



New Patient Intake Screener

Symptom Screener

Over the last 6 MONTHS how often have you experienced the following problems?

Not At All	Several Days	Most Days	Nearly Every day	
				Feeling down, depressed or hopeless
				Little interest or pleasure in doing things
				Feeling Nervous, anxious or on edge
				Not being able to stop or control worrying

Yes	No	
		Have you had an occurrence when all of a sudden you felt frightened, anxious or very uneasy?
		Have you had an occurrence when for no reason your heart suddenly began to race, you felt faint, or you couldn't catch your breath?
		Did any of these occurrences happen in a situation when you were not in any danger or the center of attention?

Not at all	A little Bit	Somewhat	Very Much	Extremely	
					Fear of embarrassment causes me to avoid doing things or speaking to others
					I avoid activities in which I am the center of attention
					Being embarrassed or looking stupid are among my worst fears

Yes	No	Have you experienced any of the following at any time in your life:
		Natural Disaster, Fire, explosion, industrial accident, transportation accident, physical or sexual assault, captivity or exposure to a war zone, life threatening illness or injury, sudden unexpected death or injury someone close to you, or serious injury, harm or death to someone else that you witnessed or caused?
		Has this event caused any significant problems or symptoms that lasted for more than a month?

Yes	No	Has there ever been a period of time when you were NOT your usual self and you felt the following:
		Felt so good/ hyper that other people thought you were not your normal self or hyper that got you into trouble?



Yes	No	
		Were so irritable that you shouted at people or started fights or arguments?
		Felt much more self-confident than usual?
		You got much less sleep than usual but found you didn't miss it?
		You felt much more talkative or spoke faster than usual?
		Thoughts racing through your head that you couldn't slow down?
		Felt so easily distracted by things around you that you had trouble concentrating?
		You had much more energy than usual?
		You were much more active or did more things than usual?
		You were much more social or outgoing than usual?
		You were much more interested in sex than usual?
		You did things that were unusual for you that other people might have thought were excessive, foolish or risky?
		Spent money that got you or your family into trouble?

The following questions relate to your eating habits:

Yes	No	
		When you eat, do you MAKE yourself sick because you feel uncomfortably full?
		Do you ever worry that you have lost control over how much you eat?
		Have you recently lost more than 14 pounds in a 3 month period?
		Do you believe yourself to be fat when others say you are too thin?
		Would you say that food dominates your life?

Yes	No	
		Have you ever been bothered by having to perform some ritual or act over and over that does not make sense?

The following questions are related to your alcohol & substance use:

Never	Monthly or less	2-4x a month	2 – 3x a week	4 or more x a week	
					How often do drink Alcohol?

1 – 2	3 – 4	5 – 6	7 – 9	10 or more	
					How many drinks do you have?

Never	Less than monthly	Monthly	Weekly	Daily	
					How often do you have 6 or more drinks on 1 occasion?

Yes	No	In the past year...
		Have you used an illegal drug or used prescription medication for NON – medical reasons?



How often have you had any of the following in the last 6 months:

Never	Rarely	Sometimes	Often	Very Often	
					Trouble wrapping up the final details of a project?
					Difficulty getting things in order when organization is required?
					Problems remembering appointments or obligations?
					When you have a task that requires a lot of thought, how often do you avoid or delay getting started?
					Do you fidget or squirm w/ your hands/feet when you have to sit for a long period of time?
					How often do you feel overly active & compelled to do things?

Please answer the following based on how you feel your 'usual' self (without symptoms):

Yes	No	
		Do you find that most people will take advantage of you if you let them know too much about you?
		Do you generally feel nervous or anxious around people?
		Do you avoid situations where you have to meet new people?
		Do you avoid getting to know people because you're worried that they may not like you?
		Has avoidance of getting to know people for fear of being disliked affected the # of friends you have?
		Do you change the way you present yourself to others because you don't know who you really are?
		Do you often feel like your beliefs change so much that you don't know what you believe anymore?
		Do you often get angry or irritated because people don't recognize your special talents/ achievements as much as they should?
Yes	No	In general, at any time...
		Have you had any unusual experiences such as hearing voices, seeing visions, or having ideas you later found out were not true?
		Have you had any unusual experiences such as mind reading, thoughts being controlled by others, seeing things on TV that refer to you specifically?

