

BRIEF PSYCHIATRIC INTAKE

Date: ___ Therapist: ___

Client: ___ DOB: ___ Age: ___

Phone: ___ Email: ___

Emergency Contact: ___ Phone: ___

Insurance: ___ Referring Provider: ___

CHIEF COMPLAINT

"In your own words, what brings you here today?"

CURRENT SYMPTOMS (Check all that apply)

Depression Anxiety Panic Sleep issues Appetite changes Concentration
 Memory Mood swings Irritability Anger Suicidal thoughts Self-harm Substance use Trauma symptoms Relationship issues Work/school problems Other: _____

Severity (1-10): _ Duration: _____

MENTAL STATUS

Appearance: Appropriate Disheveled Other: ___ **Mood:** ___ **Affect:** ___
Speech: Normal Rapid Slow Other: ___ **Thought Process:** Linear Tangential Other: _____ **Orientation:** x3 x2 x1 **Memory:** Intact Impaired **Insight:** Good Fair Poor **Judgment:** Good Poor

SAFETY ASSESSMENT

Suicidal Ideation: None Passive Active With plan **Details:** _____ **Risk Level:** Low Moderate High **Protective Factors:** _____

PSYCHIATRIC HISTORY

Previous Treatment: None Therapy Medication Hospitalization **Current Medications:** _____ **Family History:** Depression Bipolar Anxiety Substance use Suicide Other: _____

SUBSTANCE USE

Alcohol: None Social Regular Daily Amount: __ **Drugs:** None Cannabis Other: _____ **Tobacco:** None Cigarettes Vaping Amount: __

SOCIAL SUPPORT

Relationship Status: Single Partnered Married Divorced **Living Situation:** Alone Family Partner Other: _____ **Employment:** Full-time Part-time Unemployed Student **Support System:** Strong Moderate Limited None

TREATMENT GOALS

Client's Goals: 1. _____ 2. _____ 3. _____

CLINICAL IMPRESSIONS

Primary Concern: _____ **Recommended Treatment:** Weekly therapy Bi-weekly Monthly Psychiatric referral Medical referral Other: __

Next Appointment: _____

Therapist Signature: _____ **Date:** _____

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