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?

____

____

____

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and <u>underlined</u>.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) ***<u>Have you actually had any thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***<u>Have you been thinking about how you might do this?</u>*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***<u>Have you had these thoughts and had some intention of acting on them?</u>*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***<u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>***		

6) ***<u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u>***	**YES**	**NO**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
If YES, ask: ***<u>Was this within the past three months?</u>***		

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
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CASTLE ROCK
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1400 Uinta Drive – Green River, WY 82935
Office: 307-872-4500 Fax: 307-872-4595

Patient Name ____________________________ Date______________

GAD-7 Anxiety

Over the last 2 weeks how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column Totals _____ + ______ + ______ + _____ +

Total Score _______

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

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PATIENT HEALTH QUESTIONAIRE (PHQ-9)

Patient Name: ____ **Date:** _______________

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several Days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or that you have let yourself of your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety, or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Pediatric ACEs and Related Life Events Screener (PEARLS)

TEEN (Self-Report)- To be completed by: **Patient**

At any point in time since you were born, have you seen or been present when the following experiences happened? Please include past and present experiences.

Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1: Please check "Yes" where apply.

1. Have you ever lived with a parent/caregiver who went to jail/prison? ☐
2. Have you ever felt unsupported, unloved and/or unprotected? ☐
3. Have you ever lived with a parent/caregiver who had mental health issues? *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)*
4. Has a parent/caregiver ever insulted, humiliated, or put you down?
5. Has your biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?
6. Have you ever lacked appropriate care by any caregiver? *(for example, not being protected from unsafe situations, or not being cared for when sick or injured even when the resources were available)*
7. Have you ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult? ☐

   Or have you ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at you? ☐

   Or has any adult in the household ever hit you so hard that you had marks or were injured?

   Or has any adult in the household ever threatened you or acted in a way that made you afraid that you might be hurt?
9. Have you ever experienced sexual abuse? *(for example, has anyone touched you or asked you to touch that person in a way that was unwanted, or made you feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with you)* ☐
10. Have there ever been significant changes in the relationship status of your caregiver(s)? *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)* ☐

How many "Yes" did you answer in Part 1?: ☐

Please continue to the other side for the rest of questionnaire →

PART 2:	Please check "Yes" where apply.
1. Have you ever seen, heard, or been a victim of violence in your neighborhood, community or school? *(for example, targeted bullying, assault or other violent actions, war or terrorism)*	☐
2. Have you experienced discrimination? *(for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)*	☐
3. Have you ever had problems with housing? *(for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)*	☐
4. Have you ever worried that you did not have enough food to eat or that food would run out before you or your parent/caregiver could buy more?	☐
5. Have you ever been separated from your parent or caregiver due to foster care, or immigration?	☐
6. Have you ever lived with a parent/caregiver who had a serious physical illness or disability?	☐
7. Have you ever lived with a parent or caregiver who died?	☐
8. Have you ever been detained, arrested or incarcerated?	☐
9. Have you ever experienced verbal or physical abuse or threats from a romantic partners? *(for example, a boyfriend or girlfriend)*	☐

How many "Yes" did you answer in Part 2?: ☐

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

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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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