Patient Health Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following:

Never	Several Days	Most Days	Every Day	
				Little to no interest or pleasure in performing everyday tasks
				Feeling down, depressed or hopeless
				Trouble falling asleep, staying asleep, oversleeping
				Feeling tired or having little energy
				Poor appetite or overeating
				Feeling bad about yourself, letting others down, failure to self/family
				Trouble concentrating such as reading or watching tv
				Moving/ speaking slowly or feeling fidgety/restless & others have noticed
				Thoughts that you would be better off dead or hurting yourself in some way



Generalized Anxiety Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following:

Not at all	Several Days	Most Days	Every Day	
				Feeling nervous, anxious or on edge
				Not being able to stop or control worrying
				Worrying too much about different things
				Trouble relaxing
				Being so restless that it is hard to sit still
				Becoming easily annoyed or irritable
				Feeling afraid as if something awful might happen

Adult Self Report Scale

How often in the last 6 months have you experienced any of the following:

Never	Rare	Some	Often	VERY Often	How often do you....
					Have trouble wrapping up the final details of a project once challenging parts are complete?
					Have difficulty getting things in order when you have a task that requires organization?
					Have problems remembering appointments or obligations?
					Delay or avoid getting started on a task that requires a lot of thought?
					Fidget or squirm w/ hands/feet when sitting for long periods of time?
					Feel compelled to do things, as if driven by a motor/ you HAVE to do it
					Make careless mistakes when working on a boring or difficult project?
					Difficulty keeping attention when doing boring or repetitive work?
					Difficulty concentrating when people are speaking to you?
					Misplace or have difficulty finding things?
					Are you easily distracted by activity or noise around you?
					Leave your seat/ move when expected to remain seated/ stay still?
					Feel restless or fidgety?
					Have difficulty unwinding / relaxing when you have the time?
					Find yourself talking too much when you are in social situations?
					Find yourself finishing others sentences while they still are talking?
					Have difficulty waiting your turn when turn taking is required?
					Interrupt others when they are busy?



Stressors

How much stress is each category currently causing you?

None	Mild	Moderate	Severe	
				Family
				Friends
				Relationships (non – romantic/ casual)
				Educational
				Economic/ Financial
				Occupational (work)
				Housing
				Legal
				Health (Medical/ Mental)

Physical Review of Systems

Are you experiencing any physical symptoms in any of the following categories? If so, please briefly specify

None (Please check if no problems)	
	Eye/Vision
	Ears/Nose/Mouth/Throat
	Cardiovascular (heart)
	Respiratory (lungs)
	Musculoskeletal (muscles/bones)
	Gastrointestinal (stomach)
	Endocrine (Hormones/thyroid)
	Lymphatic/Hematologic (blood)
	Urinary/ Reproductive
	Neurological(head – non psyche)
	Integumentary (Skin/Hair)

Are you experiencing any of the following psychiatric symptoms:

Yes	No		Yes	No	
		Feeling depressed			Stress
		Difficulty Concentrating			Disturbing thoughts
		Phobias/unexplained fears			Manic episodes
		No pleasure from life anymore			Confusion
		Anxiety			Memory Loss
		Insomnia			Nightmares
		Excessive moodiness			Other



Substance Abuse History

Do you have a history of any **recreational** drug use/abuse?
 Do **NOT** check below if you have taken these **prescribed**

Yes	No

Yes	No	Substance	How was it used?			Age(s) of use
			Oral/ edible - Nasal	- Inhaled/smoked	- Injected	
		Amphetamines/Speed				
		Barbiturates/ Downers				
		Opiates				
		Cocaine				
		Psychedelics				
		Inhalants				
		Cannabis/ Marijuana				
		Benzodiazepines				
		PCP				

Have you received any treatment for substance abuse?

Yes	No	Treatment Type	Length of treatment	Age of treatment
		Inpatient		
		Intensive Outpatient		
		Outpatient		
		12 Step Program		
		Other		

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances?

