Sorin Bircea, M.D.
PSYCHIATRIST

Psychiatric Clinical Intake Form

(All information on this form is strictly confidential)

NAME_____**DATE**_____

Please complete all information on this form. You may choose to type it or print it and write. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Phone _____**Address**_____**E-mail**_____

What are the problem(s) you are seeking help for? (Check once for any symptoms present, twice for major symptoms)

☐**Depressed mood**	☐**Mood instability**	☐**Increased irritability**
☐**Unable to enjoy activities**	☐**Increased distractibility**	☐**Negative ruminations**
☐**Sleep pattern disturbance**	☐**Excessive energy**	☐**Obsessions/ Compulsions**
☐**Loss of interest**	☐**Talkativeness**	☐**Crying spells**
☐**Excessive guilt/ remorse**	☐**Racing thoughts**	☐**Excessive worry/ fears**
☐**Fatigue**	☐**Impulsivity**	☐**Anxiety/ panic attacks**
☐**Concentration/forgetfulness**	☐**Increased risky behavior**	☐**Avoidance**
☐**Change in appetite / weight**	☐**Self Esteem problems**	☐**Intrusive thoughts**
☐**Mental sluggishness**	☐**Anger**	☐**Hallucinations**
☐**Decreased sex drive**	☐**Restlessness**	☐**Suspiciousness**

Other symptoms: _____

Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ☐Yes ☐No. If Yes: When was the last time? _____

Have you ever tried to harm yourself in any way? ☐Yes ☐No. How about harming others? _____

Past Psychiatric History (childhood and adulthood mental health)

Office/ clinic treatment ☐Yes ☐No If **YES**, please describe when, by whom, and nature of treatment. Begin with the last one.

Dates treated By whom Reason

_____

_____

_____

_____

_____

Psychiatric Hospitalization ☐Yes ☐No If yes, please describe for what reason, when and where.

Date Hospitalized Where Reason

_____

_____

_____

Present and Past PSYCHIATRIC MEDICATIONS: If you have ever taken psychiatric medications prescribed by an office/ hospital unit, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember). Please start with the most recent medications taken.

Dates Medication name Dosage Response/Side-Effects

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Family Psychiatric History:

Has any of your blood relatives been evaluated or treated for: Bipolar disorder ☐Yes ☐No • Schizophrenia ☐Yes ☐ No Depression ☐Yes ☐ No • Post-traumatic stress ☐Yes ☐ No • Anxiety ☐Yes ☐No • Alcohol abuse ☐Yes ☐No • Other substance abuse ☐Yes ☐No • Anger ☐Yes ☐No • Self-harm ☐Yes ☐No • Suicide/ Violence ☐Yes ☐No

If **YES** to any question, please describe _____

_____

Family Medical History:

Has anyone in your family ever had medical conditions such as: High Blood Pressure, Heart disease, Obesity, Epilepsy or seizures, Diabetes, Cancer, Stroke, Head trauma, Endocrine problems (thyroid)? If **YES** to any condition, please describe:

_____

_____

_____

Substance Use: please provide the length of use, frequency and last time used. If NEVER USED, please write NO.

Marijuana _____

Methamphetamine/ Stimulants (pills) _____

Cocaine _____

Opiates (Heroin. Morphine, Methadone) _____

LSD, Ecstasy, Hallucinogens _____

Pain killers (not as prescribed) _____

Tranquilizer/sleeping pills _____

Alcohol _____

Intravenous drugs use _____

Other drugs _____Addicted to ☐gambling ☐computers ☐games?

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

Tobacco History

Using tobacco in any form (smoking, chewing)? ☐Yes ☐No. If **YES** → Length of use: _____ Frequency: _____

MEDICAL HISTORY

Allergies_____ Current Weight _____ Height _____

Current medical conditions: _____

_____

Any current problems related to your head/ lungs/ heart/ liver/ kidneys/G-I Tract/joints/ gait? _____

Past medical history: non-psychiatric hospitalizations or surgeries, seizures/ epilepsy, injuries, MVA, head trauma, loss of consciousness (from the day you were born)?

_____

_____

Date and place of last physical exam: _____Last ECG date_____ Was it: normal: ☐Yes ☐Not

Last laboratory work (blood, urine) date and results: _____

Currently prescribed NON-PSYCHIATRIC MEDICATIONS (if NONE, please write NONE)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

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For women only: Are your cycles regular? ☐Yes. ☐No. Are you planning to get pregnant in the near future? ☐Yes ☐No
Are you currently pregnant or do you think you might be pregnant? ☐Yes ☐No. Birth control method _____

Practicing sports (type, frequency, duration): _____

Family Background and Childhood History:
Were you born in the USA? ☐Yes ☐No. If No, which country were you born in? _____When did you come to the USA? _____
Who raised you as a child? _____Current family problems? _____

Trauma History:
Do you have a history of being abused ☐emotionally ☐sexually ☐physically or ☐by neglect? Please check the appropriate box.

Developmental and Educational History:
Any known complications at birth? _____Serious illnesses and/or hospitalizations as a child: _____
Special physical conditions, disabilities: _____
Highest educational level or degree attained _____Where? _____

Occupational History:
Current occupation _____ Financially stable? ☐Yes ☐No. Also supported by_____
Did you ever serve in the **military**? ☐Yes ☐No. Type of discharge: _____Medical/ mental health benefits ☐Yes ☐No.

Relationship History and Current Family:
Are you currently: ☐Married ☐Divorced ☐Single ☐Widowed How long? _____
If not married, are you currently in a relationship? ☐Yes ☐No If yes, how long? _____
Do you have children (please mention ages)? _____ Who do you live with? _____

Legal History: Have you ever been arrested? ☐Yes ☐No. Do you have any pending legal problems? _____
Past legal problems**:** _____

Spiritual life
Do you belong to a particular religion or spiritual group? ☐Yes ☐No. Which one? _____

Is there anything else that you would like us to know?

_____

_____

_____

Would you participate in a clinical research study? ☐Yes ☐No.

Signature_____**Date**_____
Emergency Contact _____Phone_____
Reviewed by _____Date _____
➔ **Please send the form to us via e-mail/ fax or bring it with you on the day of the appointment.**