David A. Fohrman, M.D.
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Psychiatric Evaluation Intake Form – Adult

Please bring any supporting documents (such as pertinent medical records, results of prior treatment, psychological testing or school reports) to the first session. All responses are confidential. No information about you or your family will be released without your prior written consent. Thank you in advance for taking the time to provide this important information.

Name: ____________________________ Age: _____Sex: ___ Date: ______ Birthdate: __/___/____

Phone number: ____________________________ E mail: _____________________________________

Address:____

Person that may be contacted in the Event of a Psychiatric Emergency – Imminent threat of harm to self or others: Name: ___________________________ cell phone: __________________________________

Others living in same house (relationship/Age): ____

____

Reason(s) for referral:

____

Has this problem been treated before: Yes ___ No ___ If yes, what treatment modalities (i.e. individual, family therapy), including medications, have been tried: _____________________________

____

Name(s) current/past mental health professionals (please continue on back side of page if necessary):

Name	Dates of Treatment	Phone number
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Can I contact these professional(s) to coordination care? (full ROI form available upon request)

If yes, please sign your name: ____ Date: __________

Current functioning:

Recent work or home-related stressors: i.e. death in family, move to new location, new medical illness:

____

____

Vocation/Profession: ______________________________ Place of employment: ___________________

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Name(s) current/past mental health professionals (continued):

Name	Dates of Treatment	Phone number
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

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Please check any of the symptoms/problems below that apply.

Symptoms/ problems		How Long m/years	Symptoms/ problems		How Long m/years
Difficulties with depression			Difficulties with anxiety		
Difficulty with sleeping (falling asleep/staying asleep)			Think about a traumatic event excessively		
Loss of interest activities			Very concerned about safety		
Low self-esteem/feeling guilty			Violent dreams/nightmares		
Loss of energy/feeling fatigued			Easily Startled/ jumpy		
Change in weight/appetite			Hypervigilant/ ‘always watch your back’		
Easily distracted			Specific fears/phobias		
Difficulty with concentration			“Panic attacks”		
Restless/fidgety			Social awkwardness		
Thoughts of death/dying			Anxiety in crowds or in public places		
Periods of time with decreased need for sleep			Obsessions – think about one topic excessively		
Period of time where felt excessively irritated/angry			Compulsion - Do one or more activities excessively		
Period of talking faster than usual or felt like mind “raced”			Excessive concern about weight/appearance		
Periods of feeling ‘euphoric’/ really happy for no reason			Issues with eating – i.e. bulimia, anorexia		
Periods of abnormal increase in productivity at home/work			Need to be perfect “perfectionist”		
Excessive/impulsive spending			Difficulty being alone		
Trouble with sexual behavior(s)			Excessive conflicts with family		
Excessively suspicious/fearful			Difficulty finding/ keeping friendships		
Seeing or hearing things that others cannot see or hear			Excessive conflict with significant other		
Memory problems			Issues with gender identify or sexual orientation		
Unusual thoughts or ideas			Excessive time spend on internet/ i-phone		
Trouble thinking clearly			Overly aggressive/violent		

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Past Mental Health History:

Suicide attempt(s)? Yes __ No __ History of hurting self (i.e. cutting, burning etc) without intent to kill self? Yes/No ___

If you are currently thinking about killing yourself before you can make it to your first appointment please, call 911 and/or let a loved one know; please get the help that you deserve before it is too late.

History of hospitalization for psychiatric reasons: yes ___ No ___

If yes, please list name of hospital, dates and length of stay (if necessary continue on back side)

Name:	Date:	Length of Stay
______________________________	_____________	______________________________
______________________________	_____________	______________________________

Have you ever taken medications to treat a psychiatric/psychological condition? Yes ___ No __

If yes, please list names, dosages, and length of treatment – including current meds (continue on back of page as necessary)

Medication	Dosages	effect/ side effects	length of treatment
___________________	____________________	_______________________	____________
___________________	____________________	_______________________	____________
___________________	____________________	_______________________	____________

Please continue on next page as necessary

Substance Use History: Amount per week on average in the last two months

Alcohol:	______	Meth:	______	Hallucinogens	______
Marijuana	______	Heroin	______	Nicotine	______
Cocaine	______	Over the Counter	______	Caffeine	______
Other	_______				

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If hospitalized, continue:

Please list name of hospital, dates and length of stay

Name:	Date:	Length of Stay

Prior Medication treatments continued

Medication	Dosage	Effect/ side effects	Length of treatment

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Past Medical History:

Any current medical problems? Yes/no ___

If yes, please list medical problems, year diagnosed, medications taking for problem and primary physician treating medical condition (continue on back of page as necessary)

Medical Problem Year diagnosed	Current Medications	Physician/ contact number
____________	______________________________	___________________________________
____________	______________________________	___________________________________
____________	______________________________	___________________________________
____________	______________________________	___________________________________

History of head trauma, loss or consciousness, seizures, or serious medical illnesses?

If yes, please briefly describe event(s) and treatments given: ___________________________________

____

Please check if you have the following current (or recurrent) medical complaints

___ Headaches
___ Fever
___Numbness/weakness
___Dizziness when get up suddenly
___Slurred speech
___Memory loss
___Visual problems
___Hearing problems
___ Chest pain

___ Abdominal pain
___ Difficulty walking
___ Recurrent cough
___ Tremors/dizziness
___ Joint Pain
___Shortness of breath
___Difficulty urinating
___Difficulty defecating
___Excessive fatigue
___Food intolerance

___Diarrhea/constipation
___Allergies
___Frequent falls, injuries
___ Rashes
___ Bothersome itchy skin
___ Other skin problems: __________
___ Other aches/pains: _______
If yes, please specify location(s)
____
___ Other symptoms: _____________

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If female, menstrual history:

Age of menarche _________________ Date of last menstrual period: ________

Cyclic mood symptoms: Yes ___ No____ Irregular/painful or heavy menses: _________________

Family History:

Is there a family history (among biological relatives) of the following: depression, anxiety, substance use or unusual thoughts or behaviors? Yes/No ___

If yes, please indicate disorder(s) and outcome of medication trials: effective, stopped due to side effects,

____

____

Is there a family history/genetic history of uncommon or rare medical disorders? Yes ___ No ___

If yes, what: ____

Did any biological relatives die due to medical (or unknown) causes at a relatively young age? Yes ___ No __ If yes, what: ____

Social History:

Significant other/ Married: First name: ________________ Time together: ________________

Quality of relationship (good/ok/ bad) ____

Children/step children: (name/ages) : ____

____

____

Other Stressors:

___ Legal Issues:	___ Financial	___ Religious/Spiritual Issues
___ Housing	___ limited Social Support	___ other: _______________

Leisure activities/Hobbies: ____

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Developmental History: (please check if yes)

____ Difficulties during pregnancy
____ possibility of exposure to alcohol/drugs in utero
____ Difficulties during delivery
____ Feeding difficulties
____ Very sensitive to touch/sounds
____ Excessive difficulty with separation
____ Excessive temper tantrums
____ Difficulties/delays with walking
____ Difficulties/delay in talking
____ Difficulty calming down (self soothing) when upset
____ Any history of serious falls or loss of consciousness

Is there any additional information that you feel I should know?

____
____
____

Please bring this with you to your first appointment.