**Psychiatry Intake Form (Age 18 and Over)**
To Be Completed by Patient

Full Legal Name________________________________ Date of Birth______________
Preferred Name________________________________ Gender________________

Who do you live with at this time?

___________________________________________________________________________

Who did you live with as a child (if this is not who you are living with now)?

___________________________________________________________________________

Were you adopted or in foster care? **Yes** **No**
Are there any firearms or other weapons in the home where you live? **Yes** **No**
Are you currently working? **Yes** **No**

What are the problems or concerns for which you are seeking help?
1.________________________________________________________________________
2.________________________________________________________________________
3.________________________________________________________________________

What mental health conditions have you previously been diagnosed with?

___________________________________________________________________________

Have you ever stayed overnight in the hospital for mental health reasons? **Yes** **No**
Have you ever been to the emergency room for mental health reasons? **Yes** **No**
Have you ever attempted to commit suicide? **Yes** **No**
Have you ever intentionally harmed yourself? **Yes** **No**

Do you have concerns regarding sexual orientation or gender identity that you would like to discuss with your psychiatrist? **Yes** **No**

Have you ever been in therapy or counseling for mental health concerns? **Yes** **No**
Current Therapist/Counselor (if applicable)______________________________________
Current Therapist/Counselor Phone or Email ______________________________________

Have you ever had testing completed by a psychologist or through your school, including IQ testing, achievement testing, or testing for autism spectrum disorder? **Yes** **No**
If so, where was the testing done? _____________________________________________

Has anyone related to you ever been treated for mental health conditions or substance abuse? Examples include depression, anxiety, OCD, ADHD/ADD, autism, learning disabilities, bipolar disorder, schizophrenia, suicide attempts, alcoholism, or drug use. **Yes** **No**
If yes, please explain:

___________________________________________________________________________

___________________________________________________________________________

List all **current** prescriptions, other medications, and supplements you are taking:

| Medication Name | Dose | Estimated Start Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

List any **past** medications that you have tried for behavioral or mental health concerns:

| Medication Name | Dose | Estimated Dates Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

If you are still in school, what school do you currently attend? ____________________

Current Grade/Year: ______________ Have you ever repeated a grade? **Yes** **No**

Have you had an IEP, 504 plan, or any other extra help at school? **Yes** **No**

If you are still in school, please include the name and contact information for anyone who you may want us to speak with:

______________________________________________

In the past, have you ever:

| | | |
|---|---|---|
| Been neglected | **Yes** | **No** |
| Been physically abused | **Yes** | **No** |
| Been emotionally or verbally abused | **Yes** | **No** |
| Been sexually abused or assaulted | **Yes** | **No** |
| Been bullied | **Yes** | **No** |
| Witnessed domestic violence | **Yes** | **No** |
| Experienced another traumatic event | **Yes** | **No** |

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Date of Document ____________
Label Psych Intake
(Result/Notes) ____________
____________ Initials TM.

Have you ever used or tried any of the following substances?

| | | |
|---|---|---|
| Nicotine (cigarettes, vaping) | **Yes** | **No** |
| Alcohol | **Yes** | **No** |
| Marijuana | **Yes** | **No** |
| Other illegal drugs | **Yes** | **No** |

*I grant permission for Pediatric Associates of Mt. Carmel to obtain information from and maintain contact with any of the persons listed above about my mental health history, if it is felt to be necessary for my care.* **Yes** **No**

Patient Signature: ______________________________

Printed Name: ______________________ Date: ______________

# Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

| Patient Name | | Today's Date | |
|---|---|---|---|

| Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment. | Never | Rarely | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| 1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done? | | | | | |
| 2. How often do you have difficulty getting things in order when you have to do a task that requires organization? | | | | | |
| 3. How often do you have problems remembering appointments or obligations? | | | | | |
| 4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started? | | | | | |
| 5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time? | | | | | |
| 6. How often do you feel overly active and compelled to do things, like you were driven by a motor? | | | | | |
| | | | | | Part A |
| 7. How often do you make careless mistakes when you have to work on a boring or difficult project? | | | | | |
| 8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work? | | | | | |
| 9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly? | | | | | |
| 10. How often do you misplace or have difficulty finding things at home or at work? | | | | | |
| 11. How often are you distracted by activity or noise around you? | | | | | |
| 12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated? | | | | | |
| 13. How often do you feel restless or fidgety? | | | | | |
| 14. How often do you have difficulty unwinding and relaxing when you have time to yourself? | | | | | |
| 15. How often do you find yourself talking too much when you are in social situations? | | | | | |
| 16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves? | | | | | |
| 17. How often do you have difficulty waiting your turn in situations when turn taking is required? | | | | | |
| 18. How often do you interrupt others when they are busy? | | | | | |
| | | | | | Part B |

**Generalized Anxiety Disorder Screener (GAD-7)**

| Over the *last 2 weeks*, how often have you been bothered by the following problems? | Not at all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritated | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| | Add columns | | | |
| | Total Score | | | |
| 8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |

When did the symptoms begin? ______________________________

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Name ____________________ Birthdate________ Doctor ________________ Today's Date ________

## A Survey from Your Healthcare Provider

Part of routine screening for your health includes considering mood and emotional concerns. Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

| | (0) Not At All | (1) Several Days | (2) More Than Half the Days | (3) Nearly Every Day |
|---|---|---|---|---|
| Feeling down, depressed, irritable or hopeless? | | | | |
| Little interest or pleasure in doing things? | | | | |
| Trouble falling or staying asleep or sleeping too much? | | | | |
| Poor appetite, weight loss, or overeating? | | | | |
| Feeling tired or having little energy? | | | | |
| Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down? | | | | |
| Trouble concentrating on things, like school work, reading or watching TV? | | | | |
| Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual? | | | | |
| Thoughts that you would be better off dead, or of hurting yourself in some way? | | | | |

In the ***past year*** have you felt depressed or sad most days, even if you felt OK sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you ***ever***, in your ***whole life***, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No



For Office Use Only: Score ______

| | | | |
|---|---|---|---|
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____________ Initials ______