MINDFUL CATHY

Catherine Kim ARNP, PMHNP LLC

Today's Date: _____

Psychiatric Adult Intake Form

Please complete all information on this form and bring to your first visit, along with a list of your medications and any recent lab results. If you are unable to complete it at home, please come 20 minutes prior to your scheduled appointment time to fill out in the office. You may need to ask family members about the family history.

Legal Name: _____ Preferred Name: _____
DOB:_____ Gender: Male/Female/Non-binary/Other _____
Address: _____
_____
Contact Phone: _____
Contact Email: _____

Insurance: _____
ID#_____ Group #: _____
Primary Care Physician_____
Phone:_____Fax/Email:_____
Current Therapist_____
Phone: _____Fax/Email:_____

What are the problem(s) you are seeking help for today? How long have you had these problems?
_____
_____
_____
_____
_____
_____

What are your treatment goals? (Short-term and/or Long-term)
_____
_____
_____

Have you ever been diagnosed or treated for these issues or any other mental health conditions?
_____
_____
_____
_____

Current Symptoms Checklist

- ☐ Depressed or sad mood
- ☐ Sleep problems
- ☐ Decreased interest in activities
- ☐ Tearfulness, crying spells
- ☐ Weight or appetite change
- ☐ Excessive guilt, worthlessness
- ☐ Low self-esteem
- ☐ Decreased libido
- ☐ Lower than usual motivation
- ☐ Lower than usual energy
- ☐ Poor concentration
- ☐ Distractibility
- ☐ Short attention span
- ☐ Forgetfulness, memory issues
- ☐ Difficulty with hygiene, grooming; basic functions
- ☐ Morbid thoughts of death
- ☐ Severe and disabling fatigue
- ☐ Self-harm or suicidal thinking
- ☐ Severe mood swings
- ☐ Emotionally hypersensitive
- ☐ Excessive energy
- ☐ Increased goal-directed activities, multiple projects
- ☐ Anger management issues
- ☐ Irritability, agitation
- ☐ Racing thoughts
- ☐ Pressured speech
- ☐ Impulsive or risky behaviors
- ☐ Excessive shopping
- ☐ Compulsive Gambling
- ☐ Excessive gaming
- ☐ Hypersexual urges, promiscuity, unsafe sex practices
- ☐ Increased use of alcohol, marijuana, or other drugs
- ☐ Cognitive or thinking/ processing problems
- ☐ Auditory, tactile, or visual hallucinations
- ☐ Paranoia or suspiciousness
- ☐ Delusional thinking
- ☐ Anxiety/Excessive worry
- ☐ Difficult to control anxiety
- ☐ Nervousness, restless, antsy
- ☐ Catastrophic thinking
- ☐ Fearfulness of social settings
- ☐ Severe difficulty leaving the house, agoraphobia
- ☐ Social anxiety
- ☐ Test anxiety
- ☐ Panic attacks
- ☐ Higher than usual avoidance
- ☐ Physical sx of stress/anxiety
- ☐ Active Fight-Flight mode
- ☐ Increased trauma-related sx
- ☐ Dissociative episodes
- ☐ Recurring nightmares
- ☐ Intrusive flashbacks or distressful memories
- ☐ Low distress tolerance
- ☐ Hypervigilant to sound, movement, light, touch
- ☐ Sensory processing issues
- ☐ Obsessive-compulsive traits
- ☐ Repetitive behaviors (e.g. counting, checking)
- ☐ Excessive hand-washing, hair-pulling, skin-picking
- ☐ Phobias: _____
- ☐ Tics/Tourettes
- ☐ Epilepsy, seizures
- ☐ Eating disorder - anorexia, bulimia
- ☐ Binge eating behaviors
- ☐ Distorted body image

☐ Other symptoms not listed:

_____

Suicide Risk and Safety

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No

Have you ever attempted suicide? ( ) Yes ( ) No

If YES: Please describe _____

Have you ever attempted to self-harm (e.g. cutting, burning, hitting)? ( ) Yes ( ) No

If YES: Please describe _____

Do you currently have thoughts of harming yourself or others? ( ) Yes ( ) No

Do you currently feel suicidal? ( ) Yes ( ) No. Are you feeling unsafe? ( ) Yes ( ) No

Do you have the means or a specific plan to kill or harm yourself? ( ) Yes ( ) No

If YES: On a scale of 1 to 10 (strongest), how strong is your desire to kill or harm yourself today? _____

Medication History

ALLERGIES (reaction): _____

Current Prescription Medications (please include name, dose, and start date) - medical and psych:

_____

_____

_____

_____

_____

Current Over-The-Counter medications or supplements:

_____

_____

Past Psychiatric Medications

Have you ever been prescribed or taken any of the following? Please circle any you have tried and feel free to add any personal notations on side effects or benefits. We can review together in person.