Yes	No		Yes	No	
		Felt that you needed to cut down on alcohol consumption/drinking			Using/ consuming more than intended
		Been annoyed by others criticizing your drinking			Unintentional overdose
		Felt guilty about drinking			DUI
		Needing a drink first thing in the morning			Arrests
		Increased tolerance (alcohol or other substance)			Physical fights or assaults
		Withdrawal effects (shakes, sweating, nausea, rapid heart rate)			Relationship conflicts
		Seizures			Problems with money
		Blackouts			Job loss or problems at work/school
		Effects on physical health			Other, please specify:



History of Psychiatric Treatment

Do you have any history of inpatient psychiatric treatment?
 (Hospitalized for more than a few hours/spent the night in a hospital/facility)

Yes	No

First Hospitalization

Name of Hospital/ Facility: _____

Reason for hospitalization: _____ Depression _____ Suicidal Thoughts _____ Suicidal Attempt
 _____ Manic Episode _____ Psychotic Episode _____ Severe Anxiety _____ Drug/Alcohol Related
 _____ Assault _____ Violence _____ Other: _____

Age of Hospitalization: _____ **Was it voluntary?** _____

Outcome of Stay: _____ Resolved or nearly resolved Problem _____ Significant Improvement
 _____ Partial Response _____ Minor Improvement/No Effect _____ Feeling worse or negative result

Second Hospitalization: (Leave blank if only had 1 event)

Name of Hospital/ Facility: _____

Reason for hospitalization: _____ Depression _____ Suicidal Thoughts _____ Suicidal Attempt
 _____ Manic Episode _____ Psychotic Episode _____ Severe Anxiety _____ Drug/Alcohol Related
 _____ Assault _____ Violence _____ Other: _____

Age of Hospitalization: _____ **Was it voluntary?** _____

Outcome of Stay: _____ Resolved or nearly resolved Problem _____ Significant Improvement
 _____ Partial Response _____ Minor Improvement/No Effect _____ Feeling worse or negative result

Do you have a history of outpatient psychiatric treatment?
 (Seen a provider for mental health symptoms & prescribed psychiatric medication)

Yes	No

If No, skip to next section

1. Name of Provider/Office/Clinic: _____

Age at start of treatment: _____

Reason for seeking Treatment: _____ Depression _____ Panic _____ Anxiety _____ Social Anxiety
 _____ Obsessive Compulsive _____ PTSD _____ Bipolar _____ Eating Disorder
 _____ Alcoholism _____ Drug Abuse _____ ADHD _____ Personality Disorder
 _____ Schizophrenia/Psychosis _____ Autism Spectrum _____ Disruptive Behavior
 Other: _____

Response to treatment: _____ Resolved/Nearly resolved Problem _____ Significant Improvement
 _____ Partial Response _____ Minor Improvement/No Effect _____ Feeling worse or negative result



(Outpatient Psychiatric treatment info continued)

2. Name of Provider/Office/Clinic seen: _____
Age at start of treatment: _____

Reason for seeking Treatment: _____ Depression _____ Panic _____ Anxiety _____ Social Anxiety
 _____ Obsessive Compulsive _____ PTSD _____ Bipolar _____ Eating Disorder
 _____ Alcoholism _____ Drug Abuse _____ ADHD _____ Personality Disorder
 _____ Schizophrenia/Psychosis _____ Autism Spectrum _____ Disruptive Behavior
 _____ Other: _____

Response to treatment: _____ Resolved/Nearly resolved Problem _____ Significant Improvement
 _____ Partial Response _____ Minor Improvement/No Effect _____ Feeling worse or negative result

Suicide/ Self Harm History

Have you ever tried to harm or kill yourself? _____ Yes _____ No (If no, Skip to next section)
 If yes, was your intent to die? ----- _____ Yes _____ No
 How many times in your life has this occurred? _____

Episode 1 Month/Year _____

Method: _____ Overdose _____ cutting _____ Gunshot _____ Drowning
 _____ Hanging _____ Jumping from height _____ Vehicle _____ Carbon Monoxide
 _____ Suffocation

Consequences: _____ No medical treatment _____ Outpatient medical visit _____ Emergency room
 _____ hospital admission (inpatient) _____ Intensive Care Unit (ICU)

Episode 2 Month/Year _____

Method: _____ Overdose _____ cutting _____ Gunshot _____ Drowning
 _____ Hanging _____ Jumping from height _____ Vehicle _____ Carbon Monoxide
 _____ Suffocation

Consequences: _____ No medical treatment _____ Outpatient medical visit _____ Emergency room
 _____ hospital admission (inpatient) _____ Intensive Care Unit (ICU)

Violence History

Have you had any history of violent behavior?
If yes, please specify:

Yes	No



Past Medical History

Who is your primary care/family physician?

