Family Psychiatry of North Jersey

**Child, Adolescent & Adult Psychiatry**

**17 Arcadian Way, Paramus, NJ 07652**
**Phone: 201-977-2889 Fax: 201-977-2890**

# PSYCHIATRIC INTAKE FORM

_____
(Last Name) (First Name) (Middle Initial)

**Birth Date** _____/_____/_____ Age_____ **Gender:** □ Male □ Female

If under 18 years:

Parents □ Married □ Separated □ Divorced □ Not Married

Parent/Guardian 1 _____
(Last Name) (First Name) Relationship

_____
Phone/Cell Email

Parent/Guardian 2 _____
(Last Name) (First Name) Relationship

_____
Phone/Cell Email

School Name_____Grade _____

School Address_____

Contact (Child Study Team, Psychologist, Etc.)_____ Title _____

School Phone_____ School Fax _____

**Marital Status** □ Never Married □ Married □ Domestic Partnership □ Separated □ Divorced □ Widowed

Emergency Contact_____Phone_____Relationship_____

Please list any children/ages_____

**Mailing Address**_____
(Street and Number)

_____
(City) (State) (Zip)

**Home Phone**_____ May we leave you a message? □ Yes □ No

**Cell** _____ May we leave you a message? □ Yes □ No
May we text you? □ Yes □ No

**E-mail**_____ May we email you? □ Yes □ No
*Please note that email is not considered to be a confidential medium of communication.

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**WHO MAY WE THANK FOR YOUR REFERRAL?**

□ Doctor/Therapist _____
(Name)

□ Friend/Acquaintance _____
(Name)

□ Attorney/Other Professional _____
(Name)

□ School/Contact Name _____
(Name)

□ Google Search □ Health Grades □ Psychology Today □ ZocDoc □ Yelp □ Don't Recall □ Other_____

## HEALTH AND SOCIAL INFORMATION

Do you currently have a primary care physician? ( ) yes ( ) no When was your last physical? _____

If yes, Dr.'s Name_____ Phone _____

Address _____

Are you currently seeing more than one Medical Health Specialist? ( ) yes ( ) no

If yes, why? _____

Please list any allergies _____

Please list any persistent physical symptoms, or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc. _____

Are you currently on medication to manage a physical health concern? ( ) yes ( ) no
If yes, please list _____

Are you having any problems with your sleep habits? ( ) yes ( ) no
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep ( ) Disturbing dreams ( ) other

How many times per week do you exercise? _____ What do you do? _____

Are you having any difficulty with appetite or eating habits? ( ) yes ( ) no
If yes, ( ) Eating less ( ) Eating more ( ) Binging ( ) Restricting ( ) Purging

Have you experienced significant weight change in the last 6 months? ( ) yes ( ) no

Do you drink alcohol? ( ) yes ( ) no If yes, how much do you drink a day? _____ A week? ____

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Do you engage recreational drug use? ( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

If yes, list 1._____ 2._____ 3._____ For how long? _____

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no Type _____

Have you had suicidal thoughts recently? ( ) frequently ( ) sometimes ( ) rarely ( ) never

Do you self harm? (i.e. cutting) ( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you ever attempted suicide or tried to harm yourself? ( ) yes ( ) no When? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

_____

Are you currently in a romantic relationship? ( ) yes ( ) no If yes, how long? _____

What is the quality of your relationship? _____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

| | |
|---|---|
| Extreme depressed mood | Yes / No If yes, when? |
| Dramatic mood swings | Yes / No If yes, when? |
| Rapid speech | Yes / No If yes, when? |
| Extreme anxiety | Yes / No If yes, when? |
| Panic attacks | Yes / No If yes, when? |
| Phobias | Yes / No If yes, when? |
| Sleep disturbances | Yes / No If yes, when? |
| Hallucinations | Yes / No If yes, when? |
| Unexplained losses of time | Yes / No If yes, when? |
| Unexplained memory lapses | Yes / No If yes, when? |
| Alcohol/substance abuse | Yes / No If yes, when? |
| Frequent body complaints | Yes / No If yes, when? |
| Eating disorder | Yes / No If yes, when? |
| Body image problems | Yes / No If yes, when? |
| Repetitive thoughts (e.g. obsessions) | Yes / No If yes, when? |
| Repetitive behaviors (e.g. frequent checking, hand washing | Yes / No If yes, when? |
| Homicidal thoughts | Yes / No If yes, when? |
| Suicidal attempts | Yes / No If yes, when? |

**TREATMENT HISTORY**

Are you currently receiving psychiatric services, counseling or psychotherapy?

( ) yes currently with (therapist/practitioners name) _____

( ) no but in the past with (therapist/practitioners name) _____

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Are you currently or previously taking prescribed psychiatric medication (antidepressants or others)?
( ) yes ( ) no If yes, please list _____

Prescribed by _____Dates taken_____

**OCCUPATIONAL INFORMATION**

Are you currently employed? ( )yes ( )full-time ( )part-time ( )no

If yes, who is your currently employer/position? _____

Please list any work-related stressors, if any _____

**RELIGIOUS/SPIRITUAL INFORMATION**

Do you consider yourself to be religious? ( ) yes ( ) no

If yes, what is your faith? _____ If no, do you consider yourself to be spiritual? ( ) yes ( ) no

**FAMILY MENTAL HEALTH HISTORY**

Are you Adopted? ( ) yes ( ) no

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

| **Difficulty** | **Yes / No** | **Family member** |
|---|---|---|
| Depression | Yes / No | |
| Bipolar disorder | Yes / No | |
| Anxiety disorder | Yes / No | |
| Panic attacks | Yes / No | |
| Schizophrenia | Yes / No | |
| Alcohol/substance abuse | Yes / No | |
| Eating disorders | Yes / No | |
| Learning disabilities | Yes / No | |
| Trauma history | Yes / No | |
| Suicide attempts | Yes / No | |
| Chronic illness | Yes / No | |
| ADHD / ADD | Yes / No | |
| Anger Management | Yes / No | |

**OTHER INFORMATION**

Why are you here today? _____

_____