University Psychiatric Practice Incorporated
4955 North Bailey Ave. Suite 130, Amherst New York 14226

Psychiatric Intake Form
(All information on this form is strictly confidential)

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

Today's date ________________________
Source of information ( ) Self ( ) other / relationship_________________________________
Name ____ Date of Birth __________________
Age: _____ Sex: _________________
Home Phone _______________________ May I leave messages on this phone? ( ) y ( ) n
Work Phone _______________________ May I leave messages on this phone? ( ) y ( ) n
Cell phone __________________________ E-mail _________________________________
Street address ____
City ______________________________________ Zip code ________________________
Emergency Contact: ____
Phone: ________________________ **Relationship to you:** ___________________________
Marital status: S___ M___ D___ W___ Non-married committed relationship? ______
Name all the people with whom you live and their relationship to you:
____
____
____
____

List the main problems for which you wish to be seen today:
1.____
2.____
3.____

What are your goals for the next few years?
1. ____
2. ____
3. ____

Do you have a history of mental health problems or hospitalizations? ( ) y ( ) n
If so, please complete the following:

Diagnosis Dates treated By whom
____
____
____
____

Are you currently receiving professional counseling or any kind of psychotherapy?
( ) y ( ) n If yes, by whom? ____

If you have ever taken 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).
Abilify(aripiprazole), **Adderall** (amphetamine), **Ambien** (zolpidem), **Anafranil** (clomipramine), **Ativan** (lorazepam), **Buspar** (buspirone), **Celexa** (citalopram), **Clozaril** (clozapine), **Concerta** (methylphenidate), **Cymbalta** (duloxetine), **Depakote** (valproate), **Desyrel** (trazodone), **Effexor** (venlafaxine), **Elavil** (amitriptyline), **Geodon** (ziprasidone), **Haldol** (haloperidol), **Invega** (paliperidone), **Klonopin** (clonazepam), **Lamictal** (lamotrigine), **Latuda**, **Lexapro** (escitalopram), **Lithium**, **Luvox** (fluvoxamine), **Lyrica** (pregablin), **Neurontin** (gabapentin), **Pamelor** (nortrptyline), **Paxil** (paroxetine), **Pristiq** (desvenlafaxine), **Prolixin** (fluphenazine), **Prozac** (fluoxetine), **Remeron** (mirtazapine), **Restoril** (temazepam), **Risperdal** (risperidone), **Ritalin** (methylphenidate), **Seroquel** (quetiapine), **Serzone** (nefazodone), **Strattera** (atomoxetine), **Tegretol** (carbamazepine), **Tofranil** (imipramine), **Trintellix**, **Valium** (diazepam), **Vybriid, Wellbutrin** (bupropion), **Xanax** (alprazolam), **Zoloft** (sertraline), **Zyprexa** (olanzapine)

____
____
____

Allergies ____
ALL Current prescription medications and how often you take them: (if none, write none)
____
____
ALL Current over-the-counter medications or supplements: ______________________
____
Current medical problems: ____________________________________
____
____
Past medical problems, hospitalizations or surgeries: ________________________
____
____
____
Name of your primary health care provider: ____________________________
Date and place of last physical exam: ________________________________
Have you ever had an EKG? ( ) y ( ) n Date ______________

For women only: Date of last menstrual period ________ Are you currently pregnant or do you think you might be pregnant? ( ) y ( ) n Are you planning to get pregnant in the near future? ( ) y ( ) n Birth control method __________________
How many times have you been pregnant? ________ How many live births? ________

University Psychiatric Practice Incorporated
4955 North Bailey Ave. Suite 130, Amherst New York 14226

Do you have a history of:

	Yes	No		Yes	No
Thyroid Disease			Epilepsy or seizures		
Anemia			Chronic pain		
Liver Disease			High Cholesterol		
Fibromyalgia			High Blood Pressure		
Chronic Fatigue			Head Trauma		
Heart Disease			Cancer		
Kidney Disease			Asthma/respiratory problems		
Diabetes			Stomach or intestinal problems		
Sexual Orientation concerns			Immunology Problems		

Do you like exciting or dangerous activities? ( ) y ( ) n
Have you had thoughts that you don't want to go on, wish you were dead, or want to kill yourself? ( ) y ( ) n
IF YES, please answer the following... If no, please skip to Family Psychiatric History.
Has anything happened recently to make you feel like this? ________________________________
____
On a scale of 0 to 10, how strong is your desire to kill yourself? _________
Have you ever thought about how you would kill yourself? ________________________________
Do you have access to firearms? ( ) y ( )n
Have you ever tried to kill or harm yourself before? ______________________________________
Is there anything that would stop you from killing yourself? ______________________________
____
If you could look into the future, what do you feel you could look forward to? _______________
____
Were you ever physically or sexually abused? ( ) y ( ) n If yes, what age? ___________
Have you ever been violent towards anybody? ( ) y ( ) n
Have you ever been arrested? ( ) y ( ) n
Do you have any pending legal problems? ( ) y ( ) n
Have you ever been treated for alcohol or drug use or abuse? ( ) y ( ) n
If yes, for which substances? ____
If yes, where were you treated and when? _______________________________________
____
How many alcoholic drinks do you consume each week? __________________________
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? ____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) y ( ) n
Have people been concerned about your drinking or drug use? ( ) y ( ) n
Do you think you may have a problem with alcohol or drug use? ( ) y ( ) n

Check if you have ever tried the following:

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

Other ____ __________

How many caffeinated beverages do you drink a day? ________________________

Cigarettes: Now? ( ) y ( ) n In the past? ( ) y ( ) n When did you quit? __________

How many per day on average? ________ For how many years? ___________________

Pipe, cigars, or chewing tobacco: Now? ( ) y ( ) y In the past? ( ) y ( ) n

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

	Yes No		Yes No
Bipolar disorder	__________	Schizophrenia	__________
Depression	__________	Post-traumatic stress	__________
Anxiety	__________	Alcohol abuse	__________
Anger	__________	Other substance abuse	__________
Suicidality	__________	Violence	__________
ADHD	__________	OCD	__________
Insomnia	__________	Psychosis	__________
Panic Attacks	__________	Other	__________

If yes, who had what problems?

____

____

____

____

Has any family member been treated with a psychiatric medication? ( ) y ( ) n If yes, what medications and how effective were they?________________________________

____

____

____

Your father's name, occupation and your relationship with him? ___________________

____

Your mother's name, occupation and your relationship with her? ___________________________
____

Were you adopted? ( ) y ( ) n
Did your parent's divorce? ( ) y ( ) n If so, how old were you when they divorced? ________
If your parents divorced, who raised you? ____
Please list the names and ages of your siblings and describe your relationship with them

____
____
____
____

What is your significant other's occupation? ____
Describe your relationship with your spouse or significant other:
____
____

Have you had any prior marriages? ( ) y ( ) n
Do you have children? ( ) y ( ) n
Names/Ages: ____
____
____

Describe your relationship with your children: ____
____
____

Has anyone in your immediate family died? ______________________________________
Who and when? ____

Have you ever served in the military? ( ) y ( ) n

What is your highest educational level or degree attained? ___________________________
Were you ever bullied? ( ) y ( ) n
Did you ever have any problems in school or with learning? ( ) y ( )

Are you currently: Working ( ) Y ( ) N
What is your occupation? ____
Where do you work? ____

PLEASE ADD ANY OTHER INFORMATION THAT YOU THINK IS IMPORTANT TO DISCLOSE ON A SEPARATE SHEET OF PAPER

I certify that the above information is true.

____
Signature and Date