Are you currently taking any NON – Psych Medication? If yes, please specify names:

Do you have a history of any of the following health problems? Check all that apply

Allergies	Glaucoma	Kidney Stones
Anemia	Gout	Liver Disease
Arthritis	High Cholesterol	Lupus
Asthma	Hearing Loss	Migraine Headaches
Back/ Spine problems	Heart Disease	Multiple Sclerosis
Cancer	Heart Defect	Obesity/Overweight
Cataracts	Heart Valve problems	Parkinson’s Disease
Chickenpox	Hemorrhoids	Polyps
Chronic Bronchitis	Hepatitis	Seizures
COPD/Emphysema	Hernia	Sexually Transmitted Infections/ STD’s
Diabetes	HIV	Sleep Apnea
Diverticulitis	High Blood Pressure	Stroke/ TIA
Fainting spells/passing out	Low Blood Pressure	Low Testosterone
Fibromyalgia	IBS/ Inflammatory Bowel Disease	Thyroid Problems
Gall Bladder Disease	Iron Deficiency	Tuberculosis/ exposure to TB
Gastritis/Ulcer	Kidney Disease	Other:

Have you had any surgery in any of the following areas? Check all that apply

Back/Neck	Hysterectomy (ovaries removed)	Prostate
Brain	Intestine	Sex Change
Cardiac	Kidney	Shoulder/Elbow/Wrist/Hand
Ear/Nose/Throat	Liver	Stomach
Gall Bladder	Lung	Tonsils
Hernia	Pancreas	Vagina
Hip/Knee/Ankle/Foot	Pelvis	Weight Loss
Hysterectomy (ovaries retained)	Penis	Other:



Have you ever taken any of the following Psychiatric Medication?

Yes No

Abilify (aripiprazole)	Invega (paliperidone)	Revia (naltrexone)
Adderall	Keppra (Levetiracetam)	Risperdal (risperidone)
Ambien (zolpidem)	Klonopin (Clonazepam)	Ritalin (methylphenidate)
Anafranil/clomipramine	Lamictal (Lamotrigine)	Rozerem (ramelteon)
Antabuse (disulfiram)	Latuda	Seroquel (quetiapine)
Ativan (lorazepam)	Lexapro (escitalopram)	Serzone (nefazidone)
Buspar (Buspirone)	Librium	Sinequan (doxepin)
Campral (acamprosate)	Lithobid	Sonata (zaleplon)
Catapres (clonidine)	Lithium	Stelazine (trifluoperazine)
Celexa (citalopram)	Lunesta (Eszopiclone)	Strattera (atomoxetine)
Clozaril (Clozapine)	Luvox (fluvoxamine)	Suboxone (buprenorphine)
Concerta	Lyrica (pregabalin)	Subutex (buprenorphine)
Contrave	Melatonin	Tegretol (carbamazepine)
Cymbalta (duloxetine)	Mellaril (thioridazine)	Tenex (guanfacine)
Cytomel	Methadone	Thorazine (chlorpromazine)
Depakote (Divalproex)	Navane (thiothixene hcl)	Topamax (topiramate)
Dexedrine	Neurontin (gabapentin)	Trazodone (Desyrel)
Doxepin (sinequan)	Orap (pimozide)	Trileptal (oxcarbazepine)
Effexor (Venlafaxine)	Pamelor (nortriptyline)	Valium (diazepam)
Elavil (amitriptyline)	Paxil (paroxetine)	Viibryd (vilazodone)
Fanapt (iloperidone)	Phentermine	Vistaril (hydroxyzine)
Fiornal	Pristiq (desvenlafaxine)	Vyvanse
Focalin	Propranolol	Wellbutrin (bupropion)
Gabitril	Provigil (modafinil)	Xanax (alprazolam)
Geodon (ziprasidone)	Prozac (fluoxetine)	Zoloft (sertraline)
Haldol (haloperidol)	Remeron (mirtazapine)	Zyprexa (olanzapine)
Intuniv	Restoril (temazepam)	

