ORLANDO PSYCHIATRIC ASSOCIATES

ORLANDO: 2345 SAND LAKE ROAD, SUITE 200.
ORLANDO, FL 32809.
TEL: (407) 851-5121, FAX: (407) 851-0439

OCOEE: 1551 BOREN DR. UNIT B. OCOEE, FL 34761
TEL: (407) 532-4940, FAX: (407) 532-4946

Adult Intake form

(Please complete all information on this form and bring it to the first visit)

1. Patient Contact Information

Patient Name _____ Age _____ Date of Birth _____
Last First Mi

Address

_____

Best contact phone number: _____

Primary Care Physician _____ Tel _____ Fax _____

Pharmacy Name _____ City_____ Zip _____ 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 ☐ Married ☐ Separated ☐ widowed ☐ Divorced

6. **Total number of marriages?** _____ How many children do you have? _____

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

8. **Highest degree obtained:** ☐ High school graduate ☐ G.E.D ☐ 4 year college degree ☐ Masters Level ☐ None

9. **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 for employment	☐ Part-time	☐ Volunteer Part-time
☐ Unemployed, looking for employment	☐ Full-time	☐ Volunteer Full-time
☐ Full-time employed ☐ Disability ☐ Retired	☐ not a student	☐ No Volunteer Work

What is your occupation? _____

Have you ever been arrested? _____ Do you have any pending legal problems? _____

What are your strengths? _____

_____

What are your weaknesses? _____

_____

10. **What is your spouse's occupation?** _____

Are you currently seeing a therapist? (Name/contact #) _____

Have you ever seen a psychiatrist/psychotherapist before? If yes, please list: _____

What are the problems you are seeking help for? _____

_____

_____

What are your treatment goals? _____

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Are you currently having any of the following problems? (Circle all that apply)

*Depression
*Loss of interest in activities
*Feeling hopeless, worthless
*Poor energy
*Poor self-esteem
*Change in appetite
*Increased or decreased fatigue
*Poor focus
*Problems going to sleep
*Thoughts of not being alive
*Periods of euphoria or unusually good mood
*Having very high energy for no reason
*Thoughts racing
*Worrying excessively
*Having tense muscles
*So anxious that you can't rest
*Having panic attacks
*Traumatic events that come back in nightmares or flashbacks
*Feeling awkward in public
*Thoughts that replay
*Repetitive or compulsive behaviors
*Phobias or fears
*Grunts, tics, or jerks
*Inattentiveness at work or school (If so, since what age _____)
*Hyperactive or fidgety
*Talking too fast
*Hearing voices
*Seeing things
*Feeling people were trying to watch or harm you
*Concerns about alcohol/drug use
*Concerns about eating too much
*Concerns about eating too little
*Memory problems
*Getting lost easily
*Forgetting how to do tasks
*Problems finding words
*Problems caring for yourself (dressing / cooking)
*Going days without sleep
*Acting impulsively

Previous Psychiatric history: Have you ever been treated for any of the following (check all that apply)

_____ Depression _____ ADHD _____ Bipolar _____ Anxiety _____ OCD _____ Schizophrenia
_____ Panic Attacks _____ PTSD _____ Alcohol Problems (including AA) _____ Anorexia/ Bulimia
_____ Drug Problems _____ ECT treatment

Please list in chronological order all prior psychiatric hospitalizations (if any) below: None

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Please List all current medications below (include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort etc.)

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

Please list previous Psychiatric medication, if any?

Name	Dosage (mg)	Approximate Date	Response / Side effects

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Family History: Has anyone in your family ever been treated for mental illness?

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grand Parent
Depression								
Anxiety								
Panic Attacks								
Post-traumatic stress								
Bipolar/Manic depression								
Schizophrenia								
Alcohol Problems								
Drug Problems								
ADHD								
Suicide attempts								
Psychiatric hospital stay								

Medical History: Do you have, or ever had any of the following (please check all that apply)? **Please write in your medical problem in each category**

	Mark ✓		Mark ✓		Mark ✓
High Blood Pressure		Gastrointestinal Problems (ulcers, Pancreatits, irritable bowel, colitis)		Viral Illness (herpes, Epstein-Barr, chronic hepatitis)	
Lung Disease		Arthritis or Rheumatoid Problems		Cancer	
Diabetes		Liver Damage or Hepatitis		Genital Problems	
Heart Disease		Other Endocrine/Hormone Problems		Eating Disorder	
Thyroid Disease		Neurological Problems (stroke, brain tumor, nerve damage)		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		Ear/Nose/Throat Problems		Head Injury	
Other medical issues		High Cholesterol		Sleep apnea	

List all prior surgeries and hospitalizations for medical illnesses

_____
_____

_____
_____

Are you allergic to any medication or food? If so, please list below

_____
_____

Are you currently pregnant (Female)? ☐ Yes ☐ No

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List all prior surgeries and hospitalizations for medical illnesses

_____

_____

Are you allergic to any medication or food? If so, please list below

_____

Are you currently pregnant (Female)? ☐ Yes ☐ No

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 past month? _____drinks ☐ DUI ☐ DWI ☐ Public intoxication ☐ Seizures ☐ DT's

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

	Use	Last Used	Last used On this approx. date	Age peak use	HX abuse?	Current use and frequency
Cocaine						
Amphetamine Or Speed						
Marijuana						
Hallucinogens (LSD, mushrooms, Mescaline)						
Ecstasy						
Pain Pills						
PCP						
Inhalants						
Cigarettes, cigars or tobacco						
Anabolic Steroids						
Heroin						
Caffeine (coffee, Tea, cola's, iced tea)						

Any other recreational drugs: ☐ Yes ☐ No If yes, please list: _____