Summit Center Psychiatric Adult Intake Form

Name____ Date______________ Date of Birth _________

Problems are you seeking help with today:____

____

____

Current Symptoms:

☐ Depression ☐ Mood swings ☐ Anger/Irritability/Temper ☐ Thoughts of death/dying ☐ Suicidal thoughts
☐ Crying spells ☐ Loss of enjoyment/interest ☐ Loss of Motivation ☐ Hopelessness/Worthlessness
☐ Withdrawal/Avoidance ☐ Fatigue/No energy ☐ Increase energy ☐ Sleep Problems ☐ Self-injury
☐ Racing thoughts ☐ Worry ☐ Anxiety or Panic attacks ☐ Agitation ☐ Impulsivity ☐ Increase in risky behavior
☐ Suspiciousness ☐ Hearing voices ☐ Seeing things ☐ Change in libido ☐ Appetite Change ☐ Homicidal thoughts
☐ Problems with attention/concentration/focus ☐ ADHD ☐ Problems with memory ☐Gender dysphoria
☐ Other – please describe:____

____

____

Suicide Risk Assessment:

Have you had thoughts that you don't want to live? ☐No ☐Yes Do you have those thoughts now? ☐No ☐Yes
Have you ever tried to kill yourself? ☐No ☐Yes Number of times ______When was most recent attempt? ___________
Has anyone in your family died by suicide? ☐No ☐Yes Who? ____

Past Treatment History:

Have you received treatment in the past for mental health problems? ☐ No ☐ Yes

Type of treatment: ☐ Talk therapy ☐ Medications ☐ Inpatient: # times? _____ When most recent________________

Past Diagnosis, if known:____

Family Psychiatric History:

Please check if family members have (or might have) of any of the following problems

☐Depression:___________________________________ ☐Schizophrenia:_________________________________
☐Bipolar:______________________________________ ☐Addictions:____________________________________
☐Anxiety:______________________________________ ☐PTSD:____
☐ADHD/ADD:___________________________________ ☐Other:_______________________________________

Substance Use/Addiction History:

Do you use tobacco products? ☐No ☐Yes – what do you use, and how much? ______________________________
Do you have problems with alcohol, drugs orprescriptiondrugs? ☐No ☐ Yes – Describe_________________________

____

Have you been treated for problems with alcohol or drugs? ☐No ☐Yes -Describe:_______________________________

____

Summit Center Psychiatric Adult Intake Form

Name____ Date______________ Date of Birth _________

Social History:

Where did you grow up? __________________________________ **Quality of childhood** ☐Great ☐Adequate ☐Difficult

Raised by____ **# Brothers** _________**# Sisters**_________

Abuse in the home? ☐ No ☐ Yes- check all that apply: ☐ Physical ☐ Emotional ☐ Sexual ☐ Neglect

Marital Status: ☐ Single, never married ☐ Married/Partnered for_____ years ☐ Divorced ☐ Widowed

past marriages?________________ Relationship with spouse/partner: ☐ Great ☐ Adequate ☐ Difficult

Do you have children? ☐ No ☐ Yes – what are their ages:____

How far did you go in school?_____________________ How did you do in school: ______________________________

Occupation: ☐ Employed ____________________ ☐ Not working by choice ☐ Unemployed ☐ Retired ☐ Disabled

Military History: ☐ No ☐ Yes: Branch___________________ When____________ Type discharge_________________

Legal History: Have you ever been arrested ☐ No ☐ Yes: describe ____

Current legal issues? ☐ No ☐Yes: describe:____

____

____

Medical History:

Primary Care Physician: ____ **Approximate Date of last exam:**____________

How would you describe your physical health?____

Please check any of the following health conditions for which you are being treated:

☐High blood pressure ☐Diabetes ☐Liver Disease ☐Heart Disease ☐Thyroid Problem

☐Stomach/Intestinal ☐High Cholesterol ☐Seizures ☐Sleep Apnea ☐Stroke

☐Headache/Migraines ☐Seizures ☐Pain where:____

☐Asthma ☐COPD/Bronchitis ☐Cancer - type:____

Medical problems not included above: ____

Past surgeries: ____

____

____

Allergies (medications or other): ____

Current Medications: ____

____

____

Summit Center Psychiatric Adult Intake Form

Name____ Date______________ Date of Birth _________

Review of Systems:

Please check if you are having any of the following problems/symptoms:

☐ Physical pain ☐ Dizziness/Passing out ☐ Chest pain ☐ Shortness of breath ☐ Cough ☐ Night sweats

☐ Too hot or too cold ☐ Movement or balance problems ☐ Vision problems ☐ Hearing loss ☐ Taste problems

☐ Urinary problems ☐ Nausea/Vomiting ☐ Diarrhea/Constipation ☐ Bloody stools ☐ Menstrual problems

Past Medication Trials:

Check any of the following medications that you have been prescribed in the past. Please add a comment about how a medication worked for you if you remember.