Antidepressants

Prozac/fluoxetine	Effexor/venlafaxine	Wellbutrin/bupropion
Zoloft/sertraline	Pristiq/desvenlafaxine	Remeron/mirtazapine
Luvox/fluvoxamine	Cymbalta/duloxetine	Viibryd/velazadone
Paxil/ paroxetine	Anafranil/clomipramine	Brintellix/vortioxetine
Celexa/citalopram	Pamelor/nortriptyline	SAM-E
Lexapro/escitalopram	Tofranil/imipramine	St. John's Wort
	Elavil/amitryptiline	

OTHER: _____

Mood Stabilizers

Tegretol/carbamazepine	Depakote/valproate	Keppra/levetiracetam
Trileptal/oxcarbazepine	Lamictal/lamotrigine	Neurontin/gabapentin
Lithobid/lithium	Topamax/topiramate	

OTHER: _____

Antipsychotic Meds

Seroquel/quetiapine	Abilify/aripiprazole	Haldol/haloperidol
Zyprexa/olanzapine	Latuda/lurasidone	Trilafon/perphenzaine
Geodon/ziprasidone	Invega/paliperidone	Prolixin/fluphenazine
Risperdal/ risperidone	Rexulti/brexiprazole	
Saphris/ asenapine	Clozaril/clozapine	

OTHER: _____

Sleep Meds

Desyrel/trazodone	Lunesta/eszopiclone	Vistaril/hydroxyzine
Silenor/Doxepin	Restoril/temazepam	Melatonin
Rozerem/Ramelteon	Seroquel/quetiapine	Valerian Root
Ambien/zolpidem	Neurontin/gabapentin	Sleeptyime tea - Camomile
Sonata/zaleplon	Benadryl/diphenhydramine	

OTHER: _____

Psychostimulants or ADHD Meds

Ritalin or Concerta/ methylphenidate	Vyvanse/lisdexamfetamine	Strattera/atomoxetine
	Dexedrine/dextroamphetamine	Intuniv/guanfacine
Adderall IR, XR; Mydayis/mixed amphetamine salts	Evekeo/amphetamine	Kapvay/clonidine
	Adzenys/amphetamine	

OTHER: _____

Anxiety Meds

Ativan/lorazepam	Valium/diazepam	Vistaril/hydroxyzine
Xanax/alprazolam	Buspar/buspirone	Inderal/propranolol
Klonopin/clonazepam	Neurontin/gabapentin	

OTHER: _____

Prior Mental Health Treatment: (e.g. therapy, psychiatry, partial or inpatient hospitalizations; names, dates)

_____

_____

_____

_____

Other psychiatric treatments:

ECT - electroconvulsive therapy	DBT - Dialectical Behavioral Therapy
rTMS - transmagnetic stimulation	CBT - Cognitive Behavioral Therapy
Biofeedback	ACT - Acceptance and Commitment Therapy
Functional Psychiatry - Supplements, Nutrition	Acupuncture

Other: _____

Psychiatric & Mental Health History

	You	Family	Which Family Member?
Bipolar Disorder	☐	☐	_____
Depression	☐	☐	_____
Anxiety	☐	☐	_____
OCD (obsessive-compulsive disorder)	☐	☐	_____
PTSD	☐	☐	_____
ADHD	☐	☐	_____
Eating disorder	☐	☐	_____
Suicide	☐	☐	_____
Schizophrenia	☐	☐	_____
Alcohol Abuse	☐	☐	_____
Other Substance Abuse	☐	☐	_____
Violence (victim or perpetrator)	☐	☐	_____
Other:_____	☐	☐	_____

Substance Use and Addiction History:

Current Use (Please circle):

Methamphetamines/speed	PCP/Peyote	Caffeine (#/day)
Cocaine/crack	Steroids	Marijuana (#/day)
Opioids: Heroin/Pain Pills	Benzodiazepines	Tobacco (#/day)
Hallucinogens (shrooms, LSD)	Dextromethorphan/DXM	Alcohol (#/day)
Ecstasy/MDMA/Mollys	Glue/huffing	

