NEW IMAGE WELLNESS

Psychiatric or Neuropsychiatric Intake Form

Identifying Information

Name: _____ Date: _____
Address: _____City: _____State: _____ Birthplace: _____
Phone: _____ Email: _____
DOB: _____Age: _____ Height: _____ Weight: _____ Sex: _____

Your Reason for this Evaluation: _____

Current Symptoms (Check All That Apply)

☐ Anxiety	☐ Impulsivity/Risky Behavior	☐ Panic Attacks
☐ Depression	☐ Crying Spells	☐ Irritability
☐ Appetite Issues	☐ Guilt	☐ Increase/Decrease Sleep
☐ Headaches	☐ Relationship/Work problems	☐ Loss of interest
☐ Libido changes	☐ Hallucinations	☐ Confusion or Memory Loss
☐ Loss/Increase of Energy	☐ Dizziness	☐ Racing Thoughts

Current Medication & Over The Counter Products for Any Reason

Name of Medication	Dosage (mg)	How often taken	Reason for Medication

Neuropsychiatric History:

Have You Ever Experienced a Head Trauma**:** Yes: ___No: ___ If yes, please explain: _____
Any Motor Vehicle Accident(s) that resulted in personal injury: _____
Any Neurological disorder that affected you mentally: _____
Sleep Study: Yes: ___No: ___ Results**:** _____

Psychiatric History:

Psychiatric/Psychotherapeutic Treatment: Who, Type, Dates, & Reason for Treatment

_____

_____

Psychiatric In or (Out) patient Treatment(s): _____

Medical, Surgical, or Hospitalization History:

Hospitalization / Surgeries: **Medical Conditions:**

Date	Illness /Procedure	Date	Illness

Common Family Medical/Psychiatric Illnesses:

	Which Family Member(s)	Elaborate
Thyroid Disease:		
Drug/ Alcohol Abuse:		
Sudden Death:		
Suicide:		

Neuro-Psychiatric Intake Form

Heart/Lung/Stroke:		
Other:		

Developmental Information:

Raised by: Birth Parents: Yes: ____ No: ____ and/or Maternal/Paternal Grandparents: Yes: ____ No: ____
Adoptive Parents/Foster Care: Yes: ____ No: ____ Parents: Separated: Yes: ____ No: ____ when (your age): _____
Where did you grow up: _____ Age you left home: _____
If born outside US, when did you first enter the US: _____ Did you often move during your life: Yes: ___ No: ____
Childhood tragedies (loss of home, poverty, war, religious/racial/discrimination, mental/physical abuse, deaths):_____
Number of siblings: ___ Your birth order?___ Any Deceased: Yes: ___ No: ___ When: ___ Cause of death:_____

Parents	Age	How is your relationship with each?
Mother/Step-Mother		
Father/Step-Father		

Education:

Types of classes: Regular: _____Advance: ____Extra Assistance: _____Repeat any grades: ____
Suspensions (# and reason): _____Highest year completed: _____
High School Diploma: Yes: ___ When (age or date)____ GED ____ When (age or date)_____
College degree: Yes: ____ No: ____ Number of credits (yrs) _____
Vo-Tech Training/ Certifications/ College degree(s) obtained (when): _____

Martial History:

If married, Spouse's Age: _____ Spouse's Health: _____ Spouse Disabled: _____ Spouse's Work: _____
If unmarried, pattern of dating history:

Marriage(s)	Date of Marriage	Separation(s) Yr/Period	Divorce: Reason/Yr
First Marriage			
Second Marriage			
Third Marriage			

Children:

Age	Which Marriage	Education	Work; Legal Issues; Education	Marital status	Grandchildren

Military History:

U.S. Military: Yes: ___ No: ___ Other National Military Service: _____ Branch: _____
Active Combat: Yes: ___No: ___ How long: _____ Discharge Year: _____
Honorable: (If not, explain:) Yes: ___No: ___Disciplinary Action: Yes___ No: ___ Disability: Yes:___ No:___
Explain:_____

Legal History:

Criminal or Drug Conviction: Yes: ___ No: ___ DWI: Yes: ___ No: ___ Incarceration: Yes: ___ No: ___
Explain: _____

Work History:

Currently employed: _____# of hours per week: _____If not, when did you last work: _____
Have you ever been deemed permanently or totally disabled: Yes: ___No: ___ By what agency: _____
List Occupation starting with current or Last Employer:

Occupation	Employer	From	To	Reason For Leaving