PSYCHIATRIC INTAKE EVALUATION

Client Name: _____ Date: ___

DOB: ___ Age: *Gender: _ Pronouns:* ____

Phone: ____ *Email:* _____

Emergency Contact: ____ *Relationship:* __

Emergency Phone: ____ *Address:* _____

Insurance: ____ *ID#:* _____

Referring Provider: ____ *Primary Care:* __

PRESENTING PROBLEM

Chief Complaint (in client's own words):

Current Symptoms: ☐ Depression/Low mood ☐ Anxiety/Worry ☐ Panic attacks ☐ Sleep problems ☐ Appetite changes ☐ Concentration issues ☐ Memory problems ☐ Mood swings ☐ Irritability ☐ Anger outbursts ☐ Suicidal thoughts ☐ Self-harm behaviors ☐ Substance use ☐ Relationship problems ☐ Work/school issues ☐ Trauma symptoms ☐ Obsessive thoughts ☐ Compulsive behaviors ☐ Hallucinations ☐ Delusions ☐ Other: _____

Onset and Duration: When did symptoms begin? _____ What was happening in your life at that time? _____

Severity (1-10 scale): Current: **_ Worst:** ***Best in past month:*** __

Functional Impairment: How are symptoms affecting: - Work/School: _____ **-** ***Relationships:*** _____ - Daily activities: _____ **- Sleep:** _____ - Appetite:

_____

MENTAL STATUS EXAMINATION

Appearance: ☐ Well-groomed ☐ Disheveled ☐ Appropriate dress ☐ Poor hygiene ☐ Unusual appearance: _____

Behavior: ☐ Cooperative ☐ Guarded ☐ Agitated ☐ Restless ☐ Withdrawn ☐ Hyperactive ☐ Psychomotor retardation ☐ Tremor ☐ Tics ☐ Other: ____

Speech: ☐ Normal rate ☐ Rapid ☐ Slow ☐ Loud ☐ Soft ☐ Pressured ☐ Monotone ☐ Slurred ☐ Other: _____

Mood: _____

Affect: ☐ Euthymic ☐ Depressed ☐ Anxious ☐ Irritable ☐ Euphoric ☐ Labile ☐ Flat ☐ Blunted ☐ Inappropriate ☐ Congruent ☐ Incongruent

Thought Process: ☐ Linear ☐ Tangential ☐ Circumstantial ☐ Flight of ideas ☐ Loose associations ☐ Thought blocking ☐ Perseveration ☐ Other: _____

Thought Content: ☐ Obsessions ☐ Compulsions ☐ Phobias ☐ Delusions ☐ Ideas of reference ☐ Paranoid ideation ☐ Grandiosity ☐ Other: _____

Perceptual Disturbances: ☐ Auditory hallucinations ☐ Visual hallucinations ☐ Tactile ☐ Olfactory ☐ Gustatory ☐ Illusions ☐ Depersonalization ☐ Derealization Details: _____

Cognitive Function: ☐ Alert ☐ Oriented x3 ☐ Oriented x2 ☐ Oriented x1 ☐ Disoriented ☐ Intact memory ☐ Memory impairment ☐ Concentration intact ☐ Concentration impaired ☐ Abstract thinking intact ☐ Concrete thinking ☐ Poor judgment ☐ Good judgment

Insight: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Absent Comments: _____

Motivation for Treatment: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Ambivalent Comments: _____

SUICIDE/HOMICIDE RISK ASSESSMENT

Suicidal Ideation: ☐ None ☐ Passive ("wish I were dead") ☐ Active without plan ☐ Active with plan

If present: Frequency: _____ **Intensity:** _____ ***Duration:*** _____ ***Plan details:*** _____ Means available: _____ Intent to act: _____

Protective Factors: ☐ Family support ☐ Religious beliefs ☐ Future goals ☐ Pets/dependents ☐ Fear of death ☐ Treatment engagement ☐ Other: ____

Risk Factors: ☐ Previous attempts ☐ Family history of suicide ☐ Substance use ☐ Isolation ☐ Hopelessness ☐ Impulsivity ☐ Chronic illness ☐ Recent loss ☐ Access to means

Previous Suicide Attempts: Date: ___ Method: __ ***Medical treatment needed: ☐ Yes ☐ No Details:*** _____

Homicidal Ideation: ☐ None ☐ Present without plan ☐ Present with plan Target: _____ Plan: _____

Overall Risk Level: ☐ Low ☐ Moderate ☐ High ☐ Imminent

Safety Plan Needed: ☐ Yes ☐ No

PSYCHIATRIC HISTORY

Previous Mental Health Treatment: ☐ None ☐ Outpatient therapy ☐ Psychiatric medication ☐ Hospitalization ☐ Partial hospitalization ☐ Intensive outpatient ☐ Residential treatment

