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| **Clinical Intake Form for Ages 6 and up**  **EVMS Psychiatry & Behavioral Sciences** | | | | | | | | | | | | | | MRN: | | |  | | | |
| Date: | | |  | | | |
| Time: | | |  | | | |
| **\*\*\*\*If you currently experience suicidal or homicidal thoughts, please dial 911 or go to your nearest emergency room. \*\*\*\*** | | | | | | | | | | | | | | | | | | | | |
| **Services Available**  Adult Psychiatric Care and Consults  Child (6+) and Adult Neuropsychological and Cognitive Testing  Electroconvulsive Therapy (ECT) Evaluation and Treatment  Transcranial Magnetic Stimulation (TMS) | | | | | | | | | **Services Unavailable**  Substance Abuse & Addiction Psychiatry  Child / Adolescent / Geriatric Psychiatric Care  Social Work / Case Management / Wraparound Services | | | | | | | | | | | |
| Name (First M.I. Last): | | | | | | | | | **🞎 M** | | | **🞎 F** | | **DOB:** | | | | | | |
| **Address** *(Street, Apt#)***:** | | | | | | | | | **City, State, & ZIP:** | | | | | | | | | | | |
| **Phone:** | | | | | May a message be left? 🞎 Yes 🞎 No | | | | | | | | **Email:** | | | | | | | |
| **Referred By:** | | | | | | | | | **PCP:** | | | | | | | | | | | |
| **Primary Insurance:** | | | | | | | | | **Insurance Phone & ID No.:** | | | | | | | | | | | |
| **Secondary Insurance:** | | | | | | | | | **Insurance Phone & ID No.:** | | | | | | | | | | | |
| Marital status: | | 🞎 Single | | | | 🞎 Partnered | 🞎 Married | | | | 🞎 Separated | | | | | 🞎 Divorced | | | 🞎 Widowed | |
| **Services you are seeking (Please choose only ONE):** | | | | | | | | | | | | | | | | | | | | |
| * Individual Therapy ONLY * Medication Evaluation and Management ONLY * Individual Therapy and Medication Management * Child (6+) or Adult Psychological Testing (ADHD, IQ, etc.) | | | | | | | | | * ECT * TMS * Adult ASD Evaluation (child services not available) * Evaluation only (Second opinion on Diagnosis, etc.) * One-time consultation | | | | | | | | | | | |
| Reason(s) for seeking treatment: | 🞎 Abuse/Trauma | | | 🞎 Bipolar Disorder | | | | | 🞎 Grieving | | | | | | 🞎 Psychosis | | | | | |
| 🞎 Anxiety/Panic/Stress | | | 🞎 Concussion/TBI/Seizure/Stroke | | | | | 🞎 Learning Problems | | | | | | 🞎 Relationship Issues | | | | | |
| 🞎 Attention Problems | | | 🞎 Depression | | | | | 🞎 Memory Problems or MCI | | | | | | 🞎 Stress | | | | | |
| 🞎 Behavioral Problems | | | 🞎 Eating Disorder  (height \_\_\_\_\_\_ weight \_\_\_\_\_\_) | | | | | 🞎 Neurological Problems | | | | | | 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **How long have you experienced the problems checked off above?** | | | | | | | | | | | | | | | | | | | | |
| **Is this your first time requesting treatment by a psychiatrist and/or a psychologist?** | | | | | | | | | | | | | | | | | | 🞎 Yes | | 🞎 No |
| **If no, when was the last time you were seen and who were you seen by?** | | | | | | | | | | | | | | | | | | | | |
| **Have you had any previous psychiatric hospitalizations?** | | | | | | | | 🞎 Yes | 🞎 No | If yes, when? | | | | | | | | | | |
| **Have you ever attempted suicide?** | | | | | | | | 🞎 Yes | 🞎 No | If yes, when? | | | | | | | | | | |
| **Do you drink alcohol (beer/wine/liquor)?** | | | | | | | | 🞎 Yes | 🞎 No | **How often?:** Rarely Occasionally Frequently Consistently | | | | | | | | | | |
| **Do you use recreational drugs (marijuana/cocaine/heroin)?** | | | | | | | | 🞎 Yes | 🞎 No | **How often?:** Rarely Occasionally Frequently Consistently | | | | | | | | | | |
| **Are you currently involved in any legal proceedings (lawsuits, divorce, personal injury, child custody, etc.)?** | | | | | | | | | | | | | | | | | | 🞎 Yes | | 🞎 No |
| **Do you have any pending disability claims OR do you plan to file a disability claim in the near future?** | | | | | | | | | | | | | | | | | | 🞎 Yes | | 🞎 No |
| **Any medical problems? If yes, please list the most severe:** | | | | | | | | | | | | | | | | | | 🞎 Yes | | 🞎 No |
| **Medications (Rx & OTC):** | | |  | | | | | | | | | | | | | | | | | |
| **Are you having difficulty attending work or with your day-to-day activities (ex: household chores)?** | | | | | | | | | | | | | | | | | | 🞎 Yes | | 🞎 No |
| **Do you have and/or utilize a support system (friends/family) to share your difficulties with?** | | | | | | | | | | | | | | | | | | 🞎 Yes | | 🞎 No |
| **Would you like to be fast-tracked into the Outpatient Training Clinic by a Resident or Intern?** | | | | | | | | | | | | | | | | | | 🞎 Yes | | 🞎 No |

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| Please complete the below items only if you are interested in Autism Spectrum Disorder (ASD) services. **Note that ASD services are for adults only.** | | | | | | | | | | |
| Do you have a formal diagnosis within the Autism Spectrum? | | | | | | | | 🞎 Yes | | 🞎 No |
| **If so, please provide the diagnosis.** | | | | | | | | | | |
| **Do you currently reside at a group home or residential treatment facility?** | | | | | | | | 🞎 Yes | | 🞎 No |
| **If yes, where do you currently reside?** | | | | | | | | | | |
| **How do you best communicate with others:** | | 🞎 spoken language | 🞎 sign language | | 🞎 written language | 🞎 communication device | | | 🞎 non-verbal | |
| **Do you display aggressive behaviors?** ex. throwing chairs, yelling, hitting others | | | | | | | | 🞎 Yes | | 🞎 No |
| **How difficult is an office visit for you?** | 🞎 have to leave in first 15 minutes | | | 🞎 can stay for 20-30 minutes | | | 🞎 can stay for an hour | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Office Use Only:** | | | |
| **Accepted by:** |  | **Scheduled for:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_ AM / PM |