University Psychiatric Practice Incorporated
4955 North Bailey Ave. Suite 130, Amherst New York 14226

Psychiatric Intake Form
(All information on this form is strictly confidential)

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history

Today's date _____
Source of information ◯ Self (◯ other / relationship_____
Name _____ Date of Birth _____
Age: _____ Sex: _____
Home Phone _____ May I leave messages on this phone? ◯ y ◯ n
Work Phone _____ May I leave messages on this phone? ◯ y ◯ n
Cell phone _____ E-mail _____
Street address _____
City _____ Zip code _____
Emergency Contact: _____
Phone: _____ Relationship to you: _____
Marital status: S☐ M☐ D☐ W☐ Non-married committed relationship? _____ Name all the people with whom you live and their relationship to you:

_____
_____
_____
_____

List the main problems for which you wish to be seen today:
1._____
2._____
3._____

What are your goals for the next few years?
1. _____
2. _____
3. _____

Do you have a history of mental health problems or hospitalizations? ◯ y ◯ n
If so, please complete the following:

Diagnosis Dates treated By whom

_____
_____
_____
_____

Are you currently receiving professional counseling or any kind of psychotherapy?
◯y ◯n If yes, by whom? _____

If you have ever taken the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember). **Abilify**(aripiprazole), **Adderall** (amphetamine), **Ambien** (zolpidem), **Anafranil** (clomipramine), **Ativan** (lorazepam), **Buspar** (buspirone), **Celexa** (citalopram), **Clozaril** (clozapine), **Concerta** (methylphenidate), **Cymbalta** (duloxetine), **Depakote** (valproate), **Desyrel** (trazodone), **Effexor** (venlafaxine), **Elavil** (amitriptyline), **Geodon** (ziprasidone), **Haldol** (haloperidol), **Invega** (paliperidone), **Klonopin** (clonazepam), **Lamictal** (lamotrigine), **Latuda**, **Lexapro** (escitalopram), **Lithium**, **Luvox** (fluvoxamine), **Lyrica** (pregablin), **Neurontin** (gabapentin), **Pamelor** (nortrptyline), **Paxil** (paroxetine), **Pristiq** (desvenlafaxine), **Prolixin** (fluphenazine), **Prozac** (fluoxetine), **Remeron** (mirtazapine), **Restoril** (temazepam), **Risperdal** (risperidone), **Ritalin** (methylphenidate), **Seroquel** (quetiapine), **Serzone** (nefazodone), **Strattera** (atomoxetine), **Tegretol** (carbamazepine), **Tofranil** (imipramine), **Trintellix**, **Valium** (diazepam), **Vybriid, Wellbutrin** (bupropion), **Xanax** (alprazolam), **Zoloft** (sertraline), **Zyprexa** (olanzapine)

_____
_____
_____

Allergies _____
ALL Current prescription medications and how often you take them: (if none, write none)

_____
_____

ALL Current over-the-counter medications or supplements: _____
_____

Current medical problems: _____
_____
_____

Past medical problems, hospitalizations or surgeries: _____
_____
_____
_____

Name of your primary health care provider: _____
Date and place of last physical exam: _____
Have you ever had an EKG? ◯y ◯n Date _____

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ◯ y ◯ n Are you planning to get pregnant in the near future? ◯ y ◯ n Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

Do you have a history of:

	Yes	No		Yes	No
Thyroid Disease			Epilepsy or seizures		
Anemia			Chronic pain		
Liver Disease			High Cholesterol		
Fibromyalgia			High Blood Pressure		
Chronic Fatigue			Head Trauma		
Heart Disease			Cancer		
Kidney Disease			Asthma/respiratory problems		
Diabetes			Stomach or intestinal problems		
Sexual Orientation concerns			Immunology Problems		

