Integrative Psychiatry Patient Intake Form

Patient Name:
Date:

TREATMENT GOALS

Describe your reason for seeking care with us.

Why now?

What are the goals or outcomes you would like to reach with our support?

How will you know when you have reached these goals or outcomes?

What are you already doing to reach these goals or outcomes?

SYMPTOMS

Mood

Feel Sad
(Currently/Past/NA)

Loss of interest
(Y/N)

Are you socially isolated?
(Currently/Past/NA)

Thoughts of suicide?
(Currently/Past/NA)

Racing thoughts?
(Currently/Past/NA)

Buying/Spending sprees?
(Currently/Past/NA)

Explosive temper
(Currently/Past/NA)

Ever experienced a manic episode?
(Currently/Past/NA)

Have you ever heard voices or seen things that weren't there?
(Currently/Past/NA)

Do you feel hopeless?
(Currently/Past/NA)

Is nothing fun?
(Currently/Past/NA)

Do you have no energy?
(Currently/Past/NA)

Are you uninterested in previously pleasurable activities?
(Currently/Past/NA)

Do you feel irritable?
(Currently/Past/NA)

Do you feel guilty?
(Currently/Past/NA)

Are you sexually overactive?
(Currently/Past/NA)

Have you ever experienced paranoia?
(Currently/Past/NA)

Sleep

Restorative sleep
(Currently/Past/NA)

Can't fall asleep

(Currently/Past/NA)

Waking up early
(Currently/Past/NA)

Use a CPAP device
(Currently/Past/NA)

Nightmares
(Currently/Past/NA)

Sleep Rating (10=Best, 0=Worst)
(1 2 3 4 5 6 7 8 9 10)

Can't stay asleep
(Currently/Past/NA)

Sleep too much
(Currently/Past/NA)

Sleepwalking
(Currently/Past/NA)

No need for sleep
(Currently/Past/NA)

Anxiety

Flashbacks
(Currently/Past/NA)

Weight loss(
Currently/Past/NA)

Restless
(Currently/Past/NA)

Feel 'on edge'
(Currently/Past/NA)

Feel fear or anxiety of: (Circle all that apply)
(crowds, bridges, buses, stores, being out of the house, heights, talking in public, choking on food, urinating in public, dying, going crazy)

Chest pain
(Currently/Past/NA)

Pounding heart
(Currently/Past/NA)

Choking sensations
(Currently/Past/NA)

Fainting/Dizziness
(Currently/Past/NA)

Startle easily
(Currently/Past/NA)

Weight gain
(Currently/Past/NA)

Worrying too much (
Currently/Past/NA)

Impatient
(Currently/Past/NA)

Nausea
(Currently/Past/NA)

Sweating
(Currently/Past/NA)

Numbness/Tingling
(Currently/Past/NA)

Hyperventilation
(Currently/Past/NA)

Dry mouth
(Currently/Past/NA)

Attention

Can’t pay attention
(Currently/Past/NA)

Easily distracted
(Currently/Past/NA)

Interrupts others
(Currently/Past/NA)

Fidgeting
(Currently/Past/NA)

Can’t concentrate

(Currently/Past/NA)

Can't finish tasks
(Currently/Past/NA)

Talking too much
(Currently/Past/NA)

Eating habits

Nutrition
(Standard American Diet, healthy SAD, Mediterranean, sugar free, gluten free, dairy free, food sensitivities, paleo/keto, whole/real food, vegan, vegetarian)

Disordered eating
(none, restricting, binging, emotional eating, obsessing about calories, purging)

Appetite
(no concerns, increased, decreased)

Other

Gambling too much
(Currently/Past/NA)

Very intense, unstable relationships
(Currently/Past/NA)

Tendency to swing between extreme over-idealizing and undervaluing people
(Currently/Past/NA)

Frantic actions to avoid abandonment by people who are close to me
(Currently/Past/NA)

Uncontrollable impulses
(Currently/Past/NA)

If yes, describe:

PAST PSYCHIATRIC HISTORY

Age at onset of first symptoms:

Number of episodes:

Number of hospitalizations:

What providers do you see for mental health? (Circle all that apply)
(Psychotherapist, Acupuncturist, Body Worker, Gynecologist, Chiropractor, Energy Worker, Other)

When was your first treatment?

Describe any suicide attempts:

Psychotherapy
(Currently/Past/NA)

Prior psychotherapy (Circle all that apply)
(talk therapy, cognitive behavioral therapy, dialectical behavioral therapy, EMDR, somatic experiencing, couples counseling, art therapy, addiction treatment, other)

Family history of mental health conditions?

Family history of suicide or suicide attempts?

MEDICATIONS

1. Medication name

Dosage:

Why prescribed:

How long did you take this medication?:

Prescriber:

Side effects:

Describe any benefits:

Are you currently taking this medication?
(Y/N)

2. Medication name

Dosage:

Why prescribed:

How long did you take this medication?

