PHYSICIANS' CLINIC
of Iowa, P.C.

NEW ADULT PATIENT INTAKE FORM

Today's Date _____ First Name _____ Middle Initial_____ Last Name _____

Nickname _____ Date of Birth _____ Gender: ☐ Male ☐ Female

Family Physician _____ Referring Physician _____

MEDICATIONS: List all current psychiatric medications you are taking.

Name of Medication (☐ See attached list for additional medications)	Dose	Frequency

Have you been hospitalized for psychiatric reasons? ☐ Yes ☐ No If yes, please list hospital name, dates and reason:

_____

_____

_____

_____

In your own words, please describe current problems as you see them: _____

_____

_____

How long have you felt this way? _____ What made you seek treatment at this time?_____

What do you hope to gain from evaluation and/or counseling? _____

_____

_____

How have you coped with difficulties in the past? Was it helpful? _____

_____

Have you seen a counselor, psychologist or psychiatrist or other mental health professional in the past? ☐ Yes ☐ No If yes:

Name of Mental Health Professional	Dates of Treatment	Reason for Seeking Help

Please check any symptoms or experiences you have had in the past month:

☐ Difficulty Falling Asleep
☐ Difficulty Getting Out of Bed
☐ Difficulty Staying Asleep
☐ Not Feeling Rested in the Morning
Hours of Sleep per Night: _____
☐ Persistent Loss of Interest in Activities
☐ General Withdrawal from Others
☐ Spending Increased Time Alone
☐ Feeling Numb
☐ Rapid Mood Changes
☐ Irritability
☐ Anxiety
☐ Panic Attacks
☐ Frequent Feelings of Guilt
☐ Avoiding Specific People, Places, Activities
☐ Difficulty Leaving Your Home
☐ Fear of Certain Objects or Situations
Describe: _____
☐ Repetitive Behaviors or Mental Acts
☐ Outbursts of Anger
☐ Feelings of Worthlessness, Hopelessness, Sadness or Helplessness
☐ Fear of Feeling or Acting Like a Different Person
☐ Changes in Eating or Appetite
___Eating More ___Eating Less
☐ Trying to Lose Weight
___Weight Gain (lbs) ___Weight Loss (lbs)
☐ Voluntary Vomiting
☐ Excessive Exercise to Avoid Weight Gain
☐ Use of Laxatives
☐ Binge Eating
☐ Difficulty Catching Your Breath
☐ Increased Muscle Tension
☐ Unusual Sweating
☐ Increased or Decreased Energy
☐ Easily Startled; Feeling "Jumpy"
☐ Tremor
☐ Dizziness
☐ Frequent Worry
☐ Physical Sensations Others Don't Have
☐ Racing Thoughts
☐ Intrusive Memories
☐ Difficulty Concentrating or Thinking
☐ Large Gaps in Memory
☐ Flashbacks
☐ Nightmares
☐ Thoughts of Harming Yourself or Suicide
☐ Thoughts of Harming Someone Else

Please continue to the back side ⟶

Please check any symptoms or experiences you have had in the past month:

- ☐ Feelings of Detachment, Outside Yourself
- ☐ Feeling Puzzled as to What is Real or Not Real
- ☐ Persistent, Repetitive, Intrusive Thoughts / Images
- ☐ Unusual Visual Experiences (Flashes of Light/ Shadows)
- ☐ Hear Voices when No One Else is Present
- ☐ Feeling that Your Thoughts are Controlled or Placed in Your Mind
- ☐ Feeling that Television or Radio is Communicating With You
- ☐ Difficulty Problem Solving
- ☐ Difficulty Meeting Role Expectations
- ☐ Dependency on Others
- ☐ Manipulation of Others to Fulfill Your Own Desires
- ☐ Inappropriate Expression of Anger
- ☐ Self Mutilation/Cutting
- ☐ Difficulty or Inability to Say No to Others
- ☐ Ineffective Communication
- ☐ Sense of Lack of Control
- ☐ Decreased Ability to Handle Stress
- ☐ Abusive Relationship
- ☐ Difficulty Expressing Emotions
- ☐ Concerns About Your Sexuality Sexual Orientation (optional): _____
- ☐ Other Symptoms or Experiences:

_____

_____

_____

_____

Have you attempted suicide? ☐ Yes ☐ No If yes, please describe: _____

_____

During your childhood, was there a significant period of time that you lived with anyone other than your natural parents? ☐ Yes ☐ No If yes:

Name: _____ Relationship to You: _____

Please mark the appropriate box if the following symptoms have been present in your family:

	Children	Father	Mother	Brother	Sister	Uncle/ Aunt	Grandparents
Nervousness							
Depression							
Hyperactivity							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Suicide Death							
Drinking/ Drug Problem							

Marital Status:

- ☐ Yes ☐ No Single
- ☐ Yes ☐ No Currently Married/ Partnered
- ☐ Yes ☐ No Divorced
- ☐ Yes ☐ No Widowed

Spouse/Partner Name:

_____

Occupation:

_____

- ☐ Yes ☐ No Retired
- ☐ Yes ☐ No Currently Disabled
- ☐ Yes ☐ No Working Full Time
- ☐ Yes ☐ No Working Part Time
- ☐ Yes ☐ No Unemployed
- ☐ Yes ☐ No Student

Highest grade level completed: _____ Discipline problems in school? ☐ Yes ☐ No If yes, please explain: _____

Were you considered hyperactive/ADHD in school? ☐ Yes ☐ No If yes, were/are you on any medication? ☐ Yes ☐ No What medication? _____

Did you serve in the military? ☐ Yes ☐ No If yes, describe briefly: _____

Have you been arrested? ☐ Yes ☐ No If yes, please describe: _____

Do you have a religious affiliation? ☐ Yes ☐ No What kinds of social activities do you participate in? _____

_____

Who do you turn to for help with problems?_____

Have you experienced abuse? (please circle if applicable) Verbally Emotionally Physically Sexually Neglected

Please describe briefly: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, age of first use: ____ How much do you drink? ___ drinks per week

Do you pass out from drinking? ☐ Yes ☐ No Do you ever black out from drinking? ☐ Yes ☐ No Do you have the shakes from drinking? ☐ Yes ☐ No

How frequently do you black out or have the shakes from drinking? _____

Do you feel you should cut down on your drinking? ☐ Yes ☐ No Do people annoy you by criticizing your drinking? ☐ Yes ☐ No

Do you ever feel bad or guilty about your drinking? ☐ Yes ☐ No Do you drink in the morning to steady your nerves or relieve a hang over? ☐ Yes ☐ No

Have you used drugs for non-medicinal purposes? ☐ Yes ☐ No If yes, ☐ Current ☐ Past Age at first use: _____ Approx. use in last 30 days _____

Please circle drugs used: Marijuana Cocaine Crack Heroin Methamphetamine Ecstasy Other

Any additional information you would like to share? _____

_____

_____

Patient Signature: _____ Date: _____

This form is destroyed after the information is entered and verified in the patient's electronic health record.