Antidepressants: ☐ Prozac/fluoxetine ☐ Zoloft/sertraline ☐ Paxil/paroxetine ☐ Lexapro/escitalopram ☐ Celexa/citalopram ☐ Luvox/fluvoxamine ☐ Effexor/venlaxine ☐ Cymbalta/duloxetine ☐ Pristiq/desvenlavaxine ☐ Wellbutrin/bupropion ☐ Remeron/mirtazapine ☐ Viibryd/vilazodone ☐ Elavil/amitriptyline ☐ Pamelor/nortiptyline

Mood Stabilizer: ☐ Lithium ☐ Lamictal/lamotrigine ☐ Depakote/valproate ☐ Topamax/topiramate ☐ Tegretol/carbamazepine ☐Trileptal/oxcarbazepine

How did the medication(s) affect you?____

____

Antipsychotic/Mood stabilizer: ☐ Seroquel/quetiapine ☐ Geodon/ziprasidone ☐ Abilify/aripiprazole ☐ Latuda/lurasidone ☐ Risperdal/risperidone ☐ Invega/paliperidone ☐ Zyprexa/olanzapine ☐ Fanapt/Iloperidone ☐ Clozaril/clozapine

How did the medication(s) affect you?____

____

Sleep Aids: ☐ Trazodone ☐ Ambien/zolpidem ☐ Lunesta/eszopiclone ☐ Restoril/temazepam ☐ Sonata/zaleplon

How did the medication(s) affect you?____

____

Antianxiety Medications: ☐ BuSpar/Buspirone ☐ Vistaril/hydroxyzine ☐ Xanax/alprazolam ☐ Ativan/lorazepam ☐ Klonopin/clonazepam ☐ Valium/diazepam ☐ Tranxene/clorazepate

How did the medication(s) affect you?____

____

Treatment of ADHD/ADD: ☐Stimulant (eg,Adderall, Ritalin, Concerta,Focalin, Metadate, Daytrona, Vyvanse) ☐Strattera ☐Tenex☐Clonidine ☐Other____________________

How did the medication(s) affect you?____

____

Summit Center Psychiatric Adult Intake Form

Name____ Date______________ Date of Birth _________

	For each of the following questions indicate "Yes" or "No"	Yes	No
1	Do you feel you are a normal drinker ("normal"- drink as much or less than most people)		
2	Have you ever awakened in the morning after drinking the night before and found you couldn't remember a part of the evening?		
3	Does any near relative or close friend ever worry or complain about your drinking?		
4	Can you stop drinking without difficulty after one or two drinks?		
5	Do you ever feel guilty about your drinking?		
6	Have you ever attended an Alcoholics Anonymous (AA) meeting?		
7	Have you ever gotten into physical fights when drinking?		
8	Has drinking ever caused problems between you and a near relative or close friend?		
9	Has any family member or close friend gone to anyone for help about your drinking?		
10	Have you ever lost friends because of your drinking?		
11	Have you ever gotten into trouble at work because of your drinking?		
12	Have you ever lost a job because of drinking?		
13	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
14	Do you drink before noon fairly often?		
15	Have you ever been told you have liver trouble such as cirrhosis?		
16	After heavy drinking have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations?		
17	Have you ever gone to anyone for help with your drinking?		
18	Have you ever been hospitalized because of drinking?		
19	Has your drinking ever resulted in your being hospitalized on a psychiatric ward?		
20	Have you ever gone to any doctor, social worker, clergy, or mental health clinic for help with any emotional problems in which drinking was a part of the problem?		
21	Have you ever been arrested more than once for drinking under the influence of alcohol?		
22	Have you ever been arrested, even for a few hours, because of other behavior while drinking?		

Summit Center Psychiatric Adult Intake Form

Name____ Date______________ Date of Birth _________

At what age did you have your first drink?________ At what age did you first try a drug?________

Please complete the following for each drug you have used: if not applicable, please skip this page.

	Age of 1st Use	When was Your Last Use	Type of Use (eg, heavy, recreational)
Alcohol			
Cocaine			
Methamphetamine			
Other Amphetamines (eg, Ritalin)			
Bath Salts			
Hallucinogens (eg, LSD, Mushrooms, PCP, salvia, ketamine)			
Heroin			
Prescription Pain Pills			
Benzodiazepines (Xanax, Valium, Klonopin, etc)			
Other Prescription Medications			
Inhalants			
Cold Medicines			
Marijuana			
K2/Spice ("Synthetic Marijuana")			
MDMA (Ecstasy/Molly)			
Other Club Drugs			
Steroids (Anabolic)			
Other:			

3033 W. Jefferson St.
Suite 107
Joliet, IL 60435
Telephone: 815-773-0772
Fax: 815-773-0771

1801 North Mill Street
Suite J
Naperville, IL 60563
Telephone: 800-786-3033
Fax: 630-357-3093

Credit Card Authorization

For internal use only.

I, _______________________________________, authorize The Summit Center to keep my signature on file and to charge my credit card listed below for:

All patient balances (less than $250) for services rendered once the claim has been processed by my insurance company. I understand that The Summit Center will contact me by telephone for all patient balances exceeding $250 prior to charging my card.

Recurring charges for services rendered for the following family members:

Patient Name: ____ DOB: __________________
Patient Name: ____ DOB: __________________
Patient Name: ____ DOB: __________________
Patient Name: ____ DOB: __________________

Check One: Visa ______ Master Card _______ Discover _______

Billing Address:____
City: ____ State: __________ Zip: ____________________

Credit Card Number: _______________________________________ Expiration Date: ________________
CVV: ___________________________ (3 numbers on the back of the card)

Cardholder Signature: ____ Date: __________________
Cardholder preferred contact number: ____

I have the right to terminate this authorization at any time and agree to do so by contacting The Summit Center at (815)773-0772.