

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 PHONE: \_\_\_\_\_  Cell  Home  Work  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 What Pharmacy do you Use? \_\_\_\_\_ Street/City \_\_\_\_\_  
 Who is your Primary Care Physician? \_\_\_\_\_

Are you involved in an investigation or legal case currently?  Yes  No

Type of Suit:

- Divorce  Worker's Comp  Child Custody  Professional Board  
 Department of Family/Children Services  Motor Vehicle  Other \_\_\_\_\_

Name of Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_  
 .....

**CONSENT FOR COMMUNICATIONS**

You have the right to request that we restrict how protected health information about you is used or disclosed. Most patients have family members and friends that occasionally become involved in their care. (For example, your spouse calls to confirm your appointment time; OR your adult child calls with questions about your medications.) Please list any restrictions to the information you have regarding how we can communicate with those you have listed below. (Example: Appointments only, financial matters only; Medications Only, etc. If there are no restrictions, please list "NONE" beside their name

Please list below any persons you will allow us to talk with about you. (If you prefer we do not speak with anyone, please write "NO ONE" across this section.

Name	Relationship to you	Phone Number	Restrictions (See instructions below)

How would you like us to communicate with you?

- Cell Phone # \_\_\_\_\_ Okay to leave voicemail?  Yes  No  
 Home Phone # \_\_\_\_\_ Okay to leave message on answering machine?  Yes  No  
 Mail (Address \_\_\_\_\_ )  
 Email \_\_\_\_\_@\_\_\_\_\_

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the manner listed above and authorize Valdosta Psychiatric Associates staff to disclose information only to those individuals listed above and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information and/or Psychotherapy Information.

\_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Patient/Legal Guardian (Minors 12-17 must sign) Witness:

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### INTAKE QUESTIONNAIRE

#### Medical History (check all that apply)

<input type="checkbox"/> Allergies/Seasonal	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Back Pain (Chronic)	<input type="checkbox"/> BPH
<input type="checkbox"/> Cancer (type) _____	<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II
<input type="checkbox"/> Disc Disease <input type="checkbox"/> Lumbar <input type="checkbox"/> Cervical	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> GERD / Gastritis
<input type="checkbox"/> Gout	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> HIV	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hypotension
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Lupus	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Obesity
<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Stroke/TIA (History of)	<input type="checkbox"/> Testosterone (Low)
<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/>	<input type="checkbox"/> No Medical Problems

Other Illnesses not listed above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

#### Surgical History

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Back <input type="checkbox"/> Lumbar <input type="checkbox"/> Cervical	<input type="checkbox"/> Bariatric Surgery	<input type="checkbox"/> Brain
<input type="checkbox"/> Cardiac Valve	<input type="checkbox"/> Cardiac Bypass	<input type="checkbox"/> Ear/Nose/Throat	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Gastric Bypass	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Hip Replacement	<input type="checkbox"/> Hysterectomy (Partial)
<input type="checkbox"/> Hysterectomy (Total)	<input type="checkbox"/> Kidney Stones Removed	<input type="checkbox"/> Kidney Removed	<input type="checkbox"/> Knee Replacement
<input type="checkbox"/> Prostate	<input type="checkbox"/> Rotator Cuff	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Surgeries not listed above: \_\_\_\_\_

#### Medications

Please list all medications you take daily including dosages and how often:


#### Allergies

Please list any drug or non-drug allergies you have:


Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Habits**

Do you smoke cigarettes currently?  Yes  No

How much per day? \_\_\_\_\_

Have you smoked in the past?  Yes  No

Do you use Oral Tobacco?  Yes  No

Do you Drink Alcohol?  Yes  No

How much per week? \_\_\_\_\_

**Please check all stressors you are experiencing currently**

<input type="checkbox"/> Economic/Financial	<input type="checkbox"/> Education/School	<input type="checkbox"/> Family Conflict	<input type="checkbox"/> Grief/Loss
<input type="checkbox"/> Legal Problems	<input type="checkbox"/> Medical Illness	<input type="checkbox"/> Work	<input type="checkbox"/> Living Situation
<input type="checkbox"/> Social Environment	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Marital Conflict	<input type="checkbox"/> Family Disruption due to divorce or separation
<input type="checkbox"/> Personal Injury	<input type="checkbox"/> Relationship		

