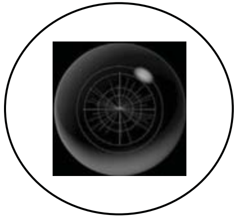

PSYCHIATRIC INTEGRAL INTAKE

Andre Marquis, Ph.D. and David Leavitt, M.D.

Client's Name ____ Age________ Date First Seen ___________________________

Home Phone (_____)_______________ (message: Y/N) Work Phone (_____)_______________ (message: Y/N)

Address ____City_______________________________ Zip___________

Date of Birth __________________ Gender (M/F) Referral Source ____

Emergency Contact: Name ____ Phone (_____)_______________

(Please use the back side of this form if you need more space to respond to *any* of the questions. Please attach medical records as appropriate.)

PRELIMINARY ISSUES AND PREVIOUS TREATMENT

What is the primary concern or problem for which you are seeking help?

____

____

____

____

What makes it better? What makes it worse?

____

____

____

Are there any ***immediate*** challenges or issues that need our attention? Yes/No If yes, please describe.

____

____

____

Have you had previous psychiatric treatment, counseling or psychotherapy? Yes/No From when to when? With whom?

____

____

If you've had treatment, what was it like for you? What most helpful? Least helpful?

____

____

____

What do you expect from your psychiatric treatment here?

____

____

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EXPERIENCE: Individual-Interior

How would you describe your general mood/feelings in the past 2 weeks?

____

____

What emotions do you tend to feel most strongly?

____

____

Please mark any of the following feelings or experiences you've had recently, or have had sometimes in the past:

_____ Difficulty concentrating
_____ Little interest or pleasure in doing things
_____ Poor or excessive appetite
_____ Excessive tiredness
_____ Feeling hopeless
_____ Feeling helpless
_____ Intense feelings of guilt
_____ Having much more energy than normal
_____ Thoughts racing through your head
_____ Needing less sleep than normal
_____ Thoughts that you would be better off dead
_____ Desire to harm yourself
_____ Desire to harm someone else
_____ Hearing or seeing things not actually there
_____ Thoughts that seem strange but that you can't seem to stop
_____ Anxiety attacks that happen for no apparent reason
_____ Constant or excessive worry about things
_____ Fear that someone is trying to harm you

Please describe more about any of the feelings or experiences above that you've had:

____

____

____

____

What are some of your strengths?

____

____

What are some of your weaknesses?

____

____

How do you respond to stressful situations, or when you experience intense emotions?

____

____

How do you make decisions (for example, do you use logic and reason, or do you trust your gut and heart)?

____

____

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Have you ever attempted to seriously harm or kill yourself or anyone else? Yes/No If yes, please describe.

____

____

____

Are you presently experiencing suicidal thoughts, or thoughts of wanting to harm someone else? Yes/No If yes, please describe.

____

____

____

Have there been any serious illnesses, births, deaths, or other losses in your family that affected you? Yes/No If yes, please describe.

____

____

____

What is your most painful memory?

____

____

____

Have you ever been a victim of, or witnessed, verbal, emotional, physical, and/or sexual abuse? Yes/No If yes, please briefly describe. Do you feel you are still affected by it?

____

____

____

In general, how satisfied are you with your life?
Not at all 1 2 3 4 5 6 7 Very

In general, how do you feel about yourself (self-esteem)?
Very bad 1 2 3 4 5 6 7 Very good

In general, how much control do you feel you have over your life and how you feel?
None at all 1 2 3 4 5 6 7 A lot

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BEHAVIOR: Individual-Exterior

Have you ever been hospitalized for a psychiatric illness (i.e., depression/feeling suicidal/nervous breakdown)? Yes/No What were your hospitalized for? From when to when?

____

____

Illnesses you have now or have had in the past:	**Past** (X)	**Present** (X)	**Comments** (briefly describe your illness and whether it is causing problems now)
Seizures			
Thyroid Disease			
Head Injury			
Other ________________			
Other ________________			
Other ________________			
Other ________________			
Other ________________			
Other ________________			

Allergic reactions to medications:

Medication: _______________ What happened: _______________

_______________ _______________

_______________ _______________

Surgeries:

What: _______________ When: _______________

_______________ _______________

_______________ _______________

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What prescription medications are you taking now?

****Please bring your bottles with you to your appointment***

Medication:	What It Is For:	When Started:	Dosage Per Day:

What vitamins / minerals / herbs / supplements are you taking now?

****Please bring your bottles with you to your appointment****

Product Name / Brand:	What It Is For:	When Started:	Dosage Per Day:

What medications have you taken in the past for any psychiatric illness? (i.e., depression, anxiety, insomnia, etc.)

Medication:	What It Was For:	Duration of Use:	Response (Did it help? Side effects?)

