Integrated Psychiatry

5444 Westheimer, Suite 1535
Houston, TX 77056

Intake Form

Today's date: ___ / ___ / _______

Last Name: ______________________ First Name: _____________________ M. I. ______

Date of Birth: _____/_____/_____ Age: _______ Gender: Male / Female

SSN: ______--______--______

Home Phone: __________________ Cell Phone: __________________ Work Phone: _______________

Address: ________________________________ City: _____________ State: _____ Zip Code: _________

Email address: ____________________________________

May we contact you through email? Yes / No May we contact you through phone? Yes / No

Marital Status: Single / Engaged / Partnership / Married / Separated / Divorced / Widowed

Emergency Contact: ___________________________ Relationship: _____________________

Emergency Contact Phone #: __________________________

How did you hear about our office? ____

Insurance Information

Primary Insurance ______________________

Insurance Prefix and ID: ________________________ Insurance Group #: _______________________

I understand that I am responsible for the balance on my account review for any professional services rendered. I have read all information on the history and certify that this information is correct to the best of my knowledge. I will notify Integrated Psychiatry and any changes in my health status or in the above information.

Patient Print: _______________________________

Patient Signature: ___________________________ Date: ___________________

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Reason for visit today:

____
____
____
____
____
____
____

Do you have any current stressors?

____
____
____
____
____

Has your sleep been affected?

____
____

Have you had any recent nightmares? ____

Has your appetite been affected?

____
____

Has your concentration been affected?

____
____

Has your energy level been affected?

____
____

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Have you had any recent suicidal thoughts? ____

-If so, when was the last time you had thoughts of suicide?

____

-If so, did it progress to a plan of how you would hurt yourself?

____

____

-If you have a plan, is it progressing to any intent to act on it?

____

Have you had any recent thoughts of harming other?

____

____

Have you had any recent hallucinations or paranoia?

____

____

Previous Psychiatric Treatment:

Have you ever been psychiatrically hospitalized? (Y/N)

-If so, where and when? ____

Are you currently in counseling or had counseling in the past? (Y/N)

-If so, with who and when? ____

Do you have any previous psychiatric diagnoses?

____

____

____

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Have you tried any prior psychiatric meds and if so what was your experience?

____
____
____
____

Have you had any prior suicide attempts? (Y/N)

-If so, when and how did they occur?

____
____
____
____

Current Medications:

____
____
____
____
____
____

Allergies:

____
____
____

Any medical diagnoses (such as diabetes, high blood pressure):

____
____
____
____
____

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Do you have any family history of psychiatric diagnoses (that run in your 1st degree relatives)?

____
____
____
____

Marital status: ______________________________

Do you have any children? ____

Do you live by yourself or with others?

____

Are you currently employed? Yes / No

If yes, what kind of work? ____

Do you find your work to be causing stress right now?

____

How often do you exercise? ____

Do you use nicotine? ____

Do you drink alcohol? Yes / No

If yes, how many drinks per week? ____

Do you use marijuana or illicit drugs? Yes / No

If yes, please specify substance and frequency of use _________________________

____

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Have you had any of the below recently? Please circle

Fever, chills, night sweats

Blurred vision, discharge or change in vision, sore throat, hearing loss or ringing of the ear

Shortness of breath

Chest pain, palpitations, loss of consciousness, or edema.

Nausea, vomiting or diarrhea, or constipation

Blood in urine, painful urination, difficulty urinating, or loss of bladder control

Muscle weakness, muscle aches, or joint pain

Rash, itching, changes in nails

Weakness or sensory deficits in extremities, tremor

Swollen glands or blood clots

Thank you for taking the time to complete this intake form. If there is anything else you think I should know, please describe below:

____

____

____

____

Blood pressure: ________________ P: ________

Height: _________ Weight: __________