HAWAII
ANXIETY AND TRAUMA
CARE

# PATIENT INTAKE FORM

**Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly.**

Name _____ Birthdate _____

Address _____ Phone Number _____

Primary Care Physician (PCP) _____ PCP's Phone _____

Do you give permission for ongoing updates to be provided to your Primary Care Physician? ☐Y ☐N

Current Psychiatrist _____ Psychiatrist's Phone _____

Do you give permission for ongoing updates to be provided to your Psychiatrist? ☐Y ☐N

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

_____

_____

What are your treatment goals? _____

_____

_____

**Current Symptoms Checklist:**
**(check once for any symptoms present, twice for major symptoms)**

| | | |
|---|---|---|
| ☐☐ Depressed mood | ☐☐ Racing thoughts | ☐☐ Excessive worry |
| ☐☐ Unable to enjoy activities | ☐☐ Impulsivity | ☐☐ Anxiety attacks |
| ☐☐ Sleep problems | ☐☐ Increased risky behavior | ☐☐ Avoidance |
| ☐☐ Loss of interest | ☐☐ Increased libido | ☐☐ Nightmares |
| ☐☐ Concentration/forgetfulness | ☐☐ Decreased need for sleep | ☐☐ Self-harm/high risk behaviors |
| ☐☐ Change in appetite | ☐☐ Excessive energy | ☐☐ On guard/alert |
| ☐☐ Excessive guilt | ☐☐ Increased irritability | ☐☐ Extreme startle response |
| ☐☐ Fatigue | ☐☐ Hallucinations | ☐☐ Cut-off/distant from others |
| ☐☐ Decreased libido | ☐☐ Suspiciousness | ☐☐ Anger outbursts |

**Suicide Risk Assessment:**

Have you ever had feelings or thoughts that you didn't want to live? ☐Y ☐N
If YES, please answer the following. If NO, please skip to the next section.

- Do you currently feel that you don't want to live? ☐Y ☐N
- Do you feel hopeless and worthless? ☐Y ☐N
- Have you ever tried to kill or harm yourself before? ☐Y ☐N
- Do you have access to guns? ☐Y ☐N If yes, please explain. _____

**Medical History:**

Current Weight _____ Height_____

Please list ALL current prescription medications and how often you take them: _____

_____

_____

_____

_____

Current medical problems: _____

_____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

_____

Date and place of last physical exam: _____

Your Personal Medical History (Check all that apply to you):

☐ Thyroid Disease
☐ Liver problems
☐ Chronic Fatigue
☐ Diabetes
☐ Asthma/respiratory problems
☐ Cancer (type) _____
☐ High blood pressure
☐ Other: _____
☐ Stomach or intestinal problems
☐ Fibromyalgia
☐ Heart Disease
☐ Epilepsy or seizures
☐ Chronic Pain
☐ Head trauma
☐ Migraines

Is there any additional personal or family medical history? ☐ Y ☐ N

If YES, please explain: _____

**Psychiatric History:**

Have you ever received outpatient psychotherapy or psychiatric treatment? ☐ Y ☐ N

If YES, please describe when, by whom, and nature of treatment: _____

_____

_____

_____

Have you ever been hospitalized for a psychiatric disorder/issue? ☐ Y ☐ N

If YES, please describe for what reason, when and where: _____

_____

_____

_____

_____

_____

**Family Psychiatric History:**

Has anyone in your family been diagnosed with or treated for:

| Disorder: | | | Who had the problem? |
|---|---|---|---|
| Bipolar disorder | ☐ Yes, | ☐ No | _____ |
| Schizophrenia | ☐ Yes, | ☐ No | _____ |
| Depression | ☐ Yes, | ☐ No | _____ |
| Post-traumatic stress | ☐ Yes, | ☐ No | _____ |
| Anxiety | ☐ Yes, | ☐ No | _____ |
| Alcohol abuse | ☐ Yes, | ☐ No | _____ |
| Anger | ☐ Yes, | ☐ No | _____ |
| Substance (drug) abuse | ☐ Yes, | ☐ No | _____ |
| Suicide | ☐ Yes, | ☐ No | _____ |
| Violence | ☐ Yes, | ☐ No | _____ |

**Substance Abuse:**

Have you ever been treated for alcohol or drug use or abuse? ☐Y ☐N

If YES, for which substances? _____

If YES, where and when were you treated? _____

How many days of the week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the highest number of drinks you will drink in a day? _____

In the past three months, what is the largest number of alcoholic drinks you have consumed in one day? _____

Have you ever felt you should cut down on your drinking/drug use? ☐Y ☐N

Have people annoyed you by criticizing your drinking or drug use? ☐Y ☐N

Have you ever felt bad or guilty about your drinking or drug use? ☐Y ☐N

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐Y ☐N

Do you think you may have a problem with alcohol or drug use? ☐Y ☐N

Have you used any street drugs in the past 3 months? ☐Y ☐N

If YES, which ones? _____

Have you ever abused prescription medication? ☐Y ☐N

If YES, which ones and for how long? _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

**Tobacco History:**

Have you ever smoked cigarettes or used other forms of tobacco? ☐Y ☐N

Do you currently use any form of tobacco? ☐Y ☐N

How many packs per day on average? _____ For how many years? _____

**Exercise Information:**

Do you exercise regularly? ☐Y ☐N

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

**Trauma History:**

Have you ever been abused (emotionally, sexually, physically, neglect)?☐Y ☐N

Have you ever experienced, or witnessed a traumatic event?☐Y ☐N

**Educational History:**

Highest Grade Completed? _____ Where? _____

Did you attend college?☐Y ☐N Where? _____ Major? _____

What is your highest educational level or degree attained? _____

**Occupational History:**

Are you currently:☐Working ☐Student ☐Unemployed ☐Disabled ☐Retired

How long in your present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military?☐Y ☐N

If YES, what branch and when? _____

Rank and MOS: _____

Were you deployed to combat?☐Y ☐N

How many deployments, where and when: _____

_____

**Relationship and Current Family History:**

Are you currently:☐Married ☐Partnered ☐Divorced ☐Single ☐Widowed How long? _____

If not married, are you currently in a relationship?☐Y ☐N If YES, how long? _____

Are you sexually active?☐Y ☐N

How would you identify your sexual orientation?

☐straight/heterosexual ☐lesbian/gay/homosexual

☐bisexual ☐transsexual

☐unsure/questioning ☐asexual

☐other ☐prefer not to answer

Have you had any prior marriages?☐Y ☐N If YES, how many? _____

For how long? _____

Do you have children? ☐ Y ☐ N

If YES, list ages and gender: _____

_____

**Legal History:**

Have you ever been arrested? ☐ Y ☐ N

Do you have any pending legal problems? ☐ Y ☐ N

**Spiritual Life:**

Do you belong to a particular religion or spiritual group? ☐ Y ☐ N

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ☐ more helpful ☐ more difficult/stressful

Is there anything else that you would like me to know? _____

_____

_____

_____

_____

_____

_____

_____

Printed Name of Client

_____ _____

Client Signature (or guardian if a minor) Date

_____ _____

Emergency Contact Name Phone Number