Prescriber:

Side effects:

Describe any benefits:

Are you currently taking this medication?
(Y/N)

3. Medication name

Dosage:

Why prescribed:

How long did you take this medication?

Prescriber:

Side effects:

Describe any benefits:

Are you currently taking this medication?
(Y/N)

4. Medication name

Dosage:

Why prescribed:

How long did you take this medication?

Prescriber:

Side effects:

Describe any benefits:

Are you currently taking this medication?
(Y/N)

Other medications:

SUPPLEMENTS

1. Supplement name

Dosage:

Why used:

How long did you take this supplement?

Prescriber, if prescribed:

Side effects:

Describe any benefits:

Are you currently taking this supplement?
(Y/N)

2. Supplement name

Dosage:

Why used:

How long did you take this supplement?

Prescriber, if prescribed:

Side effects:

Describe any benefits:

Are you currently taking this supplement?
(Y/N)

3. Supplement name

Dosage:

Why used:

How long did you take this supplement?

Prescriber, if prescribed:

Side effects:

Describe any benefits:

Are you currently taking this supplement?
(Y/N)

4. Supplement name

Dosage:

Why used:

How long did you take this supplement?

Prescriber, if prescribed:

Side effects:

Describe any benefits:

Are you currently taking this supplement?
(Y/N)

5. Supplement name

Dosage:

Why used:

How long did you take this supplement?

Prescriber, if prescribed:

Side effects:

Describe any benefits:

Are you currently taking this supplement?
(Y/N)

Other supplements:

DRUG AND ALCOHOL HABITS

Caffeine
(Currently/Past/NA)

Current caffeine servings per day:

In the past, maximum daily caffeine servings:

Nicotine
(Currently/Past/NA)

Current nicotine usage
(Amount/Frequency)

Method of nicotine use:

In the past, maximum daily nicotine use:

Age nicotine first used:

Duration of nicotine use:

Last nicotine use:

Comments of nicotine:

Alcohol
(Currently/Past/NA)

Current alcohol usage (Amount/Frequency):

In the past, maximum daily drinks:

Age alcohol first used:

Duration of alcohol use:

Alcohol last used (Time/Amount):

Comments on alcohol use:

Cannabis use
(Currently/Past/NA)

Current pattern and method of cannabis use:

In the past, maximum cannabis use:

Age first used:

Duration of cannabis use:

Last cannabis use (Time/Amount):

Comments of cannabis use:

Benzodiazepines
(Currently/Past/NA)

Current benzo usage (Amount/Frequency):

In the past, maximum doses per day:

Age first used a benzodiazepine:

Duration of benzodiazepine use:

Last benzodiazepine use (Time/Amount):

Comments of benzo use:

Opioids
(Currently/Past/NA)

Current usage (Amount/Frequency):

Duration of opiate use:

Age first used:

In the past, maximum daily opiate doses:

Last used (Time/Amount):

Comments on opiate use:

Cocaine
(Currently/Past/NA)

Current cocaine usage (Amount/Frequency):

Duration of use:

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(Currently/Past/NA)

Weight gain
(Currently/Past/NA)

Worrying too much (
Currently/Past/NA)

Impatient
(Currently/Past/NA)

Nausea
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(Currently/Past/NA)

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(Currently/Past/NA)

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(Currently/Past/NA)

Can’t concentrate

(Currently/Past/NA)

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(Currently/Past/NA)

Talking too much
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Eating habits

Nutrition
(Standard American Diet, healthy SAD, Mediterranean, sugar free, gluten free, dairy free, food sensitivities, paleo/keto, whole/real food, vegan, vegetarian)

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(Currently/Past/NA)

Uncontrollable impulses
(Currently/Past/NA)

If yes, describe:

PAST PSYCHIATRIC HISTORY

Age at onset of first symptoms:

Number of episodes:

Number of hospitalizations:

What providers do you see for mental health? (Circle all that apply)
(Psychotherapist, Acupuncturist, Body Worker, Gynecologist, Chiropractor, Energy Worker, Other)

When was your first treatment?

Describe any suicide attempts:

Psychotherapy
(Currently/Past/NA)

Prior psychotherapy (Circle all that apply)
(talk therapy, cognitive behavioral therapy, dialectical behavioral therapy, EMDR, somatic experiencing, couples counseling, art therapy, addiction treatment, other)

Family history of mental health conditions?

Family history of suicide or suicide attempts?

MEDICATIONS

1. Medication name

Dosage:

Why prescribed:

How long did you take this medication?:

Prescriber:

Side effects:

Describe any benefits:

Are you currently taking this medication?
(Y/N)

2. Medication name

Dosage:

Why prescribed:

How long did you take this medication?