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Do you have a primary care physician? Yes/No If yes, who is it? ___________________ Office phone number_________________

Please estimate your: Height_____________Weight in lbs_________________

When was your last physical?_____________Were there any noteworthy results (diseases, blood pressure, etc.)? Yes/No If so, please describe: ____

Please mark any of the following behaviors that are true of you:
_____ I eat too much
_____ I eat too little
_____ I neglect friends and family
_____ I tend to neglect myself and my own needs
_____ I have difficulty being kind and loving to myself
_____ I act in ways that end up hurting myself or others
_____ I tend to lose my temper easily
_____ I can't control some of my behaviors
_____ I sometimes spend more money than I can afford to
_____ I cry frequently

Are there any other behaviors you are concerned about? Yes/No If yes, please describe:
____
____
____

Please mark if you sometimes have the following difficulties:
_____ Headaches
_____ Menstrual problems
_____ Dizziness
_____ Heart palpitations or tremors
_____ Jitters
_____ Tingling/numbness
_____ Blackouts

Do you have other physical pains or difficulties? Yes/No If yes, what are they?
____
____
____

In general, how would you rate your physical health?
Very unhealthy 1 2 3 4 5 6 7 Very healthy

Describe your current sleeping patterns (When do you sleep? How many hours per 24 hours? Do you have trouble falling asleep, staying asleep, or waking up in the morning?)
____
____
____

Describe your normal eating habits (types of food, and how much).
____
____
____

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What experiences have you had with alternative and complementary therapies? (Please fill in below)

Type of Therapy:	**(X)**	**Comments** – (Please specify which modality in this category was used, for how long, & results)
Herbs		
Homeopathy		
Folk remedies		
Bodywork or Massage		
Chiropractic / Osteopathy		
Energy Work (i.e., healing touch, Reiki Johrei, QiGong)		
Prayer		
Self-help groups		
Acupuncture or Oriental medicine		
Ayurveda		
Exercise		
Yoga		
Chi/Qi Gong		
Hypnosis		
Relaxation		
Meditation		
Biofeedback		
Imagery		
Other ________________		
Other ________________		

Describe your drug and alcohol use (both past and present). Do you feel you currently are having problems with any substances?

____

____

____

____

Do you engage in some form of exercise (aerobic and/or strength building)? Yes/No If yes, please describe.

____

____

Do you have any communication impairments (sight, hearing, speech)? Yes/No If yes, please describe.

____

____

CULTURE: Collective-Interior

Describe your relationships, including friends, family, and co-workers.

____

____

____

____

____

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What is important and meaningful to you? What matters the most to you?

____

____

____

____

In general, how satisfied are you with your friendships and other relationships?
Not at all 1 2 3 4 5 6 7 Very

In general, how comfortable are you in social situations?
Not at all 1 2 3 4 5 6 7 Very

In general, how satisfied are you with your religion/spirituality?
Not at all 1 2 3 4 5 6 7 Very

Which emotions were encouraged or commonly expressed in your ***family of origin*** (family you grew up with)?

____

____

Which emotions were discouraged or not allowed in your ***family of origin***?

____

____

What emotions are most comfortable for you now? ________________________________

____

____

What emotions are least comfortable for you now? ________________________________

____

____

How do you identify yourself ethnically? How important is your ethnic culture to you?

____

____

Describe your sex life. How satisfied are you with your sex life?

____

____

Do you have a religious/spiritual affiliation and/or practice? Yes/No Please explain.

____

____

What beliefs do you have about religion/spirituality? How important to you are those beliefs?

____

____

Are you involved with any cultural activities or institutions? Yes/No If yes, please describe.

____

____

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SOCIAL SYSTEMS: Collective-Exterior

List your ***family of origin*** (family you grew up with), beginning with the oldest, include parents and yourself.

Name	**Age**	**Gender**	**Relationship to you** (include "step" and "half" etc.)

List your ***current family*** or all the people you currently live with (begin with the oldest person and include yourself).

Name	**Age**	**Gender**	**Relationship to you** (include "step" and "half" etc.)

Family psychiatric history	**(X)**	**List family members who have had these illnesses** (siblings, parent, grandparent, children)
Depression		
Anxiety		
Head Injury		
Bipolar or Manic-depressive		
Schizophrenia		
Alcohol or Substance abuse		
Suicides		
Psychiatric hospitalizations		
Other _______________		

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Describe your current *physical* home environment. For example, describe the layout of your home, and other general conditions, such as, privacy, is it well-lighted?, do you have A/C?, heating?, etc.

Describe your current *social* home environment (What is it like at home? How do you get along with those who live with you?)

Do you have pets? Yes/No How important are they to you? ____________________

Describe your neighborhood. (Is it safe/dangerous, nice/unpleasant, quiet/loud, etc.?)

Are you currently employed? Yes/No If so, describe the type of work you do and the hours you usually work.

How satisfied are you with the type of work you do?

Not at all 1 2 3 4 5 6 7 Very

What is your yearly income? $____________ per year. How satisfied are you with your standard of living?

Not at all 1 2 3 4 5 6 7 Very

Describe your work environment (include co-workers and supervisors who directly affect you).

Do you currently have a spouse or romantic partner? Yes/No Have you been married before? Yes/No If yes, please describe.

Do you have children? Yes/No If so, please list their names, ages, and any other important information about them.

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What aspects of your life are most stressful to you? Please describe.

____

____

____

Describe your support system (i.e., friends or family who help you in times of need)?

____

____

____

What is your educational background? ____________________________

____

____

Have you served in the military? Yes/No If yes, please describe.

____

____

Have you ever been arrested, or convicted of a crime? Yes/No If yes, please describe.

____

____

Are you involved with any organizations? Yes/No If yes, please describe.

____

____

Describe your leisure time (hobbies/enjoyment).

____

____

Do you participate in any volunteer work? Yes/No If yes, please describe.

____

____

Is there anything else you would like to mention about yourself? (Use the back of the page if you need to).

____

____

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