9550 Hickman Road, Suite 101
Clive, Iowa 50325
Phone: 515-758-8300
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PSYCHIATRIC EVALUATION INTAKE FORM:

DEMOGRAPHICS:

1. **PATIENT CONTACT INFORMATION**

Last Name_____ First Name _____MI_____

Preferred Name _____ Pronouns_____

Gender_____ Sexual Orientation_____

Address_____City/State/Zip_____

Best contact phone number _____Email address _____

Primary Care Physician _____Tel_____Fax_____

Pharmacy _____ Pharmacy Phone #_____

2. **DATE OF BIRTH _____ / _____ / _____**

3. **AGE _____**

4. **RACE / ETHNICITY (check one or more):**

☐ American Indian/Alaskan Native ☐ Asian ☐ African American
☐ Hispanic ☐ Caucasian ☐ Other _____

5. **CURRENT MARITAL STATUS (check one):**

☐ Single, never married ☐ Married, living together ☐ Separated
☐ Widowed ☐ Cohabitating with partner ☐ Divorced
☐ Married, not living together ☐ Other _____

6. **If you are married or cohabitating, how long has this been?** YEARS_____MONTHS_____

7. **Total number of Marriages?_____ How many children?_____**

8. **Spouse's/Partner's Name_____**

9. **Who else lives with you?**_____

10. **Do you have any pets? How many? What kind?**_____

11. **How many years of formal education have you completed?** YEARS_____

12. **Highest degree obtained:**

☐ High school graduate ☐ G.E.D. ☐ 4 year college degree
☐ Junior college degree/technical school diploma ☐ M.B.A/M.A./M.S./M.P.H.
☐ J.D./LL.B. ☐ Ph.D. ☐ Other _____

13. **What best describes your current employment status? (Check one from each category a, b, & c)**

a. Employment Status	b. Student Status	c. Volunteer Status
☐ Unemployed, not looking	☐ Part-time	☐ Volunteer, Part-time
☐ Unemployed, looking	☐ Full-Time	☐ Volunteer, Full-time
☐ Full-time Employed	☐ Not a student	☐ No Volunteer Work
☐ Part-time Employed		
☐ Self Employed		
☐ Retired		
☐ Social Security Disability		

14. **What is your current occupation?**_____

15. **Current Residence**

☐ Own my house/condo ☐ Renting ☐ Retirement Complex/Senior Housing

16. **What is your spouse/partner's occupation?**_____

MENTAL HEALTH HISTORY:

1. **Are you currently seeing a therapist? (NAME/CONTACT PHONE #):**

_____

2. **Have you ever seen a psychiatrist/Psychotherapist before? If yes, please list:**

_____

3. **Previous History: Have you ever been treated for any of the following? (Check all that apply):**

☐ Depression ☐ Anxiety ☐ ADHD ☐ Bipolar Disorder (Manic/Depressive)

☐ Schizophrenia ☐ Panic Attacks ☐ PTSD ☐ Alcohol Abuse ☐ Anorexia/Bulimia ☐ Binge-eating ☐ Drug Addiction ☐ OCD

Please List in chronological order all prior psychiatric hospitalizations (if any below): NONE

Approximate Date:	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list the occurrences below: NEVER

Approximate date of attempt	How did you attempt (method)

Please list ALL current medications below (include birth control pills, over the counter medications, herbal remedies – i.e. St. john's Wort, decongestants, etc)

Name of Medication	Dosage (mg)	How many times a day?	On this for how long?	Side effects (if any)	Prescribing Physician

FAMILY HISTORY: Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate PATERNAL or MATERNAL)

	Father	Mother	Brother	Sister	Children	Grandparent
Depression						
Anxiety						
Panic Attack						
PTSD						
Bipolar Type I						
Bipolar Type III						
Schizophrenia						
Alcohol Addiction						
Drug Addiction						
ADHD						
Suicide Attempts						
Psychiatric Hospitalization						

MEDICAL HISTORY: Do you have, or have you ever hand any of the following (please check all that apply)?

	YES	NO		YES	NO		YES	NO
High Blood Pressure			Gastrointestinal Problems (ulcers, Pancreatitis, IBS, Colitis)			Viral Illness (Herpes, Epstein-Barr, Chronic Hepatitis)		
Lung Disease			Arthritis or Rheumatoid			Cancer		
Diabetes (I or II)			Liver Damage or Hepatitis			Genital Problems		
Heart Disease			Other Endocrine/Hormone Problems			Eating Disorder		
Thyroid Disease			Tumor, Nerve Damage, TBI)			Eye Problems		
Anemia			Gynecological/Hysterectomy			Chronic Pain		
Asthma			Urinary Tract or Kidney Problems			Fibromyalgia		
Skin Disease			Migraine or Cluster Headaches			HIV Positive or AIDS		
Seizures Other Medical Issues			Ear/Nose/Throat Problems			Head Injury		

Other Medical Issues			High Cholesterol			Sleep Apnea		

SURGICAL HISTORY:
Please list all prior surgeries and hospitalizations for medical illness

