

SOUTH COAST PSYCHIATRY

NEW PATIENT INTAKE FORM

Demographic Information:

Today's Date: _____

Full Name: _____

Date of Birth: _____ Age: _____

Preferred Name: _____

Gender: _____

Phone (Home): _____

Email Address: _____

Phone (Cell): _____

SS #: _____

Home Address: _____ State: _____ Zip Code: _____

How do you prefer we contact you? Phone Call Text Message Email
(Check all that apply)

Relationship Status: Single Married Partnered / Committed relationship Divorced Separated

Children: Yes No

If yes, how many and what ages are they? _____

Who do you live with? _____

Occupation: _____

Education: _____
(Highest level of education, Degree, Major / Specialization)

Financially Responsible Party (if different from patient): Name: _____ Relationship: _____
Phone Number: _____

How did you find out about us? _____

Personal / Primary Care Physician Name: _____

Phone: _____

Address: _____

May we contact your personal physician to discuss medical or medication issues and/or coordinate your care?
 Yes No *If yes, please complete and sign the Consent form in attached paperwork.*

Emergency Contact Information

Family and/or friends to be contacted in an emergency:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

History of Presenting Concerns

Please explain the reason(s) you are seeking mental health evaluation/treatment.

Psychiatric Review of Symptoms

Which of the following symptoms have you experienced in the past 3 months? Check all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> Low mood | <input type="checkbox"/> Physical pain | <input type="checkbox"/> Visual hallucinations |
| <input type="checkbox"/> Low motivation | <input type="checkbox"/> Worrying | <input type="checkbox"/> Urge to harm yourself |
| <input type="checkbox"/> Trouble falling asleep | <input type="checkbox"/> Anxiety/ feeling on edge | <input type="checkbox"/> Worthlessness |
| <input type="checkbox"/> Hypersexuality | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Compulsive hand washing,
cleaning, counting |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Urges to harm others |
| <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Excessive sleep | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Euphoria |
| <input type="checkbox"/> Traumatic event | <input type="checkbox"/> Auditory hallucinations | <input type="checkbox"/> Rapid mood swings |
| <input type="checkbox"/> Dissociation | <input type="checkbox"/> Thoughts of harming yourself | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Concentration problems |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Anger | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Irritability | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Intrusive thoughts | <input type="checkbox"/> Auditory hallucinations |
| <input type="checkbox"/> Lack of interest in life | <input type="checkbox"/> Ruminating | <input type="checkbox"/> Increased energy |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Feelings of guilt or shame |
| <input type="checkbox"/> Inability to enjoy things | <input type="checkbox"/> Trouble staying asleep | <input type="checkbox"/> Other (specify: |
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Social withdrawal | |

Medical Review of Symptoms

Which of the following symptoms have you experienced in the past 6 months? Check all that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Chest pain on exertion |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Bruising easily | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Increased sweating | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Difficulty staying awake during the day/ falling asleep during day |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Constipation | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Racing heart beat | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Heartburn / Indigestion |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Feeling hotter than usual |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Changes in sense of smell | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nerve pain/ Neuropathy | <input type="checkbox"/> Jaw clenching / grinding |
| <input type="checkbox"/> Urination problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Imbalance | <input type="checkbox"/> Feeling colder than usual | <input type="checkbox"/> Loss of sensation / Numbness |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Increased thirst | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Increased urination | <input type="checkbox"/> OTHER (specify): |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Skin rashes | |

Has anyone in your life noticed a change in your behavior(s) in the past 3 months?

- Yes
 No
 I don't know

Family History

Has anyone in your immediate or extended family every attempted or died by suicided? If so, please specify the relative and method.

- Yes
 No

Details:

Has anyone in your immediate or extended family ever been diagnosed with a mental health condition? If so, please specify which family members and what diagnoses.

- Yes
 No

Details:

SOUTH COAST PSYCHIATRY

Substance Use History

(Do not include prescription medications prescribed to you AND taken as prescribed)

<input type="checkbox"/> Check here if no history of any substance use						
DRUG	AGE/DATE OF FIRST USE	TYPE	ROUTE OF USE	QUANTITY / AMOUNT OF CONSUMPTION	FREQUENCY OF USE	AGE/DATE OF LAST USE
<input type="checkbox"/> ALCOHOL						
<input type="checkbox"/> TOBACCO						
<input type="checkbox"/> NICOTINE PRODUCTS						
<input type="checkbox"/> CAFFEINE						
<input type="checkbox"/> CANNABIS MARIJUANA THC						
<input type="checkbox"/> KRATOM						
<input type="checkbox"/> COCAINE						
<input type="checkbox"/> METHAMPHETAMINE						
<input type="checkbox"/> OPIOIDS / OPIATES (e.g. oxy, heroin, fentanyl)						
<input type="checkbox"/> BENZODIAZEPINES (e.g. Xanax, Klonopin)						
<input type="checkbox"/> ECSTASY / MDMA						
<input type="checkbox"/> PSYCHEDELICS (e.g. LSD, Psilocybin)						
<input type="checkbox"/> KETAMINE						
<input type="checkbox"/> SPICE / SYNTHETIC MARIJUANA						
<input type="checkbox"/> PRESCRIPTION DRUGS NOT PRESCRIBED TO YOU						

SOUTH COAST PSYCHIATRY

Past Medical History

How often do you see your primary care physician?

