

Intake Form

Please fill out all applicable parts of this form and fax it to me 443-957-9477. You may also email it me at psychiatrybaltimore@gmail.com; but please note that email is not a secure means of communication. Please attach additional sheets if necessary.

Name: _____ Birth date _____

Reason for coming in for evaluation: _____

Family Psychiatric History

Family Member:	Current age or age at death (specify year and cause of death, if known):	Please list any problems with mental health or substance abuse:
Father		
Mother		
Sibling (provide name)		
Sibling (provide name)		
Sibling (provide name)		
Sibling (provide name)		

Has there been any mental illness, substance abuse, or suicide in your extended family? If so, please provide details here: _____

Personal History

Where were you born and raised? _____

What is your family's ethnic background? _____

Were there any problems with your birth, development, or childhood health (please specify)? _____

Were there any problems at home when you were growing up (please specify)? _____

Did you experience any significant disruptions while growing up (e.g., prolonged separation from one or both parents, significant geographical move)? _____

Have you ever been bullied or sexually, physically, or emotionally abused? If so, please specify and give dates: _____

How far have you gone in school so far? Please list all degrees, including date received, major, and institution from which you graduated. _____

Did you ever repeat a grade or require special education? _____

Were you ever suspended or expelled from school, or did you get into any other significant trouble at school? _____

Did you get into any trouble outside of school (fights, fire setting, cruelty to animals, theft, etc.)? _____

What jobs have you had in the past, and when? _____

Have you had any trouble finding or keeping long-term jobs? _____

Are you working or in school now? If so, please specify: _____

If you're currently working, how satisfied are you with your job? _____

What are your current sources of financial support? _____

Do you live alone? If not, with whom do you live? _____

Have you ever been married? If so, give dates of marriage and (if relevant) separation/divorce: _____

If you've had any relationship problems, including sexual problems, please specify: _____

Please list your closest supports (friends, family, caretakers), if any: _____

Have you ever been pregnant? If you terminated one or more pregnancies, please specify dates. If you have children, please list their names and ages and specify if they have any physical or mental health problems: _____

Have you ever had problems with the law (please specify)? _____

Do you have any financial problems, such as debt? _____

Do you have a religion, and if so, how important is it to you? _____

Please list any hobbies or activities that give you pleasure: _____

Medical History

Please list current and past medical problems (with dates), including history of seizures, head trauma, or loss of consciousness: _____

Please list names and doses of all current medications, including over-the-counter or herbal: _____

For women only, please give date of last menstrual period and specify whether your periods are regular, whether they are associated with any pain, and whether they are associated with any changes in your mood . If you are on a birth control pill, please specify which one and indicate whether it has any effect on your mood: _____

Please list any drug allergies (including your reaction to the drug): _____

Please check any of the following problems or tests you have had in the last year. If given a choice (weight loss or gain, e.g.), please circle applicable symptom(s). Where appropriate, please indicate what body part was tested (X-ray: chest, e.g.).

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Weight loss or gain
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Enlarged lymph nodes	<input type="checkbox"/> Heat or cold intolerance
<input type="checkbox"/> Excessive urination	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Excessive appetite
<input type="checkbox"/> Hair loss	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Light hurts your eyes
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Ear pain or discharge	<input type="checkbox"/> Severe nosebleeds
<input type="checkbox"/> Mouth ulcers	<input type="checkbox"/> Persistent hoarseness	<input type="checkbox"/> Daily cough
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Asthma/wheezing	<input type="checkbox"/> Chest pain/discomfort
<input type="checkbox"/> Skipped/irregular heartbeat	<input type="checkbox"/> Fainting episode/black-out	<input type="checkbox"/> Swollen legs or feet
<input type="checkbox"/> Leg pain with walking	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Frequent belly pain	<input type="checkbox"/> Abdominal bloating	<input type="checkbox"/> Nausea and/or vomiting
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Change in bowel habits
<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Black or tarry stools	<input type="checkbox"/> Light or clay-colored stools
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Jaundice (yellow skin or eyes)	<input type="checkbox"/> Trouble urinating
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Dark or cola-colored urine	<input type="checkbox"/> Abnormal vaginal bleeding
<input type="checkbox"/> Missed menstrual periods	<input type="checkbox"/> Vaginal/penile discharge	<input type="checkbox"/> Anemia
<input type="checkbox"/> Easy bruising or bleeding	<input type="checkbox"/> Persistent rash or itching	<input type="checkbox"/> Moles with changed appearance
<input type="checkbox"/> Lump or swelling of testicle	<input type="checkbox"/> Breast lump or new discharge	<input type="checkbox"/> Joint or muscle pain
<input type="checkbox"/> Limb weakness	<input type="checkbox"/> Persistent loss of sensation/numbness	<input type="checkbox"/> Headaches
<input type="checkbox"/> Dizzy spells	<input type="checkbox"/> Memory problems	<input type="checkbox"/> Coordination problems
<input type="checkbox"/> Seizures	<input type="checkbox"/> X-Ray of:	<input type="checkbox"/> CT scan of:
<input type="checkbox"/> MRI of:	<input type="checkbox"/> EKG	<input type="checkbox"/> EEG
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	

