Linda Corey, ARNP

New Client Intake Form

Name _____ Preferred name _____ Pronouns _____

Referred by _____ Age _____ Race _____

Emergency contact _____ Relationship _____Phone number _____

What are the issues for which you are seeking care?

1. _____
2. _____
3. _____

Please check of any of the symptoms you have been recently experiencing:

__ Depressed mood
__ More depressed in the winter
__ Loss of interest in activities
__ Excessive guilt
__ Feelings of worthlessness
__ Hopelessness
__ Recurrent thoughts of death
__ Thinking about suicide
__ Suicide attempt
__ Moving slower than usual
__ Moving faster than usual
__ Decreased concentration
__ Increased appetite
__ Decreased appetite or weight loss without dieting
__ Sleeping too much
__ Difficulty falling asleep
__ Difficulty staying asleep
__ Fatigue
__ Increased irritability
__ Feeling nervous or on edge
__ Muscle tension
__ Teeth grinding
__ Panic attacks
__ Excessive energy
__ Decreased need for sleep
__ Sexual indiscretion
__ Excessive spending
__ Increased risky behavior
__ Intrusive thoughts
__ Impulsivity
__ Rituals
__ Binging on food
__ Inducing vomiting
__ Restricting calories
__ Thoughts of hurting or killing others
__ Hallucinations
__ Delusions
__ Paranoia
__ Nightmares
__ Flashbacks
__ Cutting or self harm behavior
__ Chronic feelings of emptiness
__ Fear of abandonment
__ Unstable friendships
__ Difficulty controlling anger
__ Frequent mood changes in the course of a day
__ Fear of embarrassment
__ Social situations avoided or endured anxiety

Primary care provider: _____ Date of last physical: _____

Therapist: _____

Other provider: _____

For women: Are you sexually active? _____ Is there a chance that you might be pregnant? _____

Are you planning to become pregnant? _____ Form of contraception used? _____

ALLERGIES: _____

Current prescription and over-the-counter medications, contraceptives, vitamins/minerals, or supplements:

Name	Dose	Frequency	Estimated start date

Current medical problems: _____

_____

_____

Have you ever had any of the following conditions?

__ Anemia
__ Asthma
__ Cancer
__ Cardiac structural problems
__ Chronic pain
__ Diabetes
__ Eating Disorder
__ Gastrointestinal problems
__ Glaucoma
__ Gynecological problems
__ Hormone problems
__ Head injury
__ Heart murmur
__ High or low blood pressure
__ High cholesterol
__ HIV positive or AIDS
__ Kidney problems
__ Liver problems
__ Lung disease
__ Mouth, nose or throat problems
__ Neurological problems
__ Seizure
__ Sleep apnea
__ Snoring
__ Stroke
__ Suicide attempt
__ Thyroid disease
__ Urological problems

If you have a special diet of any kind, please describe: _____

Hospitalizations:

Location	Dates	Reason

Previous psychiatric symptoms and treatments including therapy:

Diagnosis	When symptoms began	Treatment

Previous psychiatric medications:

Medication:	Dose:	Dates:	Effective?	Side effects?
Prozac (fluoxetine)				
Zoloft (sertraline)				
Luvox (fluvoxamine)				
Paxil (paroxetine)				
Celexa (citalopram)				
Lexapro (escitalopram)				
Effexor (venlafaxine)				
Cymbalta (duloxetine)				
Pristiq (desvenlafaxine)				
Viibryd (vilazodone)				
Trintellix (vortioxetine)				
Wellbutrin (bupropion)				
Remeron (mirtazapine)				
Serzone (nefazodone)				
Anafranil (clomipramine)				
Pamelor (nortriptyline)				
Elavil (amitriptyline)				
Tofranil (imipramine)				
Norpramin (desipramine)				
EMSAM				

Medication:	Dose:	Dates:	Effective?	Side effects?
Liothyronine/T3 (Cytomel)				
Adderall (amphetamine)				
Concerta (methylphenidate				
Ritalin (methylphenidate)				
Strattera (atomoxetine)				
Vyvanse				
Lithium				
Lamictal (lamotrigine)				
Tegretol (carbamazepine)				
Trileptal (oxcarbazepine)				
Depakote (valproic acid)				
Neurontin (gabapentin)				
Lyrica (pregabalin)				
Seroquel (quetiapine)				
Zyprexa (olanzapine)				
Risperdal (risperidone)				
Geodon (ziprasidone)				
Abilify (aripiprazole)				
Rexulti (brexpiprazole)				
Latuda (lurasadone)				
Saphris (asenapine)				
Haldol (haloperidol)				
Trazodone				
Doxepin				
Ambien (zolpidem)				
Lunesta (eszopiclone)				
Other:				

Were you adopted? _____

Have any relatives been diagnosed with bipolar disorder? _____ ADHD? ____ Schizophrenia? _____

Has anyone in your family been treated with a psychiatric medication? _____

List any that were effective: _____

Please note any psychiatric conditions you believe your family members have:

Mother	
Father	
Sibling	
Sibling	
Sibling	

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

_____

As far as you know, did you meet your developmental milestones? (e.g. walking and talking when expected)

_____

Do you currently smoke cigarettes? _____ How many per day? _____

Do you use other tobacco products? (please specify) _____

How many days per week do you drink any alcohol? _____

How many drinks do you typically have? _____

In the past 3 months, what is the largest amount of drinks you have consumed in one day? _____

Have you ever felt you should cut down on your drinking? _____

Have people annoyed you by criticizing your drinking? _____

Have you ever felt bad or guilty about your drinking? _____

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)? _____

Do you use marijuana or other recreational drugs? _____

If so, which ones? _____

How frequently? _____

Have you ever been treated for alcohol or drug abuse? _____ Please explain: _____

_____

_____

Have you ever abused prescription medication? _____ If yes, which one(s)? _____

Social:

Where did you grow up? _____

Did your parents divorce? _____ If so, how old were you? _____

What are the sex and ages of your siblings? _____

_____

Who were you raised by? _____

Overall, how would you describe your childhood? _____

_____

Do you have a history of being abused emotionally, sexually, physically, or by neglect? _____ If so, please describe what, at what age, and by whom: _____

_____

_____

Have you had a trauma in your life that you believe is causing you to have symptoms now (accident, assault, natural disaster, etc.? _____

If yes, please describe including the age this occurred: _____

_____

_____

_____

Were you in a special education program? _____

What was your highest level of education? _____ Degrees earned: _____

What is the last college you attended? _____ Major? _____

What is your current occupation? _____

Where do you work or go to school? _____

Do you like your job? _____

How would you describe your sexual orientation? _____

Are you currently in a relationship? _____

Describe your relationship with your significant other(s): _____

_____

Do you have any children? _____ If so, list ages and gender: _____

_____

What is your living situation? _____

From whom do you receive emotional support? _____

Current legal problems: _____

Are you involved with a religious or spiritual group? _____

What do you do for fun? _____

Do you regularly exercise? _____ How often? _____ What type of exercise? _____

_____

Do you regularly meditate? _____ Do you do yoga? _____

Do you engage in any other wellness activities (please describe)? _____

What are your goals for treatment?

_____

_____

_____

_____

Is there anything else you would like me to know?

_____

_____

_____

_____