**Please give a brief description of the reason you are here today:** \_\_\_\_\_

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**Please check any symptoms you are now experiencing**

- Anxiety
- Anger
- Appetite Disturbance
- Behavior Problems
- Decreased Concentration
- Decreased Energy
- Decreased Pleasure and Interest in things
- Depressed Mood
- Feelings of hopelessness, helplessness or worthlessness
- General Stress
- Grief/Loss
- Uncontrolled Fear or Phobia
- Unexplained or chronic pain
- Thoughts of hurting someone else
- Hallucinations (hearing voices, seeing things)
- Falling Asleep during the daytime
- Impulsiveness
- Insomnia (trouble fall sleep or staying asleep)
- Irritability
- Isolating (staying away from others)
- Mania (unusually hyperactive, talkative)
- Memory Impairment
- Nightmares
- Panic Attacks
- Sexual Dysfunction
- Thoughts of hurting myself
- Rapid weight loss or weight gain

**Please list any other symptoms not listed above:**

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Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Past Psychiatric History**

Have you ever been treated by a psychiatrist or counselor in the past?  Yes  No

**Out Patient Treatment**

Provider:	Dates of Treatment:
Provider:	Dates of Treatment:
Provider:	Dates of Treatment:

What were you being treated for? \_\_\_\_\_

**Inpatient Treatment**

Facility Name:	Type of Admission	Date/Year
<input type="checkbox"/>	<input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary	
<input type="checkbox"/>	<input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary	
<input type="checkbox"/>	<input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary	

**Reason for Admission:**

<input type="checkbox"/> Depression	<input type="checkbox"/> Drug/Alcohol	<input type="checkbox"/> Manic Episode	<input type="checkbox"/> Psychotic Episode
<input type="checkbox"/> Severe Anxiety	<input type="checkbox"/> Suicidal Ideations	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Violence/Assaultive Behaviors

**Family History**

Has anyone in your family ever been treated for psychiatric condition or Substance Abuse?  Yes  No

Family History is unavailable

Family Member	Type of problem
<input type="checkbox"/> Mother	
<input type="checkbox"/> Father	
<input type="checkbox"/> Spouse	
<input type="checkbox"/> Brother	
<input type="checkbox"/> Sister	
<input type="checkbox"/> Son	
<input type="checkbox"/> Daughter	
<input type="checkbox"/> Maternal Grandmother	
<input type="checkbox"/> Maternal Grandfather	
<input type="checkbox"/> Paternal Grandmother	
<input type="checkbox"/> Paternal Grandfather	
<input type="checkbox"/> Aunt	
<input type="checkbox"/> Uncle	
<input type="checkbox"/> Other?	

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Father:  Living  Deceased (Age \_\_\_\_\_)

Brief Description of your Father: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mother:  Living  Deceased (Age \_\_\_\_\_)

Brief Description of your Mother: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Siblings:  # Living \_\_\_\_\_  # Deceased \_\_\_\_\_

If you were not raised by your biological parents, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your cultural background: (Hispanic, Italian, German, Irish, etc) \_\_\_\_\_

**Substance Abuse History**

Do you have a history of Substance Abuse?  Yes  No

Type of substance Used	Quantity Used	Frequency of Use

Have you experienced any of the following as a result of your drug or alcohol use?