- Weekly Monthly Every few months Annually I don't have a primary care doctor

Have you ever been treated for any medical problem(s) or undergone any surgeries? Please check all that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Diabetes Mellitus Type I | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heavy metal poisoning |
| <input type="checkbox"/> Diabetes Mellitus Type II | <input type="checkbox"/> Autoimmune disease (e.g. Lupus, Rheumatoid arthritis) | <input type="checkbox"/> Vitamin D Deficiency |
| <input type="checkbox"/> Seizures / Epilepsy | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> B12 Deficiency |
| <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Obstructive Sleep Apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cardiac arrhythmia (e.g. atrial fibrillation) | <input type="checkbox"/> Bariatric surgery |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Chronic kidney disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Liver failure |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> OTHER (specify): |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypothyroidism | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) | |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Prostate problems | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Traumatic brain injury | |
| <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Concussion | |
| <input type="checkbox"/> Irritable bowel disease (e.g. Crohn's, UC) | <input type="checkbox"/> Dementia (e.g. Alzheimer, Lewy Body, Vascular) | |
| <input type="checkbox"/> Celiac Disease | | |

When was the last time you completed blood work / labs?

- < 1 month ago Within the last 6 months 6-12 months ago > 1 year ago

Are you allergic to any medication(s)? If yes, specify what medication(s):

SOUTH COAST PSYCHIATRY

Past Psychiatric History

When was the first time you saw a mental health professional and what was your reason for seeking mental health treatment?

When was the first time you saw a psychiatrist?

I have never seen a psychiatrist before

Name of your last / most recent psychiatrist	Dates

Have you ever been admitted to a psychiatric / mental health hospital? If so, please specify the location and dates.

Yes

No

Details:

Have you ever participated in a residential drug rehabilitation program? If so, please specify the name of the program and dates.

Yes

No

Details:

Have you ever participated in a Residential Program, Partial Hospitalization Program, or Intensive Outpatient Program? If so, please provide the names and dates of each.

Yes

No

Details:

SOUTH COAST PSYCHIATRY

Past Psychiatric History *continued*

Have you ever seen a therapist? Yes No

If so, which therapy modalities have you tried? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> I don't know | <input type="checkbox"/> Prolonged Exposure (PE) |
| <input type="checkbox"/> Cognitive Behavioral Therapy (CBT) | <input type="checkbox"/> Neurofeedback / Biofeedback |
| <input type="checkbox"/> Dialectical Behavioral Therapy (DBT) | <input type="checkbox"/> Eye Movement Desensitization and Reprocessing (EMDR) |
| <input type="checkbox"/> Psychodynamic therapy | <input type="checkbox"/> Somatic Therapy |
| <input type="checkbox"/> Psychoanalysis | <input type="checkbox"/> Psychedelic-assisted therapy |
| <input type="checkbox"/> Internal Family Systems (IFS) | <input type="checkbox"/> Ketamine-assisted therapy |
| <input type="checkbox"/> Interpersonal Therapy | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Exposure Response Prevention (ERP) | |
| <input type="checkbox"/> Cognitive Processing Therapy (CPT) | |

Are you currently seeing a therapist?
(If so, please provide details below) Yes No

Therapist name:

Date (approx.) that you started seeing this therapist:

How often you meet w/ therapist:

Have you ever attempted suicide? Yes No

If yes, please provide dates:

Have you ever intentionally harmed yourself?
(e.g. cutting, burning, hitting, biting) Yes No

If yes, please provide dates:

Have you ever struggled with an eating disorder? Yes No

Details:

SOUTH COAST PSYCHIATRY

Social History

Have you ever intentionally hurt someone?

Yes

No

Details:

Have you ever been arrested for violence?

Yes

No

Details:

Have you ever received a DUI? If so, please specify.

Yes

No

Details:

Are you employed?

Yes

No

On Medical Leave

Retired

What do you do for work?

Who would you consider your support system?

SOUTH COAST PSYCHIATRY

Social History *continued*

Have you ever been a victim of abuse and/or trauma?

Yes

No

I don't know

If yes please specify

- Mental/Emotional Abuse/Trauma
- Physical Abuse/Trauma
- Sexual Abuse/Trauma
- Catastrophy Trauma (e.g. fire, flood)
- Other Abuse/Trauma

In a few sentences, how would you describe your childhood?

PATIENT ATTESTATION

I, the undersigned, certify that the information provided in this form is true and accurate to the best of my knowledge.

I, the undersigned, provided the answers to the questions even if someone else helped me fill out the form.

PATIENT NAME	PATIENT SIGNATURE	DATE

GUARDIAN/REPRESENTATIVE SIGNATURE <i>(If applicable)</i>	RELATIONSHIP TO PATIENT	DATE