Behavioral Addiction (gambling, compulsive behaviors, internet, sexual)

Other: _____

Past Use (Please circle):

Methamphetamines/Speed	PCP/Peyote	
Cocaine/crack	Steroids	Caffeine
Opioids: Heroin/Pain Pills	Benzodiazepines	Marijuana
Hallucinogens: shrooms, LSD	Dextromethorphan/DXM	Tobacco
Ecstasy/MDMA/Mollys	Glue/huffing	Alcohol

Behavioral Addiction (gambling, compulsive behaviors, internet, sexual)

Other: _____

Have you ever had a serious problem with alcohol, marijuana, and/or other drugs? Yes ( ) No ( )
Have you ever been arrested for being intoxicated? for example, have you had a DUI? Yes ( ) No ( )
Have you ever "blacked out" from alcohol or drugs? Yes ( ) No ( )
Have you ever been treated for alcohol or drug use or abuse? Yes ( ) No ( )
If yes, for which substances? where/how?_____
If yes, tell me more about your recovery _____

Medical History

Current Medical Problems:

_____
_____
_____
_____

How is your general health? _____When was your last annual physical? _____
Are you on a special type of diet/restrictions? _____
Do you move regularly (e.g. exercise, yoga, weights)? Yes ( ) No ( )
If yes, please describe: _____
Any history of surgeries? Yes ( ) No ( ) If yes, please list procedures and dates: _____

For women:

Date of last menstrual period _____
PMS issues? Yes ( ) No ( ) Describe _____
Perimenopausal issues? Yes ( ) No ( ) Describe _____
Are you currently pregnant? Yes ( ) No ( ) Are you planning to get pregnant in the near future? Yes ( ) No ( )
Birth control method -_____
# of pregnancies _____ # of live births _____ # of living children _____

	You	Family	Which family member (s)?
Thyroid Disease	☐	☐	_____
Anemia	☐	☐	_____
Liver problems	☐	☐	_____
Kidney Disease	☐	☐	_____
Diabetes	☐	☐	_____
Asthma	☐	☐	_____
Migraines	☐	☐	_____
IBS/Crohn's/Colitis	☐	☐	_____
Cancer	☐	☐	_____
Chronic Pain	☐	☐	_____
Heart Disease	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____
High Cholesterol	☐	☐	_____
High Blood Pressure	☐	☐	_____
Head Injury	☐	☐	_____
Sleep Apnea	☐	☐	_____
Autoimmune Disease: _____	☐	☐	_____
Other: _____	☐	☐	_____

Social History

Family Background

How would you describe your childhood? _____

List your siblings/ages: _____

Were you adopted? Yes ( ) No ( ). Are you close with your family of origin?_____

Did your parents divorce? Yes ( ) No ( ) If yes, how old were you when they divorced?_____

Any history of learning disabilities or special education in school? Yes () _____ No ( )

Has anyone in your immediate family died? Yes ( ) No( ) Who and when? _____

Current social support network - e.g. family, friends, pets, church, support group, etc

_____

Please share anything about yourself - e.g. hobbies, interests, personal goals:

_____

Trauma History

Do you have a history of being abused emotionally, sexually, physically, or by neglect? Yes ( ) No ( )

Have you ever been a victim or perpetrator of domestic violence or sexual assault? Yes ( ) No ( )

Have you ever served in the military? Yes ( ) No ( ) Were you in active combat? Yes ( ) No ( )

Other trauma history:_____

Education/ Occupational HIstory

What is your highest level of education? _____

Are you currently: Working ( ) Not working by choice ( ) Unemployed ( ) Disabled ( ) Retired ( )

What is/was your occupation? _____

Any work-related stressors?_____

Relationship History

What is your current living situation? pets?_____

Do you have children? List ages/gender _____

Are you currently: Married ( ) Single ( ) Divorced ( ) Widowed ( ) Partnered ( ) Other relationship ( )

Are you sexually active? Yes ( ) No ( )

Please describe your relationship with your partner:_____

Do you feel safe in your current relationship(s)? _____

Legal History

Have you ever been arrested? Yes ( ) No ( ) Do you have any current legal problems? Yes ( ) No ( )

Have you ever been or are you currently on medical disability? Yes ( ) No ( )

Other: _____

Spiritual Life

Do you belong to a particular organized religion or spiritual group? Yes ( ) No ( )

If yes, what is the level of your involvement? _____

Is there anything else that you would like your psychiatric nurse practitioner to know?

_____