF** **LEAP** **IHS** **VA**

Employment

Are you currently employed? ☐ **Yes** ☐ **No**

If yes, employer's name: _____

What type of work do you do? _____

Describe ALL your employment history (most recent first) include type of job, dates, & reason for leaving.

_____

_____

LEGAL HISTORY:

Have you been arrested? ☐ **Yes** ☐ **No** **If yes, describe below.**

_____

Current legal problems? _____

SPIRITUALITY:

Do you have a religious affiliation? ☐ **Yes** ☐ **No**

Spiritual/Cultural Beliefs: _____

Are there any special beliefs are customs you would like to keep related to your care? _____
_____

ABUSE HISTORY:

Have you been abused? ☐ **Verbal** ☐ **Emotional** ☐ **Physically** ☐ **Sexual** ☐ **Neglected**

Describe your abuse: _____
_____
_____
_____

CHEMICAL DEPENDANCY HSITORY:

Do you drink alcohol? ☐ **Yes** ☐ **No** **What Kind?** _____

If yes, age of 1st use. _____

How much do you drink? _____

How often do you drink? _____

Have you ever passed out from drinking? How often? _____

Have your ever blacked out from drinking? How often? _____

Have you ever had the "shakes"? How often? _____

Have you ever felt you should cut down on your drinking/drug use? ☐ **Yes** ☐ **No**

Have people annoyed you by criticizing you drinking/drug use? ☐ **Yes** ☐ **No**

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? ☐ **Yes** ☐ **No**

Do you use tobacco? **Yes** **No**

Age Started: _____ **Age When You Quit:** _____

How often? _____ **What form?** _____

History of treatment (either inpatient or outpatient)? _____

Where? _____ When? _____

By Whom? _____

Other Substances

Directions: Please answer below these questions with the drug; ever used, age at 1st use, approx. use in last 30 days.

Marijuana: _____
Cocaine: _____
Crack: _____
Heroin: _____
Methamphetamine: _____
Ecstasy: _____

QUESTIONS?
Is there anything else you would like to us to know about you?

_____
_____
_____
_____
_____
_____