Do you like exciting or dangerous activities? ◯ y ◯ n
Have you had thoughts that you don't want to go on, wish you were dead, or want to kill yourself? ◯ y ◯ n
IF YES, please answer the following... If no, please skip to Family Psychiatric History.
Has anything happened recently to make you feel like this? _____
_____
On a scale of 0 to 10, how strong is your desire to kill yourself? _____
Have you ever thought about how you would kill yourself? _____
Do you have access to firearms? ◯ y ◯ n
Have you ever tried to kill or harm yourself before? _____
Is there anything that would stop you from killing yourself? _____
_____
If you could look into the future, what do you feel you could look forward to? _____
_____
Were you ever physically or sexually abused? ◯ y ◯ n If yes, what age? _____
Have you ever been violent towards anybody? ◯ y ◯ n
Have you ever been arrested? ◯ y ◯ n
Do you have any pending legal problems? ◯ y ◯ n
Have you ever been treated for alcohol or drug use or abuse? ◯ y ◯ n
If yes, for which substances? _____
If yes, where were you treated and when? _____
_____
How many alcoholic drinks do you consume each week? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? ◯ y ◯ n
Have people been concerned about your drinking or drug use? ◯ y ◯ n
Do you think you may have a problem with alcohol or drug use? ◯ y ◯ n

Check if you have ever tried the following:

	Yes	No	If yes, when did you last use?
Methamphetamine	◯	◯	_____
Cocaine	◯	◯	_____
Stimulants (pills)	◯	◯	_____
Heroin	◯	◯	_____
LSD or Hallucinogens	◯	◯	_____
Marijuana	◯	◯	_____
Pain killers (not as prescribed)	◯	◯	_____
Methadone	◯	◯	_____
Tranquilizer/sleeping pills	◯	◯	_____
Ecstasy	◯	◯	_____
Alcohol	◯	◯	_____

Other _____ _____

How many caffeinated beverages do you drink a day? _____

Cigarettes: Now? ◯ y ◯ n In the past? ◯ y ◯ n When did you quit? _____

How many per day on average? _____ For how many years? _____

Pipe, cigars, or chewing tobacco: Now? ◯ y ◯ n In the past? ◯ y ◯ n

Has anyone in your family been diagnosed with or treated for:

	Yes	No		Yes	No
Bipolar disorder	_____		Schizophrenia	_____	
Depression	_____		Post-traumatic stress	_____	
Anxiety	_____		Alcohol abuse	_____	
Anger	_____		Other substance abuse	_____	
Suicidality	_____		Violence	_____	
ADHD	_____		OCD	_____	
Insomnia	_____		Psychosis	_____	
Panic Attacks	_____		Other	_____	

If yes, who had what problems?

_____

_____

_____

_____

Has any family member been treated with a psychiatric medication? ◯ y ◯ n If yes, what medications and how effective were they?_____

_____

_____

_____

Your father's name, occupation and your relationship with him? _____

_____

Your mother's name, occupation and your relationship with her? _____
_____
Were you adopted? ◯ y ◯ n
Did your parent's divorce? ◯ y ◯ n If so, how old were you when they divorced? _____
If your parents divorced, who raised you? _____
Please list the names and ages of your siblings and describe your relationship with them
_____
_____
_____
_____
What is your significant other's occupation? _____
Describe your relationship with your spouse or significant other:
_____
_____
Have you had any prior marriages? ◯ y ◯ n
Do you have children? ◯ y ◯ n
Names/Ages: _____
_____
_____
Describe your relationship with your children: _____
_____
_____
Has anyone in your immediate family died? _____
Who and when? _____

Have you ever served in the military? ◯ y ◯ n

What is your highest educational level or degree attained? _____
Were you ever bullied? ◯ y ◯ n
Did you ever have any problems in school or with learning? ◯ y ◯ n

Are you currently: Working ◯ Y ◯ N
What is your occupation? _____
Where do you work? _____

PLEASE ADD ANY OTHER INFORMATION THAT YOU THINK IS IMPORTANT TO DISCLOSE ON A SEPARATE SHEET OF PAPER

I certify that the above information is true.

Signature and Date