COMPREHENSIVE PSYCHIATRIC ASSOCIATES

INTAKE QUESTIONS - NEW PATIENTS

Patient's Name: _____Age: _____ DOB: _____ Date: _____

Contact number: _____ Email: _____

Name of your Insurance: _____

If Patient is under 18: Person calling/Relationship: _____

If parents are divorced, *Do both agree with treatment*? ____Yes _____ No **

If Divorced, is there a parenting plan in place and/or *who has custody for Medical Authority*? _____

Have you ever been seen at Signature Psychiatric Hospital? Y__ N ___ If so: When_____

What are Presenting problems:

_____ ADHD: Problems with Attention, Concentration, School grades _____

_____ Bipolar Mood Disorder: _____

_____ Depression: Hopelessness, Isolation:_____

_____ Anger Management ** _____

_____ Anxiety Other:_____

When did symptoms start? _____

_____

_____

Any *current suicidal* thoughts: Y/N *Past suicidal* thoughts: Y/N Self Harm: Y/N Current _____ or Past _____

Any past psychiatric inpatient treatment: Y/N Facility Name: _____

Substance Abuse: Y/N What Substances: _____

Last use? _____ *** Past Substance Treatment (Residential or Detox treatment): _____

_____

Current Provider: Y/N Name_____

If Changing Psychiatric Providers, Why: _____

Current / Past Psychiatrist / Therapist (Write details): _____

_____

PCP: _____ Last Seen: _____

Current Meds: _____

_____

Prescribed By: _____

Past Medical History (What medical problems were diagnosed): _____

_____

_____

Any history of Autism or Autistic Spectrum Diagnosis / Developmental Disability? ** _____

Approved: YES / NO Date: _____ Reviewed by: _____