<input type="checkbox"/> Arrests	<input type="checkbox"/> Consuming more than intended	<input type="checkbox"/> Blackouts	<input type="checkbox"/> DUI
<input type="checkbox"/> Employment Issues	<input type="checkbox"/> Family/Marital Conflict	<input type="checkbox"/> Feeling guilty	<input type="checkbox"/> Financial problems
<input type="checkbox"/> Fighting	<input type="checkbox"/> Health Problems	<input type="checkbox"/> Increased Tolerance	<input type="checkbox"/> Increased tolerance
<input type="checkbox"/> Unintentional Overdose	<input type="checkbox"/> Physical Health Problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Withdrawal Symptoms

List any other consequences not listed above: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Education History**

<input type="checkbox"/> Currently in school – Grade _____	<input type="checkbox"/> Less than a high school education	<input type="checkbox"/> Graduated from high school
<input type="checkbox"/> GED Obtained	<b>HIGHEST GRADE COMPLETED?</b> _____	<input type="checkbox"/> Associates Degree
<input type="checkbox"/> College Degree	<input type="checkbox"/> Some College	<input type="checkbox"/> Professional Degree
<input type="checkbox"/> Technical Degree	<input type="checkbox"/> Master’s Degree	

**Employment History**

**Employment Status:**

Full-time     Part-time     Unemployed     Retired     Disabled     Homemaker

Name of Employer: \_\_\_\_\_ How long at your current job? \_\_\_\_\_

Occupation: \_\_\_\_\_

**Military Service History:**

<input type="checkbox"/> Never been in the military	<input type="checkbox"/> Active Duty Military	<input type="checkbox"/> Parent is active duty military
<input type="checkbox"/> Spouse is Active Duty military	<input type="checkbox"/> Retired from the military	<input type="checkbox"/> Honorably discharged from military
<input type="checkbox"/> Veteran	<input type="checkbox"/> Medically discharged from military	<input type="checkbox"/> Dishonorable discharge

**Branch of Service:**

<input type="checkbox"/> Air Force	<input type="checkbox"/> Army	<input type="checkbox"/> Marines	<input type="checkbox"/> Navy
<input type="checkbox"/> National Guard	<input type="checkbox"/> Reserves	<input type="checkbox"/> Coast Guard	

**General Social History:**

**Marital Status:**

<input type="checkbox"/> Single/Never married	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Partnership/Serious Relationship

**Current level of satisfaction in the relationship is**

<input type="checkbox"/> not applicable.	<input type="checkbox"/> very Satisfied.	<input type="checkbox"/> somewhat satisfied.	<input type="checkbox"/> dissatisfied.
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Number of Marriages \_\_\_\_\_

Number of Children: \_\_\_\_\_

**List the Names and Ages of Children**


Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Residential Status:**

<input type="checkbox"/> Own A home	<input type="checkbox"/> Rent	<input type="checkbox"/> Live w/parents	<input type="checkbox"/> Foster Care
<input type="checkbox"/> Homeless	<input type="checkbox"/> Nursing Home Facility	<input type="checkbox"/> Live w/roommate(s)	

Housing Conditions are:

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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List the members of your current household:


**Social Supportive Network:**

<input type="checkbox"/> Supportive Family	<input type="checkbox"/> Friends	<input type="checkbox"/> Religious Congregation	<input type="checkbox"/> Co-workers
<input type="checkbox"/> Internet-based	<input type="checkbox"/> Social Services	<input type="checkbox"/> Sponsor	<input type="checkbox"/>

**Cultural:**

<input type="checkbox"/> Caucasian	<input type="checkbox"/> African-American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian
<input type="checkbox"/> Native American	<input type="checkbox"/> Bi-Racial	<input type="checkbox"/> Indian	<input type="checkbox"/>

**Sexual Orientation:**

<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Homosexual	<input type="checkbox"/> Bi-Sexual	<input type="checkbox"/> Transgendered
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**Religion**

<input type="checkbox"/> Denomination:	<input type="checkbox"/> Participate in religious activities	<input type="checkbox"/> Do not participate in religious activities
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