



**Saint Alphonsus**

**Behavioral Health Services**

1055 N. Curtis Rd. • Boise, ID 83706 • (208) 367-2121

**Name:**

**Nickname:**

**Date:**

**DOB:**

**OUTPATIENT ADULT INTAKE FORM**

*Name of person completing this section (if different than patient) and relationship to patient:*

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All information you provide will be kept confidential.**

What problems are you having which prompted you to come to this clinic?

What are your goals/expectations for treatment?

**PAST PSYCHIATRIC TREATMENT:**

Have you ever been hospitalized for psychiatric reasons?  No  Yes

If yes, when and where?

Have you ever had outpatient treatment by a psychiatrist?  No  Yes

If yes, when and by whom?

Have you ever received counseling or psychotherapy in the past?  No  Yes

If yes, when and by whom?

Which psychiatric medications have you taken in the past and what were the benefits and/or side effects you had from them?  None

Are you taking any psychiatric medications now?  No  Yes

*If yes, please check all current medications*

- Depakote
- Lamictal
- Lithium
- Neurontin
- Trileptal
- Topamax
- Tegretol

- Ambien
- Lunesta
- Rozerem
- Sonata
- Somnote (chloral hydrate)
- Trazodone

- Abilify
- Geodon
- Risperdal
- Seroquel
- Zyprexa
- Zyprexa Zydis

- Ativan
- Klonopin
- Xanax
- Valium
  
- Campral
- Antabuse

- Celexa
- Effexor
- Lexapro
- Paxil
- Prozac
- Wellbutrin XL
- Zoloft
- Cymbalta
- Remeron
- Luvox

- Adderall
- Adderall XR
- Concerta
- Focalin
- Focalin XR
- Metadate
- Metadate CD
- Ritalin
- Strattera
- Provigil
- Dexedrine

Other:

Prescribing Physician:

**Please review the following and check any current symptoms that pertain to you.**

- Depressed Mood
- Stopped enjoying usual activities
- Lost or Gained weight without meaning to
- Sleep too much or not enough
- Agitated or sluggish
- No energy/always tired
- Feel guilty/worthless
- Can't think or concentrate
- Thoughts of death or suicide

- Inflated self-esteem
- Don't seem to need sleep
- Excessive talking
- Racing thoughts
- Highly distractible
- Try to do way too much
- Impulsive behavior
- See or hear things that may not be real
- Suspect or believe things that may not be real.

Patient Name: \_\_\_\_\_

<input type="checkbox"/> Often tense/unable to relax <input type="checkbox"/> Excessive worry <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Afraid/unable to leave home <input type="checkbox"/> Extreme unreasonable fears <input type="checkbox"/> Intense fear of social situations <input type="checkbox"/> Can't prevent repetitive thoughts <input type="checkbox"/> Can't prevent repetitive behaviors <input type="checkbox"/> Intrusive, upsetting memories of past event <input type="checkbox"/> Always on guard/never feel safe <input type="checkbox"/> Body overreacts to "stress"	<i>Life Problems that Currently affect you:</i> <input type="checkbox"/> Problems/losses within my family <input type="checkbox"/> Problems/losses among my friends/community <input type="checkbox"/> Educational problems <input type="checkbox"/> Occupational problems <input type="checkbox"/> Housing problems <input type="checkbox"/> Financial/economic problems <input type="checkbox"/> Can't get adequate health care <input type="checkbox"/> Problems with the law, legal system
<input type="checkbox"/> Destructive/violent thoughts or behaviors <input type="checkbox"/> Attempts to hurt, harm, or mutilate self <input type="checkbox"/> Anger outbursts	<input type="checkbox"/> Discipline problems at work <input type="checkbox"/> Careless, high-risk behavior
<b><u>GENERAL MEDICAL HISTORY</u></b>	
Do you have a Primary Care Physician? <input type="checkbox"/> No <input type="checkbox"/> Yes Name:	
Date of Last Physical Exam: _____ Date of Last Laboratory Work: _____	
Do you suffer from any of the following general medical problems?	
<input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Attack <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Pace Maker Implant	<input type="checkbox"/> Cancer <input type="checkbox"/> Lung Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Neurological Disorders <input type="checkbox"/> Seizures <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fainting <input type="checkbox"/> Vertigo/Dizziness <input type="checkbox"/> Motor Difficulties <input type="checkbox"/> Serious Head Injury <input type="checkbox"/> Recurring Headaches	<input type="checkbox"/> Arthritis <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Muscle Stiffness <input type="checkbox"/> Weakness <input type="checkbox"/> Tremors <input type="checkbox"/> Numbness <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Uncontrolled Movements
<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Hormone Problems <input type="checkbox"/> Fever or Sweats <input type="checkbox"/> Blood Disease <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Nose Bleed	<input type="checkbox"/> Liver Disease <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Unusual Diet <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Skin Rash <input type="checkbox"/> Skin Ulcer/Lesion