If you have ever had any **side effects** to any psych medication, please specify what medication & the side effect(s) you experienced or the reason why you stopped any psych medication for any other reasons:

Are you allergic to any medications or other substances? Yes No

Yes, Specify what it is, & what reaction you had: _____



Family History

Do you have any family members with a history of **mental health issues**? If yes, Please elaborate what problems they had (ex: Mom – depression) _____

Do you have any family members with a history of any medical problems? _____

Developmental & Educational History

When **your mother** was pregnant with **you**, did she have any of the following problems? ___ No problems

___ Exposure to drugs/alcohol during pregnancy

___ A difficult pregnancy

___ Problems with delivery

___ Other: _____

Did you have any complications after your birth?

___ Premature

___ Jaundice

___ breathing difficulties

___ None

Did you have any delays /difficulties in reaching the following milestones?

___ Walking

___ Talking

___ Toilet Training

___ Sleeping Alone

___ Being away from parents

___ Making Friends

Other: _____

How would you best describe your childhood home atmosphere?

___ Normal

___ Supportive

___ Parental fighting

___ Parental Violence

___ Financial difficulties

___ Frequent Moving

___ Other: _____

Did you experience any of the following challenges during your **childhood**?

___ None

___ Tantrums

___ Bed wetting

___ Running away from home

___ Fighting

___ Stealing

___ Property damage

___ Fire Setting

___ Animal cruelty

___ Separation anxiety

___ Victim of bullying

___ Engaged in bullying

___ Depression

___ Death of a parent

___ Parental Divorce

Did you have any of the following problems in school? ___ None

___ Fighting

___ School phobia

___ Truancy

___ Detentions

___ Suspensions

___ Expulsions

___ School refusal

___ Class failures

___ Repetition of grades

___ Special education

___ Remedial classes

Did you have any additional schooling outside of the standard classroom setting?

___ Speech classes

___ Tutoring

___ Accommodations

___ Other: _____

What is your highest level of education:

___ Less than High School

___ High School/GED

___ Some College

___ 2 year degree

___ 4 year degree

___ Graduate/professional degree



General Social History

How would you best describe your social situation?

- Supportive social network Few friends Substance use base friends
 No friends Distant from family of origin Family conflict
 Other: _____

What is your current marital status? single, never married Married/ permanent partnership
 Divorced Separated/divorce in process Widowed

What is the status of your intimate relationship? Never been in a serious relationship
 Not currently in a serious relationship
 Currently in a serious relationship

What is the satisfaction level of your intimate relationship?
 Not Applicable Very Satisfied Satisfied Somewhat Satisfied Dissatisfied

What is your sexual orientation? Heterosexual Homosexual Bisexual

What is your current living situation?
 Rent Own Group home Foster care Homeless

Who do you live with? Live Alone Roommates Partner/spouse Parent(s)
 Siblings Children Other: _____

Do you currently participate in spiritual activities? Yes No

What is your occupation status?
 Employed full time Employed part time Temp/seasonal Retired
 Full Time Student Part time student Homemaker Disability
 Unemployed (seeking work) Unemployed (Not seeking work)

What is your currently yearly income?
 Less than 11k 11k – 25k 26k – 75k 76k – 100k More than 100k

What is your longest period of continuous employment? _____

What is your longest period of unemployment? _____

For Females Only ~ Menstruation & Pregnancy History

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For Females Only ~ Menstruation & Pregnancy History

At what age did you begin menstruation? _____

Which of these best describe your current premenstrual symptoms?

- Dysphoria (state of unease) Cramps Appetite Change
 Bloating Sleep Disturbance None of these

Do you have a method of contraception (birth control)? None

- Intrauterine (IUD) Hormonal (implant, injection, patch, pill, ring)
 Barrier (condom, spermicide) Fertility Awareness based
 Permanent (sterilization, infertility) Other: _____

Have you ever been pregnant? Yes No - How many times? _____

If you HAVE been pregnant, have you given birth? Yes No - How many times? _____

If you have NOT given birth, have you had any miscarriages? Yes No - How many times? _____

If you have NOT given birth, have you had any abortions? Yes No - How many times? _____