Previous Therapists/Psychiatrists: Name: ____ ***Dates: _ Helpful: ☐ Yes ☐ No Name:*** ____ Dates: ___ **Helpful: ☐ Yes ☐ No Name:** _____ Dates: _____ Helpful: ☐ Yes ☐ No

Previous Psychiatric Hospitalizations: Date: _ **Hospital:** __ ***Reason:*** ___ ***Date:*** __ **Hospital:** __ ***Reason:*** _____

Previous Diagnoses: ☐ Major Depression ☐ Bipolar Disorder ☐ Anxiety Disorders ☐ PTSD ☐ ADHD ☐ Eating Disorder ☐ Substance Use Disorder ☐ Personality Disorder ☐ Psychotic Disorder ☐ Other: _____

Family Psychiatric History: ☐ Depression ☐ Bipolar ☐ Anxiety ☐ Schizophrenia ☐ Substance abuse ☐ Suicide ☐ Other: _____ Relationship to client: _____

CURRENT MEDICATIONS

Psychiatric Medications:

Medication	Dose	Frequency	Prescriber	Start Date	Helpful?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Medical Medications:

Allergies/Adverse Reactions:

Medication Compliance: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Barriers to compliance: _____

SUBSTANCE USE HISTORY

Current Use:

Alcohol: ☐ None ☐ Occasional ☐ Regular ☐ Daily Amount: __ ***Last use:*** _____

Tobacco: ☐ None ☐ Cigarettes ☐ Vaping ☐ Chewing tobacco Amount: __ ***Last use:*** _____

Cannabis: ☐ None ☐ Occasional ☐ Regular ☐ Daily Amount: __ ***Last use:*** _____

Other Substances: ☐ Cocaine ☐ Methamphetamine ☐ Heroin ☐ Prescription drugs (non-prescribed) ☐ Other: _____ *Details:* _____

Substance Use Impact: ☐ No problems ☐ Mild problems ☐ Moderate problems ☐ Severe problems Areas affected: _____

Previous Treatment: ☐ None ☐ AA/NA ☐ Outpatient ☐ Inpatient ☐ Detox Details: _____

Family History of Substance Use: ☐ None ☐ Alcohol ☐ Drugs ☐ Both Relationship: _____

MEDICAL HISTORY

Current Medical Problems: ☐ Diabetes ☐ Hypertension ☐ Heart disease ☐ Thyroid disorder ☐ Seizures ☐ Head injury ☐ Chronic pain ☐ Sleep apnea ☐ Autoimmune disorder ☐ Other: _____

Recent Medical Changes:

Hospitalizations/Surgeries: Date: _ **Reason:** _____ ***Date:*** _____ Reason: _____

Primary Care Provider: _____

Last Physical Exam: _____

Pregnancy/Reproductive Health: ☐ N/A ☐ Currently pregnant ☐ Trying to conceive ☐ Postpartum ☐ Menstrual irregularities ☐ Menopause ☐ Hormonal changes

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TRAUMA HISTORY

Childhood Trauma: ☐ Physical abuse ☐ Sexual abuse ☐ Emotional abuse ☐ Neglect ☐ Witnessing violence ☐ Medical trauma ☐ Natural disaster ☐ Other: _____

Adult Trauma: ☐ Physical assault ☐ Sexual assault ☐ Domestic violence ☐ Combat exposure ☐ Serious accident ☐ Medical trauma ☐ Death of loved one ☐ Natural disaster ☐ Other: _____

Trauma Symptoms: ☐ Flashbacks ☐ Nightmares ☐ Avoidance ☐ Hypervigilance ☐ Emotional numbing ☐ Intrusive thoughts ☐ Dissociation ☐ Sleep problems ☐ Concentration problems

Previous Trauma Treatment: ☐ None ☐ EMDR ☐ Trauma-focused therapy ☐ Other: _____

SOCIAL HISTORY

Relationship Status: ☐ Single ☐ Dating ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic partnership

Relationship Quality: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Abusive Support from partner: ☐ High ☐ Moderate ☐ Low ☐ None

Children: ☐ None ☐ Number: _ **Ages: _____** ***Custody issues: ☐ None ☐ Present Details: _____***

Living Situation: ☐ Alone ☐ With family ☐ With roommates ☐ With partner ☐ Group home ☐ Homeless ☐ Other: _____ Housing stability: ☐ Stable ☐ Unstable

Employment: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student Occupation: _____ Job satisfaction: ☐ High ☐ Moderate ☐ Low Work stress: ☐ High ☐ Moderate ☐ Low

Financial Status: ☐ Stable ☐ Some concerns ☐ Significant stress ☐ Crisis

Education: ☐ Less than high school ☐ High school ☐ Some college ☐ College degree ☐ Graduate degree ☐ Trade school