NONE

_____

_____

ALLERGIES:
Please list all allergies to medications or food

NONE

_____

_____

SUBSTANCE USE / ABUSE:
Regarding alcohol, when was your last drink_____

In the past 30 days, about how many of those days have you had at least one alcoholic drink?_____

What is the maximum number of drinks you have had in one day in the past month? _____Drinks

DUI_____ DWI _____ Public Intoxication _____ Seizures_____ DTs_____

Please check the appropriate boxes that apply to you for the following substances:

	Never Used	Past Use	Current Use	Last Date Used	Age of 1st Use	Frequency of Use	Duration of Use (wk, yrs)
Cocaine							
Amphetamine or Speed							
Marijuana							
Diet Pills							
Hallucinogens (LSD, Mushrooms, Mescaline)							
Ecstasy, GHB							
Tranquilizers							
Pain Pills							
Inhalants							
Sleeping Pills							
Laxatives/Diuretics							
Cigarettes/Tobacco							
PCP or Angel Dust							
IV Drug Use							
Heroin							
Anabolic Steroids							
Caffeine (coffee, tea, soda)							
Benzodiazepines (xanax, valium, ativan, Restoril, Librium)							

EMERGENCY CONTACT:_____ **PHONE:**_____

Please review the following list of medications. If you have taken any of these medications, please fill out the specific boxes related to that medication.

Brand Name	Generic Name	Taken	How Long	What dose	How Often	Did it Help	Side Effects
Selective Serotonin Reuptake Inhibitors (SSRIs)							
Luvox	Fluvoxamine						
Paxil	Paroxetine						
Paxil CR	Paroxetine						
Celexa	Citalopram						
Lexapro	Escitalopram						
Zoloft	Sertraline						
Prozac	Fluoxetine						
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)							
Effexor	Venlafaxine						
Effexor XR	Venlafaxine						
Pristiq	Desvenlafaxine						
Cymbalta	Duloxetine						
Other Antidepressants							
Desyrel	Trazadone						
Serzone	Nefazodine						
Wellbutrin XL/SR	Bupropion XL/SR						
Remeron	Mirtazapine						
Viibryd	Vilazodone						
Tricyclic Antidepressants							
Adapin	Doxepin						
Anafranil	Clomipramine						
Asendin	Amoxapine						
Elavil	Amitriptyline						
Ludiomil	Maprotiline						
Norpramin	Desipramine						
Pamelor	Nortriptyline						
Sinequan	Doxepin						
Surmontil	Trimipramine						
Tofranil	Imipramine						
Vivactil	Protriptyline						
Other Psychotropics (have you taken any of these?)							
Abilify	Buprenorphine	Dexedrine	Ambien	Klonopin	Emsam	Provigil	Thorazine
Risperdal	Campral	Adderall	Buspar	Ativan	Nardil	Depakote	Dalmane
Invega	Antabuse	Vyvanse	Restoril	Xanax	Parnate	Lithium	Orap
Geodon	Suboxone	Strattera	Sonata	Hydroxyzine	Dalcion	Lamictal	Navane

Zyprexa	Naltrexone	Concerta	Valium	Niravam	Phentermine	Trilafon	Dyanavel
Seroquel	Ambien CR	Halcion	Vistaril	Tranxene	Tegretol	Moban	Prolixin
Symbyax	Valproic Acid	Focalin	Atarax	Methadone	Cylert	Topamax	Stelazine
Clozapine	Adderall XR	Ritalin	Librium	Meridia	Loxitane	Mellaril	Haldol
Rozerem	Metadate	Daytrana	Lunesta	Saphris			

FINANCIAL HISTORY:

Responsible Party ☐ Self ☐ Parent/Guardian ☐ Spouse

Full Name_____**Gender** MALE / FEMALE

Date of Birth_____ / _____ / _____ **Phone**_____

Method of Payment ☐ Self-Pay ☐ Insurance

PRIMARY INSURANCE

Insurance Company_____ **Policy/Member ID**_____

Group Number_____ **Insurance Phone Number**_____

Relationship to Policy Holder ☐ Self ☐ Parent/Guardian ☐ Spouse

Full Name_____**Gender** MALE / FEMALE

Date of Birth_____ / _____ / _____ **Phone**_____

Policy Holder Address_____**City**_____**State**____**Zip**_____

SECONDARY INSURANCE

Insurance Company_____ **Policy/Member ID**_____

Group Number_____ **Insurance Phone Number**_____

Relationship to Policy Holder ☐ Self ☐ Parent/Guardian ☐ Spouse

Full Name_____**Gender** MALE / FEMALE

Date of Birth_____ / _____ / _____ **Phone**_____

Policy Holder Address_____**City**_____**State**____**Zip**_____

CREDIT CARD AUTHORIZATION FORM WILL BE SENT SEPARATELY. Please note we do keep a card on file for all patient accounts, to be able to better facilitate virtual appointments and past due balances.

HOW DID YOU HEAR ABOUT US?_____