CASTLE ROCK MEDICAL CENTER

Psychiatry Outpatient Intake Form
medical.records@crhd.org
Upon completion, email to above address

Name _____ Date _____

Preferred name _____ Age _____ Date of Birth _____

Pronouns _____

Phone number _____ E-mail _____

Address _____

Pharmacy _____

Emergency contact _____ Relationship _____ Phone _____

Referred by _____

What are the issues for which you are seeking care?

_____

_____

Have you ever had any of the following conditions? (Check all that apply)

- ❑ Anemia
- ❑ Asthma
- ❑ Cancer
- ❑ Cardiac structural problems
- ❑ Chronic pain/Fatigue
- ❑ Diabetes
- ❑ Gastrointestinal problems
- ❑ Glaucoma
- ❑ Gynecological problems
- ❑ Hormone problems
- ❑ Head injury
- ❑ Heart murmur
- ❑ High or low blood pressure
- ❑ High cholesterol
- ❑ HIV positive or AIDS
- ❑ Immunological disease
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Lung disease
- ❑ Mouth, nose or throat problems
- ❑ Neurological problems
- ❑ Seizure
- ❑ Sleep apnea
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Urological problems

Have you experienced any of the following symptoms in the past month? (Check all that apply)

- ❑ Thoughts about harming self
- ❑ Thoughts about harming other/others
- ❑ Recurrent thoughts of death
- ❑ Suicide attempt
- ❑ Depressed mood
- ❑ More depressed in the winter
- ❑ Loss of interest in activities
- ❑ Excessive guilt
- ❑ Feelings of worthlessness
- ❑ Hopelessness
- ❑ Moving slower than usual
- ❑ Moving faster than usual
- ❑ Decreased concentration
- ❑ Increased appetite/weight gain
- ❑ Decreased appetite/weight loss
- ❑ Sleeping too much
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Nightmares
- ❑ Flashbacks
- ❑ Fatigue
- ❑ Feeling nervous or on edge
- ❑ Muscle tension
- ❑ Panic attacks
- ❑ Increased irritability
- ❑ Excessive energy
- ❑ Decreased need for sleep
- ❑ Sexual indiscretion
- ❑ Excessive spending
- ❑ Increased risky behavior
- ❑ Intrusive thoughts
- ❑ Impulsivity
- ❑ Rituals
- ❑ Fear of gaining weight
- ❑ Restricting calories
- ❑ Binging on food/compensatory behavior
- ❑ Hallucinations (auditory, visual, tactile)
- ❑ Delusions
- ❑ Paranoia
- ❑ Self-harm behavior
- ❑ Chronic feelings of emptiness
- ❑ Fear of abandonment
- ❑ Unstable relationships
- ❑ Difficulty controlling anger
- ❑ Frequent mood changes in course of a day
- ❑ Fear of embarrassment
- ❑ Social situations avoided
- ❑ Alcohol or substance abuse

Allergies _____

Current medical problem(s) _____

_____

Current medications and/or supplements (prescribed or non-prescribed):

Name	Dose	Frequency	Estimated start date

Primary care provider (PCP) :_____ Date of last physical: _____

Do you give consent to communicate with your PCP, if needed? ☐Yes ☐No

For women

Is there a chance that you might be pregnant? ☐Yes ☐No ☐Maybe

Are you planning to become pregnant in the next 6 months? ☐Yes ☐No ☐Maybe

Psychiatric History

Have you ever seen a psychiatrist? ☐Yes ☐No Name: _____

If yes, do you give consent to communicate with your psychiatrist, if needed? ☐Yes ☐No

Have you ever seen a psychologist, therapist or other mental health professional? ☐Yes ☐No

If yes, name/location of the services _____

Reasons services utilized & for how long? _____

Reasons for discontinuation _____

Have you ever had psychological evaluation? If yes, reason _____

Past suicide attempt(s)?

Date	Age	Mean(s) used	Treatment received?	Hospitalized?

Non-suicidal self-harm?

Date	Age	Method(s) used	Treatment received?	Hospitalized?

Do you have access to firearm? ☐Yes ☐No

Past psychiatric diagnoses (Check all that apply)

- ❑ Addiction
- ❑ Anxiety
- ❑ Attention deficit hyperactivity disorder (ADHD)
- ❑ Bipolar disorder
- ❑ Dementia
- ❑ Depression
- ❑ Eating disorder
- ❑ Impulse control disorder
- ❑ Obsessive-compulsive disorder (OCD)
- ❑ Panic disorder
- ❑ Personality disorder
- ❑ Post-traumatic stress disorder (PTSD)
- ❑ Psychosis
- ❑ Schizophrenia
- ❑ Other: _____

Previous psychiatric medications

Name of Medicine	Highest daily dose	Total duration	Effective? (Yes/No)	Reason for discontinuation

Past treatment/hospitalizations

Please include substance abuse treatment/rehab, Partial Hospitalization (PHP), Intensive Outpatient (IOP), ECT, TMS.

Location	Approximate Dates	Reason

Family history of mental illness

Please include any biological members of your family, maternal and/or paternal.

