NAME: _____ **Date:** _____

Ivy Collaborative Healthcare
New Adult Intake Form

What is/are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

List any <u>recent</u> family difficulties or upsetting events (ex. Illness or death of a family member or close relative, moves, financial challenges, marital stress, abuse (emotional/sexual/physical)?

_____

_____

What have you done to help these challenges? _____

_____

What would you like to gain from working with us? What are your treatment goals? _____

_____

_____

Current Symptoms Checklist: (check <u>once</u> for any symptom **present**, check twice for major symptoms)

☐☐ Depressed mood	☐☐ Unable to enjoy activities	☐☐ Loss of interest in pleasurable activities
☐☐ Excessive guilt	☐☐ Fatigue	☐☐ Concentration/forgetfulness
☐☐ Change in appetite	☐☐ Change in sleeping patterns	☐☐ Racing thoughts
☐☐ Impulsivity	☐☐ Increase risky behavior	☐☐ Sleeping less
☐☐ Excessive energy	☐☐ Increased irritability	☐☐ Increased libido
☐☐ Deceased libido	☐☐ Crying spells	☐☐ Unprovoked anxiety attacks
☐☐ Loss of interest in pleasurable activities	☐☐ Excessive guilt	☐☐ Excessive worry
☐☐ Paranoia	☐☐ Hallucinations	☐☐ Avoidance
☐☐_____	☐☐_____	☐☐ _____

MEDICAL HISTORY: ☐**None**

☐ Arthritis	☐ Asthma	☐ Bleeding Disorder	
☐ Blood Clots (or DVT)	☐ Coronary Artery Disease	☐ Diabetes	☐ Heart Murmur
☐ Structural Heart Abnormality	☐ High Cholesterol	☐ High Blood Pressure	☐ Kidney Disease
☐ Thyroid Disease	☐ Head trauma	☐ Loss of Consciousness	☐ Concussion
☐ Seizures	☐ Other _____		

Allergies: include anything you are allergic to (medications, food, bee stings, etc) and how each affects you**:** ☐ **None**

<u>Allergy</u>	**<u>Reaction</u>**
_____	_____
_____	_____

Preferred Pharmacy/Location: _____

Preferred Lab/Location: _____

SOCIAL HISTORY:

Family Members at home (spouse, parents, children, siblings and/or other relatives):

1. Name_____ Relationship to the patient:_____
2. Name_____ Relationship to the patient:_____
3. Name_____ Relationship to the patient:_____
4. Name_____ Relationship to the patient:_____
5. Name_____ Relationship to the patient:_____

Education:

List highest grade completed: ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Occupation: Currently Working? ☐Yes, describe: _____ ☐ No ☐ On Disability ☐ Retired

Hobbies/Extracurricular activities/Interests: _____

Smoking History: ☐ Never smoked ☐ Former Smoker ☐ Current Smoker _____ packs/cigars per day

Alcohol: Do you drink alcohol? ☐ No ☐ Yes. How often? ☐ Occasionally ☐<3 times a week ☐ >3 times a week How many drinks per week? ____

List any Illicit Substance used on more than one time to get high, feel better or change your mood? ☐ None ☐ Yes. _____

Guns in the home?: ☐ No ☐ Yes Is gun safety being practiced?

PAST FAMILY PSYCHIATRIC HISTORY: List any family member (out to 'greats' or first cousins) who have been diagnosed with:

Depression: ☐**None** _____

Anxiety: ☐**None** _____

Bipolar: ☐**None** _____

Schizophrenia: ☐**None** _____

ADHD: ☐**None** _____

Mental Retardation/Autism/Learning Disability: ☐**None** _____

Substance Use (alcohol, drugs): ☐**None** _____

Has any family member died of sudden/unexpected death under 50yo (including but not limited to drowning, unexplained car accident, sudden infant death syndrome/SIDS)? ☐**Yes** ☐**No**

Has any member family died by suicide? ☐**Yes** ☐**No**

PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY OF PATIENT:

List ALL Psychiatric and Non-Psychiatric Medications taken regularly within the past 30 days (including over the counter, herbal medications, and vitamins) ☐ **None**

Name of Medication	How many milligrams (mg)?	When is it taken? (am, pm, twice a day, etc.)	Reason for medicine?
1			
2			
3			
4			

List any previous Psychiatric Diagnoses: ☐ None _____

_____

_____

Previous <u>ALL Psychiatric Medications</u> tried in the past: ☐ None

Medication	Dose	Frequency (daily, as needed, etc)	Duration of treatment (ex. days, weeks, months, years)	Side Effect(s) (if any)
1)				
2)				
3)				
4)				
5)				

Psychiatric Hospitalizations and/or Residential Treatment: ☐ None

Dates	Hospital	Reason for Hospitalization

Have you ever worked with a Psychiatrist before? ☐Yes ☐ No **Engaging in talk therapy before**? ☐Yes ☐ No

Please list their names and indicate what kind of treatment, when and how long were you were in treatment?

_____

_____

Have you ever tried to commit suicide in the past? ☐ No ☐ Yes (when/what age?) _____

Have you every tried to hurt yourself in the past? ☐ No ☐ Yes (when/what age?) _____

Any history of violent behavior? ☐ No _____ ☐ Yes (when/what age?) _____

REVIEW OF SYSTEMS: Please check(✓) all **<u>problems</u>** you are experiencing **TODAY:**

Constitutional	Weight loss ☐ Fevers ☐ Chills ☐ Poor appetite ☐ Fatigue ☐ Weight gain ☐ Insomnia ☐ Night sweats ☐
Eyes	Blurry vision ☐ Eye pain ☐ Eye discharge ☐ Eye redness ☐ Decrease in vision ☐ Dry eyes ☐ Double vision ☐
ENT	Sore throat ☐ Hoarseness ☐ Ear pain ☐ Hearing loss ☐ Ear discharge ☐ Nose bleeds ☐ Tinnitus ☐ Sinus problems ☐
Cardiovascular	Chest pain ☐ Palpitations ☐ Rapid heart rate ☐ Heart murmur ☐ Poor circulation ☐ Swelling in the legs or feet ☐
Respiratory	Shortness of breath ☐ Chronic cough ☐ Coughing up blood ☐ History of Tuberculosis ☐ Excess sputum production ☐
Gastrointestinal	Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the stool ☐ Frequent heartburn ☐ Trouble swallowing ☐
Genitourinary	Increased urinary frequency ☐ Blood in the urine ☐ Incontinence ☐ Painful urination ☐ Urinary retention ☐ Frequent UTI's ☐
Skin	Rash ☐ Hives ☐ Hair loss ☐ Skin sores or ulcers ☐ Itching ☐ Skin thickening ☐ Nail changes ☐ Mole changes ☐
Psychiatric	Anxiety ☐ Depression ☐ Alcohol or drug dependence ☐ Suicidal thoughts ☐ Panic attacks ☐ Use of anti-depressants ☐
Neurological	Seizures ☐ Tremors ☐ Migraines ☐ Numbness ☐ Dizziness/Vertigo ☐ Loss of balance ☐ Slurred speech ☐ Stroke ☐
Heme/Lymphatic	Low blood count ☐ Easy bruising ☐ Swollen lymph nodes ☐ Transfusions ☐ Prolonged bleeding ☐ Blood clots ☐
Allergic/Immun	Allergic reactions ☐ Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive ☐ Positive tuberculin skin test (PPD) ☐

Thank you for completing this form

Who may we thank for your referral (Physician, Nurse, Teacher, Counselor, Family, Friend): _____

Your signature serves as a comprehensive signature acknowledgement for the following forms and policies. Please access the patient portal or the practice's website to review and print your documents or they can be printed for you upon request. You further acknowledge that you have read, understand and accept each policy in its entirety.

✓ **HIPPA Privacy Notice** ✓ **Financial Policies** ✓ **Notice of Privacy Practices**

Patient Signature: _____ **Date**: _____

(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

Reviewed by Physician/APRN: _____ **Date**: _____