FOX BEND
COUNSELING

Anthony R. Kokalj LCPC, Cosme Lozano MD, Althea Olson LCSW, Erica Sokol LCPC

Psychiatric Intake Form

All Information on this form is strictly confidential

Name _____Date _____

Date of Birth _____ Primary Care Physician _____ Referred By _____

Current Therapist/Counselor_____ Therapist Phone_____

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

1. _____

2. _____

3. _____

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

☐ Depressed Mood	☐ Racing Thoughts	☐ Excessive Worry
☐ Unable to enjoy activities	☐ Impulsivity	☐ Anxiety Attacks
☐ Sleep Pattern Disturbance	☐ Increase Risky Behavior	☐ Avoidance
☐ Loss of Interest	☐ Increased Libido	☐ Hallucinations
☐ Concentration/Forgetfulness	☐ Decreased Need for Sleep	☐ Suspiciousness
☐ Change of appetite	☐ Excessive Energy	☐ _____
☐ Excessive Guilt	☐ Increased Irritability	☐ _____
☐ Fatigue	☐ Crying Spells	☐ _____
☐ Decreased Libido		

Suicide Risk Assessment

Have you ever had feeling or thoughts that you did not want to live? ☐ Yes ☐ No

Have you ever tried to kill or harm yourself before? _____

If you are currently having thoughts about harming yourself and feel that you may act on these thoughts or impulses, STOP filling out this form, CALL 911 OR VISIT THE EMERGENCY ROOM AT YOUR NEAREST HOSPITAL

Medical History

Allergies _____

_____

Current Height _____ Current Weight_____

For Women Only: Are you currently pregnant or do you think you might be pregnant? ☐ Yes ☐ No

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

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

Please check any family medical issues that apply to you and indicate the family member

	Yes	**No**	
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	☐	☐	_____
Liver Problems	☐	☐	_____
Other	☐	☐	_____

Past Psychiatric History

Outpatient Treatment ☐ **Yes** ☐ **No**

If yes, please describe when, by whom, reason for treatment and nature of treatment.

_____

_____

_____

Psychiatric Hospitalization ☐ **Yes** ☐ **No**

If yes, please describe for what reason, when, where, and the dates of hospitalization.

_____

_____

_____

Family Psychiatric History

Please check and indicate the family member who has been diagnosed or treated for:

	Yes	**No**	
Bipolar Disorder	☐	☐	_____
Depression	☐	☐	_____
Anxiety	☐	☐	_____
Anger	☐	☐	_____
Suicide	☐	☐	_____
Schizophrenia	☐	☐	_____
Post-Traumatic Stress	☐	☐	_____
Alcohol Abuse	☐	☐	_____
Other Substance Abuse	☐	☐	_____

Has any family member been treated with psychiatric medication? ☐ Yes ☐ No

If yes, who was treated, with 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, please indicate the treatment, for what and when?

_____

_____

_____

Tobacco History

Have you ever smoked cigarettes? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No How many packs per day on average? _____ How many years? _____

In the past? ☐ Yes ☐ No How many years did you smoke? _____ When did you quit? _____

Do you use pipe, cigars, or chewing tobacco? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

What kind? _____ How often per day on average? _____ How many years? _____

Educational History

Did you attend college? □ Yes □ No

Where? _____ Major _____

What is your highest level of education or degree obtained? _____

Occupational History

Are you currently: □ Employed □ Not working by choice □ Unemployed □ Disabled □ Retired

How long in the present position? _____

What is/was your occupation? _____

Social History

Are you currently: □ Married □ Divorced □ Single □ Widowed

How long? _____

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_____

_____

Legal History

Have you ever been arrested? □ Yes □ No

Do you currently have any pending legal problems? □ Yes □ No

Please describe_____

_____

By signing below, I agree that all the information provided is true and accurate.

_____

Signature of Patient Date

_____

Emergency Contact Telephone #