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?

_____

_____

_____

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
2. Did you lose a parent through divorce, abandonment, death, or other reason?	☐
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
6. Did you live with anyone who went to jail or prison?	☐
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
9. Did you feel that no one in your family loved you or thought you were special?	☐
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ◯ **Not Much** ◯ **Some** ◯ **A Lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

5/5/20

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** 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) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

	YES	**NO**
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** 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: ***Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
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CASTLE ROCK MEDICAL CENTER

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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	☐	☐	☐	☐