Patient Name: \_\_\_\_\_

<input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> HIV <input type="checkbox"/> Sexual Difficulties <input type="checkbox"/> Gynecological Problems <input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Visual Spots <input type="checkbox"/> Double Vision <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Speaking Problems
<input type="checkbox"/> Memory Problems <input type="checkbox"/> Early Fatigue <input type="checkbox"/> Daytime Sleepiness <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Concentration Problems	<input type="checkbox"/> Sinus or Nasal Problems <input type="checkbox"/> Recurrent Infection of any kind <input type="checkbox"/> Depressed Immune System <input type="checkbox"/> Recent Trauma <input type="checkbox"/> Other
Do you take any prescription medications for your general medical problems? <input type="checkbox"/> No <input type="checkbox"/> Yes (List)	
Do you take over the counter medications or herbal supplements? <input type="checkbox"/> No <input type="checkbox"/> Yes (List)	
Are you allergic to any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes List medications and allergic reactions	
Have you undergone any surgical procedures? <input type="checkbox"/> No <input type="checkbox"/> Yes Please list the surgical procedure with the date(s) of surgery:	
Do you have problems with chronic physical pain? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Rate average pain level: Circle one 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (worst)	
Have you ever suffered a severe head injury with loss of consciousness or concussion? <input type="checkbox"/> No <input type="checkbox"/> Yes (Describe)	
<b><u>ALCOHOL, DRUG AND TOBACCO USE</u></b> <input type="checkbox"/> Check if none	
<b><u>Alcohol</u></b> Current use / date of last use:	
Past use:	
Problems related to use? <input type="checkbox"/> No <input type="checkbox"/> Yes (Legal, Financial, Health, Relationship) List:	
Treatment required? <input type="checkbox"/> No <input type="checkbox"/> Yes (Describe)	

Patient Name: \_\_\_\_\_

**ILLICIT DRUG AND / OR PRESCRIPTION DRUG ABUSE**

Substance	Date of Last Use	Problems Related to use	Treatment Required
Benzodiazepines (Valium, Xanax, Ativan)		YES NO	YES NO
Caffeine		YES NO	YES NO
Marijuana		YES NO	YES NO
Cocaine		YES NO	YES NO
Designer Drugs (Club Drugs: G, X)		YES NO	YES NO
Hallucinogens (LSD, Mushrooms)		YES NO	YES NO
Inhalants (Gasoline, Glue, Aerosol)		YES NO	YES NO
Methamphetamines (Speed, Ice, Ritalin)		YES NO	YES NO
Opiates/Methadone (Vicodin, Oxycontin, Heroin)		YES NO	YES NO
OTHER		YES NO	YES NO

**Tobacco**  None Amount per day:

**SOCIAL HISTORY**

Where were you born?

Where did you grow up?

Did your parents stay together while you were growing up?  Yes  No

How old were you when they separated?

Father's occupation while you were growing up:

Mother's occupation while you were growing up:

How many siblings do you have?  None \_\_\_ Brothers \_\_\_ Sisters

Were there any complications at your birth (premature birth, major medical problems?)

No  Yes (Describe)

Any problems in your early development (learning to walk, talk, etc)?

No  Yes (Describe)

Did you suffer from any major illnesses / injuries while you were growing up?

No  Yes (Describe)

Patient Name: \_\_\_\_\_

Are you / were you a victim of any form of physical / sexual / emotional abuse?

Physical Abuse :  No  Yes Age of occurrence: \_\_\_\_\_

Sexual Abuse :  No  Yes Age of occurrence: \_\_\_\_\_

Emotional Abuse:  No  Yes Age of occurrence: \_\_\_\_\_

Did you graduate from High School?  No  Yes Last Grade Attended:

What type of jobs have you had in the past?

Are you currently employed?  No  Yes If yes, where?

Do you have any form of medical insurance?  None  Private  MCAID  MCARE

Are you receiving or applying for :  SSD  SSI  MCAID

Are you currently involved in a romantic relationship?  No  Yes

Spouse's / partner's first name

How long have you been together?

How would you describe your relationship?

What is your spouse's / partner's occupation?

Have you been involved in any previous significant intimate / romantic relationships?  No  Yes  
(Describe)

Do you have any children?  No  Yes  
Names & Ages:

What are some things you enjoy doing (hobbies, sports, past times)?

Have you ever been convicted of any crimes, incarcerated in prison, or placed on probation?  
 No  Yes (Describe)

**FAMILY HISTORY**

Is there any history of mental illness or substance abuse among your blood relatives?  
 No  Yes If yes, please describe below:

Fathers Side:

Mothers Side:

Patient Name: \_\_\_\_\_

**SOCIAL SUPPORTS**

Is there anyone you trust or confide in during times of trouble?  No  Yes  
(Name supports)

Do you have any religious ties or involvement in a church?  No  Yes (Describe)

**CURRENT LIVING SITUATION**

Do you live in a  House  Apartment  Manufactured Home  Other  
 Own or  Rent

Do you live in  Boise  Meridian  Eagle  Kuna  Nampa  Other

Do you live alone?  Yes  No If not, who else lives with you?

Do you have plans to move in the near future?  Yes  No If yes, where:

Do you have any pets?  No  Yes (List)

**Advanced Directives**

Do you have a Psychiatric Advanced Directive?

**Reviewed By:** \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_