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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 ConsultsChild (6+) and Adult Neuropsychological and Cognitive TestingElectroconvulsive Therapy (ECT) Evaluation and TreatmentTranscranial Magnetic Stimulation (TMS) | **Services Unavailable**Substance Abuse & Addiction PsychiatryChild / Adolescent / Geriatric Psychiatric CareSocial 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 |

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