EVMS
PSYCHIATRY AND
BEHAVIORAL SCIENCES

CHKD Transfer Program Clinical Intake Form

MRN: ________________________________ **Date:** ________________________________ **Time:** ______________________

******If you are currently experiencing suicidal or homicidal thoughts, please dial 911 or go to your nearest emergency room.******

SERVICES AVAILABLE

Adult Psychiatric Care and Consults
Electroconvulsive Therapy (ECT) Evaluation and Treatment
Transcranial Magnetic Stimulation (TMS)

SERVICES UNAVAILABLE

Child / Adolescent
Social Work / Case Management / Wraparound Services

Name *(First, M.I., Last)*: ____ **M** **F** **DOB:** ____________

Address *(Street, Apt. #)*: ____

____ **City, State, Zip:** _____________________________________

Phone: __________________ **Leave a message?** **Y** **N** **Email:** ____________________________________

Referred by: ______________________________________ **PCP:** ____

Primary Insurance: ____

Insurance Phone & ID No.: ____

Secondary Insurance: ____

Insurance Phone & ID No.: ____

Marital Status:	**Single**	**Partnered**	**Married**
	Separated	**Divorced**	**Windowed**

Services you are seeking (Please choose only ONE)**:**

Individual Therapy ONLY
Medication Evaluation and Management ONLY
Individual Therapy and Medication Management
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	Concussion/TBI/Seizure/ Stroke	Greiving	Psychosis
	Anxiety/Panic/Stress	Depression	Learning Problems	Relationship Issues
	Attention Problems	Eating Disorder (height______weight______)	Memory Problems or MCI	Stress
	Behavioral Problems		Neurological Problems	Other________________ ____________________
	Bipolar Disorder			

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 Occassionally Frequently Consistently

Do you use recreational drugs (marijuana/cocain/heroine)**?** **Yes** **No**

How often? Rarely Occassionally 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**

Medication (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**

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**

RETURN FAX # 757-446-5918