Social Support: ☐ Strong ☐ Moderate ☐ Limited ☐ Isolated Sources: _____

Legal Issues: ☐ None ☐ Current charges ☐ Probation ☐ Past convictions Details: _____

Cultural/Religious Background:

Importance in life: ☐ Very important ☐ Somewhat important ☐ Not important

DEVELOPMENTAL HISTORY

Birth/Early Development: ☐ Normal pregnancy/delivery ☐ Complications ☐ Developmental delays ☐ Early behavioral problems Details: _____

School History: ☐ Good student ☐ Average ☐ Struggled academically ☐ Behavioral problems ☐ Special education ☐ Learning disabilities ☐ ADHD diagnosis Details: _____

Childhood Relationships: ☐ Good family relationships ☐ Family conflict ☐ Good peer relationships ☐ Social difficulties ☐ Bullying (victim/perpetrator) Details: _____

MENTAL HEALTH SCREENING

Depression Screening (PHQ-9): Over the past 2 weeks, how often have you been bothered by:

Symptom	Not at all (0)	Several days (1)	More than half (2)	Nearly every day (3)
Little interest or pleasure	☐	☐	☐	☐
Feeling down, depressed	☐	☐	☐	☐
Sleep problems	☐	☐	☐	☐
Feeling tired	☐	☐	☐	☐
Poor appetite/overeating	☐	☐	☐	☐
Feeling bad about yourself	☐	☐	☐	☐
Trouble concentrating	☐	☐	☐	☐
Moving/speaking slowly or restless	☐	☐	☐	☐
Thoughts of self-harm	☐	☐	☐	☐

Total Score: _____ (0-4 minimal, 5-9 mild, 10-14 moderate, 15-19 moderate-severe, 20-27 severe)

Anxiety Screening (GAD-7): Over the past 2 weeks, how often have you been bothered by:

Symptom	Not at all (0)	Several days (1)	More than half (2)	Nearly every day (3)
Feeling nervous, anxious	☐	☐	☐	☐
Not being able to control worry	☐	☐	☐	☐
Worrying too much	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being restless	☐	☐	☐	☐
Becoming easily annoyed	☐	☐	☐	☐
Feeling afraid something awful might happen	☐	☐	☐	☐

Total Score: _____ (0-4 minimal, 5-9 mild, 10-14 moderate, 15-21 severe)

STRENGTHS AND RESOURCES

Personal Strengths: ☐ Intelligence ☐ Creativity ☐ Sense of humor ☐ Resilience ☐ Empathy ☐ Problem-solving skills ☐ Communication skills ☐ Leadership ☐ Artistic abilities ☐ Other: _____

Coping Strategies (current): ☐ Exercise ☐ Meditation ☐ Prayer ☐ Journaling ☐ Music ☐ Art ☐ Reading ☐ Socializing ☐ Nature ☐ Pets ☐ Hobbies ☐ Therapy ☐ Support groups ☐ Other: _____

Support System: ☐ Family ☐ Friends ☐ Partner ☐ Coworkers ☐ Religious community ☐ Support groups ☐ Mental health professionals ☐ Medical providers ☐ Other: _____

Motivation for Change: ☐ Very motivated ☐ Motivated ☐ Somewhat motivated ☐ Ambivalent ☐ Unmotivated What would you like to be different? _____

TREATMENT GOALS

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

Therapist's Observations:

Recommended Treatment: ☐ Individual therapy ☐ Group therapy ☐ Family therapy ☐ Couples therapy ☐ Psychiatric evaluation ☐ Medical evaluation ☐ Psychological testing ☐ Substance abuse treatment ☐ Case management ☐ Other: _____

Frequency: _____

Modality: _____

Estimated Duration: _____

DIAGNOSTIC IMPRESSIONS

Primary Diagnosis:

Secondary Diagnoses:

Rule Out:

Medical Conditions:

Psychosocial Stressors:

GAF Score: ___ Level of Functioning: _____

TREATMENT PLAN

Short-term Goals (1-3 months): 1. _____ **2.** _____ ***3.*** _____

Long-term Goals (6-12 months): 1. _____ **2.** _____ ***3.*** _____

Interventions:

Referrals Needed: ☐ Psychiatry ☐ Primary care ☐ Specialist ☐ Testing ☐ Other services Details: _____

Crisis Plan: Warning signs: _____ ***Coping strategies:*** _____ ***Support contacts:*** _____ ***Emergency contacts:*** _____

THERAPIST NOTES

Clinical Observations:

Therapeutic Relationship:

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Guarded ☐ Poor Factors affecting prognosis: _____

Special Considerations:

SIGNATURES

Client Signature: _____ Date: ___

Therapist Signature: _____ Date: _____

Therapist Name (Print): _____

License #: ____ *Credentials:* _____

Next Appointment: _____

Follow-up Needed: _____

This intake evaluation is confidential and protected by HIPAA regulations.