Prescriber:

Side effects:

Describe any benefits:

Are you currently taking this medication?
(Y/N)

3. Medication name

Dosage:

Why prescribed:

How long did you take this medication?

Prescriber:

Side effects:

Describe any benefits:

Are you currently taking this medication?
(Y/N)

4. Medication name

Dosage:

Why prescribed:

How long did you take this medication?

Prescriber:

Side effects:

Describe any benefits:

Are you currently taking this medication?
(Y/N)

Other medications:

SUPPLEMENTS

1. Supplement name

Dosage:

Why used:

How long did you take this supplement?

Prescriber, if prescribed:

Side effects:

Describe any benefits:

Are you currently taking this supplement?
(Y/N)

2. Supplement name

Dosage:

Why used:

How long did you take this supplement?

Prescriber, if prescribed:

Side effects:

Describe any benefits:

Are you currently taking this supplement?
(Y/N)

3. Supplement name

Dosage:

Why used:

How long did you take this supplement?

Prescriber, if prescribed:

Side effects:

Describe any benefits:

Are you currently taking this supplement?
(Y/N)

4. Supplement name

Dosage:

Why used:

How long did you take this supplement?

Prescriber, if prescribed:

Side effects:

Describe any benefits:

Are you currently taking this supplement?
(Y/N)

5. Supplement name

Dosage:

Why used:

How long did you take this supplement?

Prescriber, if prescribed:

Side effects:

Describe any benefits:

Are you currently taking this supplement?
(Y/N)

Other supplements:

DRUG AND ALCOHOL HABITS

Caffeine
(Currently/Past/NA)

Current caffeine servings per day:

In the past, maximum daily caffeine servings:

Nicotine
(Currently/Past/NA)

Current nicotine usage
(Amount/Frequency)

Method of nicotine use:

In the past, maximum daily nicotine use:

Age nicotine first used:

Duration of nicotine use:

Last nicotine use:

Comments of nicotine:

Alcohol
(Currently/Past/NA)

Current alcohol usage (Amount/Frequency):

In the past, maximum daily drinks:

Age alcohol first used:

Duration of alcohol use:

Alcohol last used (Time/Amount):

Comments on alcohol use:

Cannabis use
(Currently/Past/NA)

Current pattern and method of cannabis use:

In the past, maximum cannabis use:

Age first used:

Duration of cannabis use:

Last cannabis use (Time/Amount):

Comments of cannabis use:

Benzodiazepines
(Currently/Past/NA)

Current benzo usage (Amount/Frequency):

In the past, maximum doses per day:

Age first used a benzodiazepine:

Duration of benzodiazepine use:

Last benzodiazepine use (Time/Amount):

Comments of benzo use:

Opioids
(Currently/Past/NA)

Current usage (Amount/Frequency):

Duration of opiate use:

Age first used:

In the past, maximum daily opiate doses:

Last used (Time/Amount):

Comments on opiate use:

Cocaine
(Currently/Past/NA)

Current cocaine usage (Amount/Frequency):

Duration of use:

Age cocaine first used:

In the past, maximum cocaine use per day:

Last used cocaine (Time/Amount):

Comments on cocaine use:

Amphetamines
(Currently/Past/NA)

Current usage (Amount/ Frequency):

In the past, maximum usage per day:

Age amphetamine first used:

Last used (Time/Amount):

Duration of amphetamine use:

Comments:

Kratom
(Currently/Past/NA)

Current kratom use:

In the past, maximum Kratom use:

Age Kratom first used:

Duration of Kratom use:

Kratom last used (amount/time):

Comments on kratom use:

Psychedelics (Circle all that apply)
(psilocybin, MDMA, LSD, DMT, Ayahuasca, other psychedelics)

Age first used:

In the past, maximum frequency of use:

Current usage (Amount/Frequency):

Duration of use:

Last used (Time/ Amount):

Comments of psychedelic use:

Drug of choice:

Adverse consequences:

Ever used intravenous drugs?
(Currently/Past/NA)

Have you ever felt you should cut down on using any drug or alcohol?
(Currently/Past/NA)

Have people annoyed you by criticizing your drug use or your drinking?
(Currently/Past/NA)

Have you ever felt bad or guilty about your drug use or your drinking?
(Currently/Past/NA)

Have you ever used substances first thing in the morning to steady your nerves (eye-opener)?
(Currently/Past/NA)

Total number of 'yes' responses to 4 above questions:

Previous or Current Involvement with AA or NA?
(Y/N)

If yes, sponsor:

Substance treatment programs:

Describe any legal consequences

Pornography use
(Currently/Past/NA)

Current pornography use
(none, several times a day, daily, once a week, once a month, rare use)

In the past, maximum pronography use
(none, several times a day, daily, once a week, once a month, rare use)

Age first used:

Duration of use:

Excessive gaming or screen time?
(Currently/Past/NA)

