

# Summit Center Psychiatric Adult Intake Form

**X** 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     Helplessness     Loss of Motivation     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/desvenlaxine     Lexapro/escitalopram  
 Celexa/citalopram     Luvox/fluvoxamine     Effexor/venlaxine     Wellbutrin/bupropion     Paxil/paroxetine  
 Zoloft/sertraline     Remeron/mirtazapine     Viibryd/vilazodone     Elavil/ amitriptyline     Pamelor/nortriptyline

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 1 <sup>st</sup> 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 for services rendered once the claim has been processed by my insurance company. I understand that SCMHC will charge my card for any outstanding balances, including late cancellation and no-show fees when assigned, without additional authorization. I also understand that there will be a 3% charge on any credit card transactions.

I certify that the below information is true and accurate and that I am an authorized user on the credit/debit card below.

Recurring charges for services rendered for the following family members:

Patient Name: _____	DOB: _____

\*\*We do not accept American Express

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

✗ Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Cardholder contact number: \_\_\_\_\_