Mental health diagnosis/addiction/genetic diagnosis	Relationship
Suicide completed/attempted?	**Relationship**

Substance use

Do you currently smoke cigarettes/or vape e-cigs? ☐Yes☐No If yes, how many per day? _____

Do you use other tobacco products? ☐Yes☐No If yes, what type? _____

Do you drink alcohol? ☐Yes☐No If yes, how many days per week? _____

Do you use marijuana or other recreational drugs? ☐Yes ☐No

If yes, please specify _____ How frequently? _____

Have you ever abused prescription medication? ☐Yes☐No If yes, which one(s)? _____

Have you ever consumed recreational substances intravenously or shared needles? ☐Yes ☐No

Do you believe you struggle with substance use? ☐Yes ☐No

Does a family member/friend think you struggle with substance use? ☐Yes ☐No

Are you interested in receiving treatment/resources? ☐Yes ☐No

Social History

Where were you born? _____ Where did you grow up? _____

Who were you raised by? _____

Overall, how would you describe your childhood? _____

_____

What was your highest level of education? _____

Degree(s) earned: _____

What is your current occupation? _____

Are you currently married or in a relationship? ☐Yes☐No Partner's Name: _____

What is your living situation? _____

Do you feel safe in your current environment? _____

From whom do you receive emotional support? _____

Current legal problems? ☐Yes☐No If yes, please specify _____

Are you involved with a religious or spiritual group? _____

What do you do for fun? _____

Is there anything else you would like us to know?

_____

_____

_____

What do you hope to accomplish in treatment?

_____

_____

_____

Short Mood and Feelings Questionnaire

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way *in the past two weeks.*

If a sentence was true about you most of the time, check **True.**
If it was only sometimes true, check **Sometimes.**
If a sentence was not true about you, check **Not True.**

	Not True	Sometimes	True
1. I felt miserable or unhappy	❑	❑	❑
2. I didn't enjoy anything at all	❑	❑	❑
3. I felt so tired I just sat around and did nothing	❑	❑	❑
4. I was very restless	❑	❑	❑
5. I felt I was no good any more	❑	❑	❑
6. I cried a lot	❑	❑	❑
7. I found it hard to think properly or concentrate	❑	❑	❑
8. I hated myself	❑	❑	❑
9. I was a bad person	❑	❑	❑
10. I felt lonely	❑	❑	❑
11. I thought nobody really loved me	❑	❑	❑
12. I thought I could never be as good as other kids	❑	❑	❑
13. I did everything wrong	❑	❑	❑

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Vanderbilt ADHD Parent Rating Scale

Child's Name .....

Date of Birth ..... Grade ..... Today's Date .....

Completed by ..... Relationship to child: ❑ Mom ❑ Dad ❑ Other .....

Each rating should be considered in the context of what is appropriate for the age of your child.
When completing this form, please think about your child's behaviors in the past 6 months.

	Symptoms	Never	Occasionally	Often	Very Often
1.	Does not pay attention to details or makes careless mistakes, such as in homework	0	1	2	3
2.	Has difficulty sustaining attention to tasks or activities	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7.	Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8.	Is easily distracted by extraneous stimuli	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat when remaining in seated is expected	0	1	2	3
12.	Runs about or climbs excessively when remaining seated is expected	0	1	2	3
13.	Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks too much	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting his or her turn	0	1	2	3
18.	Interrupts or intrudes in on others (butts into conversations or games)	0	1	2	3
19.	Argues with adults	0	1	2	3
20.	Loses temper	0	1	2	3
21.	Actively defies or refuses to comply with adults' requests or rules	0	1	2	3
22.	Deliberately annoys people	0	1	2	3
23.	Blames others for his or her mistakes or misbehavior	0	1	2	3
24.	Is touchy or easily annoyed by others	0	1	2	3
25.	Is angry or resentful	0	1	2	3
26.	Is spiteful and vindictive	0	1	2	3
27.	Bullies, threatens, or intimidates others	0	1	2	3
28.	Initiates physical fights	0	1	2	3
29.	Lies to obtain goods for favors or to avoid obligations ("cons" others)	0	1	2	3
30.	Is truant from school (skips school) without permission	0	1	2	3
31.	Is physically cruel to people	0	1	2	3

Vanderbilt ADHD Parent Rating Scale

Child's Name .....

Today's Date.....

Symptoms		Never	Occasionally	Often	Very Often
32.	Has stolen things of nontrivial value	0	1	2	3
33.	Deliberately destroys others' property	0	1	2	3
34.	Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35.	Is physically cruel to animals	0	1	2	3
36.	Has deliberately set fires to cause damage	0	1	2	3
37.	Has broken into someone else's home, business, or car	0	1	2	3
38.	Has stayed out at night without permission	0	1	2	3
39.	Has run away from home overnight	0	1	2	3
40.	Has forced someone into sexual activity	0	1	2	3
41.	Is fearful, anxious, or worried	0	1	2	3
42.	Is afraid to try new things for fear of making mistakes	0	1	2	3
43.	Feels worthless or inferior	0	1	2	3
44.	Blames self for problems, feels guilty	0	1	2	3
45.	Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
46.	Is sad, unhappy, or depressed	0	1	2	3
47.	Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
Overall school performance	1	2	3	4	5
Reading	1	2	3	4	5
Writing	1	2	3	4	5
Mathematics	1	2	3	4	5
Relationship with parents	1	2	3	4	5
Relationship with siblings	1	2	3	4	5
Relationship with peers	1	2	3	4	5
Participation in organized activities (eg, teams)	1	2	3	4	5

For Office Use Only

Symptoms:

Number of questions scored as 2 or 3 in questions 1-9: .....

Number of questions scored as 2 or 3 in questions 10-18: .....

Total symptom score for questions 1-18: .....

Number of questions scored as 2 or 3 in questions 19-26: .....

Number of questions scored as 2 or 3 in questions 27-40: .....

Number of questions scored as 2 or 3 in questions 41-47: .....

Comments:

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