EDMOND PSYCHIATRIC ASSOCIATES
2000 Sonoma Park Drive
Edmond, OK, 73013
Jennifer Morris, MD
Lyndsey Jones APRN, CNP Ashley Burns, APRN, CNP Sarah "Vaden" Danielson PA-C

Name: _____Date of Birth: _____ Date: _____

Psychiatric Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Primary Care Physician _____ Current Counselor _____ Phone#: _____

What are the problem(s) you are seeking help for?

1. _____
2. _____
3. _____

What are your treatment goals? _____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood	( ) Sleep pattern	( ) Hallucinations	( ) Excessive energy
( ) Racing thoughts	disturbance	( )	( ) Excessive guilt
( ) Excessive worry	( ) Increase risky	Concentration/forgetful	( ) Increased irritability
( ) Unable to enjoy	behavior	( ) Decrease need for	( ) Fatigue
activities	( ) Avoidance	sleep	( ) Crying spells
( ) Impulsivity	( ) Loss of interest	( ) Suspiciousness	( ) Decreased libido
( ) Anxiety attacks	( ) Increased libido	( ) Change in appetite	

Your Medical History:

Allergies _____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

Name: _____ Date: _____

Current over-the-counter medications or supplements: _____
Current medical problems _____
_____
Past medical problems, non-psychiatric hospitalization or surgeries _____
_____

For women only:

Date of last menstrual period _____ Birth control method _____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No Are you planning to get pregnant in the near future? ( ) Yes ( ) No How many times have you been pregnant? ____ How many live births? ____

Do you have any concerns regarding physical health that you would like to discuss with me? ( ) Yes ( ) No
Date and place of last physical exam:_ _____

Personal and Family Medical History:

	You	Family	Which Family Member
Thyroid Disease	( )	( )	_____
Anemia	( )	( )	_____
Liver Disease	( )	( )	_____
Chronic Fatigue	( )	( )	_____
Kidney Disease	( )	( )	_____
Diabetes	( )	( )	_____
Asthma/respiratory problems	( )	( )	_____
Stomach or intestinal problems	( )	( )	_____
Cancer (type)	( )	( )	_____
Fibromyalgia	( )	( )	_____
Heart Disease	( )	( )	_____
Epilepsy or seizures	( )	( )	_____
Chronic Pain	( )	( )	_____
High Cholesterol	( )	( )	_____
High blood pressure	( )	( )	_____
Head trauma/concussions	( )	( )	_____
Liver problems -	( )	( )	_____
Other	( )	( )	_____

Name: _____ Date: _____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain _____
_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?
_____

For patients under 18 years old: Born at how many weeks? _____ Developmental History? _____
_____

Past Psychiatric History
Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment. ___
Reason Dates treated
By whom
_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.
Reason Date Hospitalized
Where
_____
_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Dates Dosage Response/Side-Effects

Antidepressants

Prozac (fluoxetine)	Lexapro (escitalopram)	Remeron (mirtazapine)	Pristiq
Zoloft (sertraline)	Effexor (venlafaxine)	Serzone (nefazodone)	Vivactil
Luvox (fluvoxamine)	Cymbalta (duloxetine)	Pamelor (nortrptyline)	Viibryd
Paxil(paroxetine)	Anafranil (clomipramine)	Tofranil (imipramine)	Emsam
Celexa(citalopram)	Wellbutrin (bupropion)	Elavil (amitriptyline)	Other _____

_____

Mood Stabilizers

Tegretol/trileptal (carbamazepine)	Lithium	Lamictal (lamotrigine)
	Depakote (valproate)	Other _____

_____

Antipsychotics/Mood Stabilizers

Seroquel (quetiapine)	Abilify (aripiprazole)	Latuda
Zyprexa (olanzepine)	Clozaril (clozapine)	Saphris
Geodon (ziprasidone)	Risperdal	Other _____

_____

Sedative/Hypnotics

Ambien (zolpidem)	Rozerem(ramelteon)	Desyrel (trazodone)
Sonata (zaleplon)	Restoril (temazepam)	Other _____

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ADHD medications

Adderall (amphetamine) Ritalin (methylphenidate)
Concerta Strattera (atomoxetine)
(methylphenidate) Other _____

Antianxiety medications

Xanax (alprazolam) Klonopin Tranxene Other _____
Xanax XR (clonazepam) (clorazepate)
Ativan (lorazepam) Valium (diazepam) Buspar (buspirone)

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No How many days a week do you get exercise? _____

How much time each day do you exercise? _____ What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder ( ) Yes ( ) No Anxiety ( ) Yes ( ) No Suicide ( ) Yes ( ) No
Schizophrenia ( ) Yes ( ) No Alcohol abuse ( ) Yes ( ) No Violence ( ) Yes ( ) No
Depression ( ) Yes ( ) No Anger ( ) Yes ( ) No
PTS/PTSD ( ) Yes ( ) No Substance abuse ( ) Yes ( )No

If yes, who had what problems? _____
Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No
If yes, who was treated and what medications and how effective was the treatment? _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____
How many days per week do you drink any alcohol? _____ What is the least number of drinks you will drink in a day? _____ What is the most number of drinks you will drink in a day? _____

In the past 3 months, what is the largest amount of alcoholic drinks you have consumed in 1 day? _____ Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No Have you ever felt

bad/guilty about your drinking or drug use? ( ) Yes ( ) No Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No If yes, which ones? _____

_____

Have you abused prescription medication? ( ) Yes ( ) No If yes, which ones and for how long _____

_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers (not prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____

Other _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No How many packs/ day on average? _____ How many years?_____
In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No
What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up? _____
List your siblings and their ages _____

Name: _____ Date: _____

_____

What was your father's occupation? _____ What was your mother's occupation? _____
Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with? _____
Has anyone in your immediate family died? _____ Who and when? _____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No
Educational History:
Did you attend college? _____ Where? _____ Major? _____
What is your highest educational level or degree attained? _____
Occupational History:
Are you currently: ( ) Working ( ) Not working by choice ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____ What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Relationship History and Current Family:
Are you currently: ( ) Married ( ) Divorced ( ) Single ( ) Widowed How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
Are you sexually active? ( ) Yes ( ) No Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____
How long? _____ Do you have children? ( ) Yes ( ) No. If yes, list ages and gender _____

_____

Describe your relationship with your children: _____
List everyone who currently lives with you? _____

Legal:
Have you ever been arrested? _____ Do you have any pending legal problems? _____
Any history of DUI's or Public Intoxications? _____
Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Signature _____ Date _____

Emergency Contact Telephone # _____