Current gaming habits
(none, 0-3 hours a week, 3-6 hours a week, 6-9 hours a week, 10+ hours a week, rare use)

MEDICAL INFORMATION

Name of your primary care provider (PCP):

PCP contact information:

Past medical history (Circle all that apply)
(Migraine headaches, Thyroid disease, Celiac disease, heart attack, diabetes, high blood pressure, high cholesterol, stroke, cancer, asthma, stomach ulcers, arthritis, seizures, HIV, tuberculosis)

Bowel problems (Circle all that apply)
(none, food sensitivities, constipation, diarrhea, bloating, gas, IBS, ulcerative colitis, Crohn's disease, blood in stool, prior treatment for dysbiosis, candida, or parasites)

Surgical history (Circle all that apply)
(none, AP, angioplasty, appendectomy, adenoidectomy, tonsillectomy, CABG, heart valve repair, cataract surgery, cholecystectomy, colonoscopy, cAH, thyroidectomy, breast biopsy, partial mastectomy, full mastectomy, laparotomy, hemorrhoidectomy, intestinal surgery, hernia repair, D&C, BTL, cesarean section, GU-TURP, orthopedic, hip replacement surgery, below the knee amputation, septoplasty, rhinoplasty, tympanostomy, back, vasectomy, weight loss surgery, history of malignant hyperthermia, other)

Which providers do you see? (Circle all that apply)
(chiropractor, acupuncturist, allergist, massage therapist, dermatologist, cardiologist, nephrologist, Ob/Gyn, other)

Current or past major injuries
(Currently/Past/NA)

Location of any chronic pain or tension:

Chronic pain
(Currently/Past/NA)

If chronic pain, please explain:

How do you describe your sex drive?

How do you describe your sexual orientation?

LIFESTYLE

Diet
(Standard American Diet, Mediteranian, paleo/keto, vegetarian, vegan, gluten free, dairy free, soy free)

Describe any mindfulness practices:

Do you exercise regularly?
(Y/N)

If yes, list activities and frequencies:

List three interests/activities that support your body:

Describe your relationship to your body:

RELATIONSHIPS

Briefly describe and themes or patterns in your relationships:

If you are married or in a committed relationship, please list your spouse/partner's name:

How long have you been together:

How long have you known one another?

Do you live together?
(Y/N)

Describe your friendships:

How many children do you have?

Ages of your children:

Who do you live with (family, friends, roommates, partner, etc.)?

Any family history of alcoholism?
(Currently/Past/NA)

Describe family history of alcoholism:

Any family history of drug addiction
(Currently/Past/NA)

Describe family history of drug addiction:

Any family history of personality disorders?
(Currently/Past/NA)

Describe family history of personality disorders:

Does your spouse/partner… (answer all that apply)

Support your decision to pursue mental health care?
(Currently/Past/NA)

Earn an income?
(Currently/Past/NA)

If yes, how?

Abuse alcohol or drugs or have any chemical addictions?
(Currently/Past/NA)

If yes, describe:

Have a history of psychiatric treatment?
(Currently/Past/NA)

If yes, describe:

EMPLOYMENT HISTORY

Are you employed?
(Currently/Past/NA)

Present or most recent employer
(full time, part time, temporary, self employed)

Occupation:

How long have you worked in this position?

Do you enjoy what you do most of the time?:

What are your vocational goals?

EDUCATIONAL HISTORY

Highest year of education completed:

Field of study:

Are you currently enrolled in any classes?
(Currently/Past/NA)

If yes, where?

What are your educational or training goals?

CHILDHOOD HISTORY

Describe your family during the time you were growing up
(argumentative, distant, close, not close, other)

Describe your relationship with your parents/caregivers:

Were you a "planned" child?
(Y/N/ Don't know)

What do you know about your conception, intrauterine life, and birth?

Did you have siblings?
(Y/N)

Your birth order amongst your siblings:

Number of times your family moved before you turned 18:

How did this affect you?

Who was your closest connection in childhood:

Family history of mental illness (Select all that apply)
(chronic mental illness, disability, severe mental illness, suicide or suicide attempt(s), criminal history, severe trauma, other, schizoprenia, bipolar, depression, ECT treatment)

Describe any major losses and/or deaths you experienced before age 18:

Describe your feelings and impressions about your childhood:

Family of origin (Select all that apply)
(divorced, emotionally distant, characterized by neglect/abuse, impacted by losses, healthy & emotionally connected)

LOSSES AND TRAUMAS

Any history of physical abuse?
(Y/N)

History of sexual assault or rape?
(Y/N)

Any history of legal problems
(Y/N)

If yes, explain:

Any major losses after age of 18?
(Y/N)

If yes, explain:

RELIGION/SPIRITUALITY

Religious/spiritual community (past):

Religious/spiritual community (present):

If you could have a super power what would it be and why?