EVMS
PSYCHIATRY AND BEHAVIORAL SCIENCES

# Head and Neck Oncology 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/ ☐ Greiving ☐ Psychosis
☐ Anxiety/Panic/Stress ☐ Stroke ☐ Learning Problems ☐ Relationship Issues
☐ Attention Problems ☐ Depression ☐ Memory Problems or ☐ Stress
☐ Behavioral Problems ☐ Eating Disorder ☐ MCI ☐ Other_____
☐ Bipolar Disorder (height_____weight_____) ☐ Neurological Problems _____

**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**