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
□Hearing Voices	□Loss of Motivation	□Hopelessness	□Withdrawal/Avoidance	□Fatigue □Increase energy	□Sleep Problems
□Self-injury	□ Racing thoughts	□Anxiety or Panic attacks	□Suicidal Thoughts	□Hearing voices	□Agitation
□Impulsivity	□Suspiciousness	□Increase in risky behavior	□Change in libido	□Appetite Change	□Seeing Things
□ADHD	□Problems with attention/concentration/focus		□Gender Disphoria	□Problems with memory	□Worry

□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 and indicate relationship/self

□Depression:_____ □Bipolar:_____
□Anxiety:_____ □ADHD/ADD:_____
□Schizophrenia:_____ □Addictions:_____
□PTSD:_____ □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 or prescription drugs? □No □Yes – Describe_____
_____
Have you been treated for problems with alcohol or drugs? □No □Yes -Describe:_____
_____

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:_____
_____
_____

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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: _____

_____

_____

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/cold □Movement/balance issues □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 comment about how a medication worked for you.

Antidepressants: □Prozac/fluoxetine □ Cymbalta/duloxetine □Pristiq/desvenlavaxine □ Lexapro/escitalopram
□Celexa/citalopram □Luvox/fluvoxamine □ Effexor/venlaxine □ Wellbutrin/bupropion □ Paxil/paroxetine
□Zoloft/sertraline □Remeron/mirtazapine □Viibryd/vilazodone □ Elavil/amitriptyline □Pamelor/nortiptyline
How did the medication(s) affect you?_____

Mood Stabilizer: □Tegretol/carbamazepine □Lamictal/lamotrigine □Depakote/valproate □Topamax/topiramate
□Lithium □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: □Sonata/zaleplon □Lunesta/eszopiclone □Restoril/temazepam □Trazodone□Ambien/zolpidem
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?_____

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?		

	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:			

the Summit Center

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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 SCMH will charge my card for any outstanding balances at the end of each month, when the monthly billing cycle is completed. I understand that SCMH will contact me by telephone for all patient balances exceeding $250 prior to charging my card. I also understand that there will be a 3% charge on any credit card transactions.

**Cards will be run on the last weekday of the month. If you prefer to pay by check or cash, we will notate your account. If payment is not received by the next billing cycle, your card will be automatically run.

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 _____
(Sorry, we do not accept American Express)

Billing Address:_____City: _____ State: _____ Zip: _____

Credit Card Number: _____ Expiration Date: _____ CVV: _____ (on back)

XCardholder Signature: _____ Date: _____ Cardholder contact number: _____