Please list past surgeries (including dates): _____

Please list names and numbers for all your doctors, including specialists: _____

Current height _____ Current weight _____ Date of last physical exam _____

Have you had any recent labs, and were the results normal? _____

Substance History

Substance:	Current use (specify amount/frequency):	Maximum use (specify dates):	Last use:	Age of onset:	Have you ever tried to quit?
Alcohol					
Nicotine					
Caffeine					
Marijuana					
Other street drug (please specify)					
Other street drug (please specify)					

Past Psychiatric History

Dates of past outpatient mental health treatment	Names and contact information of past providers	Why you sought treatment and nature of the treatment	Was it helpful?

Approximate Dates of Past Psychiatric Hospitalizations	Name of hospital	Reason for admission

Approximate Dates of Past Emergency Room Visits for Mental Health	Name of Hospital	Reason for visit

Approximate Dates of Past Treatment with Psychiatric Medication	Name of medication	How well did the medicine work for you (please include benefits and side effects)?

Have you ever intentionally hurt yourself before? If so, please give approximate dates and describe what you did: _____

Have you ever attempted suicide before? If so, please give approximate dates and describe what you did: _____

Have you ever been violent toward another person or intentionally hurt a person or pet before? If so, please give approximate dates, and describe what you did: _____

Do you have access to a gun or other means to kill or injure yourself or another person? If so, what do you have, and where is it? _____

Are you currently having any thoughts of hurting or killing yourself or someone else? If so, please specify: _____

Please respond yes or no to the following questions:

Have you ever experienced 2 weeks or more of sad mood or emotional numbness and changes in your energy level, self-attitude, sleep, appetite, concentration, or ability to experience pleasure?

Have you ever had thoughts of suicide or of not wanting to go on with life?

Have you ever experienced a few days or more during which you've had remarkably more energy than usual and have felt that you could get by on less sleep?

Are you concerned that you worry too much?

Did you experience anxiety when you had to be apart from your parents as a child (e.g., for summer camps, sleepovers, etc.)?

Have you ever experienced habits such as eye-blinking, nose-twitching, sniffing, throat-clearing, grunting, tapping or touching, or other "tics"?

Do you experience intrusive thoughts or images that you recognize as being absurd or extreme, but that keep coming into your head like a broken record?

Do you repeatedly engage in any mental or physical action that you recognize as being absurd or extreme, but that you feel you need to do in order to prevent harm or distress?

Do you have any extreme fears that cause you to avoid the things or situations that you fear?

Have you ever had the sudden onset of the following symptoms: shortness of breath, racing heart, nausea, dizziness, sweating, feeling that things are unreal, fear of dying or going crazy?

Have you ever experienced a traumatic situation such as sexual or physical abuse, a natural disaster, an accident, or other terrifying experience?

If you've experienced a traumatic situation in the past, does it affect your life today?

Have you ever heard sounds or seen things that were hard to explain?

Have you ever worried that people are out to get you, or that you're guilty of something terrible?

Do you have concerns about your weight or body image?

Have you ever restricted calories, binged, induced yourself to vomit, or used diuretics or laxatives?

Sleep Quality

Do you have difficulty falling or staying asleep? _____

Do you have any other problems with sleep? _____

Do you snore? _____

Are you excessively sleepy during the day? _____

Personality

How would you describe your personality? _____

How would others describe you? _____

Goals for treatment

What do you hope will be different for you at the end of our work together? _____

What goals do you have for the future? _____

Is there anything I haven't asked you about that would be important for me to know in order to best help you?

THANK YOU FOR COMPLETING THIS FORM!