HELIOS PSYCHIATRY INC.

2995 Woodside Road, Suite 300
Woodside, CA 94062

I N T A K E   F O R M

Please provide the following information and answer the questions below.
Please note: all information you provide here is protected as confidential information.
If anything does not apply to you simply write N/A or leave blank. Feel free to skip any questions you are not comfortable answering or place a star next to anything you would like to talk about but do not want to write down.

Personal Information:

Date: ___________________________

Last Name: ______________________ First Name: ___________________________ M.I.________

Age: _____ Date of Birth: ________________ With what gender do you identify:_________

Preferred Pronoun:__________

Street Address: ____

____

City: ___________________________ State: _____ Zip code: ____________________

Home phone: ___________________________ Ok to leave a message: _____________

Cell phone: _____________________________ Ok to leave a message: _____________

Work phone: ____________________________ Ok to leave a message: _____________

Emergency contact: _______________________ Relationship to you: _______________

Address:____

Home Phone: ____

Cell/Work Phone:____

Primary Care Physician____

(For women) OBGYN?____

What is your preferred Pharmacy (please indicate location with street address)?

____

____

What are the problem(s) you are seeking help for?

1.____

2.____

3.____

Are you currently in treatment with another provider?

___Yes

___No

If yes, please indicate the name of your current provider and phone number:

Provider Name: ______________________

Provider Phone: ______________________

What are your treatment goals?

____

____

____

What are the most significant stressors in your life at this time?

____

____

What is your employment status?

___Employed or Self-Employed

___Unemployed, but looking for work

___Unemployed and currently not looking for work.

___Retired

Name of employer: ________________

How would you describe your personality?

____

____

Current Symptoms Checklist:

(check once for any symptoms present, twice for major symptoms)

( ) Depressed mood ( ) Racing thoughts ( ) Excessive worry

( ) Unable to enjoy activities ( ) Impulsivity ( ) Anxiety attacks

( ) Sleep pattern disturbance ( ) Increase risky behavior ( ) Avoidance

( ) Loss of interest ( ) Increased libido ( ) Hallucinations

( ) Concentration/forgetfulness ( ) Decrease need for sleep ( ) Suspiciousness

( ) Change in appetite ( ) Excessive energy ( ) other: __________________________

( ) Excessive guilt ( ) Increased irritability ( ) Fatigue ( ) Crying spells ( ) Decreased libido

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

If YES, please answer the following. If NO, please skip to Your Medical History below:

Do you currently feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts?

____

When was the last time you had thoughts of dying?

____

Has anything happened recently to make you feel this way?

____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?

____

Would anything make it better?

____

Have you ever thought about how you would kill yourself?

____

Is the method you would use readily available?

____

Have you planned a time for this?

____

Is there anything that would stop you from killing yourself?

____

Do you feel hopeless and /or worthless?

____

Have you ever tried to kill or harm yourself before?

____

Your Medical History:

Allergies_____________________________ Current Weight _____________

Height _____________ Are you happy with your weight?________________Have you recently lost or gained weight?__________________

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

____

____

____

____

____

____

Current over-the-counter medications or supplements:

____

Current medical problems:____

Past medical problems, nonpsychiatric hospitalization or surgeries

____

____

(For women) Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.
Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method ____
How many times have you been pregnant? ________ How many live births? ________
Do you have any concerns about your physical health that you would like to discuss with me?
( ) Yes ( ) No

Date and place of last physical exam:____

Personal and Family Medical History:

You Family Which Family Member
Thyroid Disease ---------------------- ( ) ( ) ________________________
Anemia-------------------------------- ( ) ( ) ________________________
Liver Disease ------------------------ ( ) ( ) ________________________
Chronic Fatigue ---------------------- ( ) ( ) ________________________
Kidney Disease ----------------------- ( ) ( ) ________________________
Diabetes ------------------------------- ( ) ( ) ________________________
Asthma/respiratory problems ------ ( ) ( ) ________________________
Stomach or intestinal problems --- ( ) ( ) ________________________
Cancer (type) ------------------------ ( ) ( ) ________________________
Fibromyalgia -------------------------- ( ) ( ) ________________________
Heart Disease ------------------------ ( ) ( ) ________________________
Epilepsy or seizures ------------------ ( ) ( ) ________________________
Chronic Pain ------------------------- ( ) ( ) ________________________
High Cholesterol -------------------- ( ) ( ) ________________________
High blood pressure------------------ ( ) ( ) ________________________
Head trauma ------------------------- ( ) ( ) ________________________
Liver problems ----------------------- ( ) ( ) ________________________

Other ---------------------------------- (   ) (   ) _________________________

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain
____
____
____
When your mother was pregnant with you, were there any complications during the pregnancy or birth that you know of?
____
____

<u>Past Psychiatric History</u>
Past Psychiatric Medications: If you have ever taken any of the following medications, 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).

Have you ever been hospitalized for psychiatric reasons? If so when and for how long?
____

Have you ever attempted suicide?____
Have you ever engaged in cutting behaviors?____

Dates Dosage Response/Side-Effects
Antidepressants
Prozac (fluoxetine)
____
Zoloft (sertraline)
____
Luvox (fluvoxamine)
____
Paxil (paroxetine)
____
Celexa (citalopram)
____
Lexapro (escitalopram)
____
Effexor (venlafaxine)
____
Cymbalta (duloxetine)

____

Wellbutrin (bupropion)

____

Remeron (mirtazapine)

____

Serzone (nefazodone)

____

Anafranil (clomipramine)

____

Pamelor (nortrptyline)

____

Tofranil (imipramine)

____

Elavil (amitriptyline)

____

Other ____

Mood Stabilizers

Tegretol(carbamazepine)

____

Lithium

____

Depakote (valproate)

____

Lamictal (lamotrigine)

____

Tegretol (carbamazepine)

____

Topamax (topiramate)

____

Other

____

Antipsychotics/Mood Stabilizers

Seroquel (quetiapine)

____

Zyprexa (olanzapine)

____

Geodon (ziprasidone)

____

Abilify (aripiprazole)

____

Clozaril (clozapine)

____

Haldol (haloperidol)

____

Prolixin (fluphenazine)

____

Other

____

Sedative/Hypnotics

Ambien (zolpidem)

____

Sonata (zaleplon)

____

Rozerem(ramelteon)

____

Restoril (temazepam)

____

Desyrel (trazodone)

____

Other ____

ADHD medications

Adderall (amphetamine)

____

Concerta (methylphenidate)

____

Ritalin (methylphenidate)

____

Strattera (atomoxetine)

____

Other ____

Antianxiety medications

Xanax (alprazolam)

____

Ativan (lorazepam)

____

Klonopin (clonazepam)

____

Valium (diazepam)

____

Tranxene (clorazepate)

____

Buspar (buspirone)

____

Other ____

Your Exercise Level:

Do you exercise regularly? (   ) Yes (   ) No

How many days a week do you get exercise?

____

How much time each day do you exercise?

____

What kind of exercise do you do?

____

Sleep:

Do you have?

- Difficulty falling asleep?_________________________
- Awakenings during the night?____________________
- Poor or unrefreshing sleep?______________________

If so, how long have you been experiencing this problem for? (duration)

____

How many times per week do you experience this?(frequency)

____

Past and current treatments and responses?

____

Sleep-Wake Schedule (average, variability):

Bedtime:______________________

Time to fall asleep?

- Factors prolonging sleep onset________________
- Factors shortening sleep______________________

Do you awaken during the night?

- number, characterization, duration________________________

Do you take naps during the day?

Eating Habits:

1. Do you spend a lot of time thinking about and trying to lose weight?
2. Is your value as a person largely determined by your appearance?
3. Do you often feel out-of-control when eating?
4. Do you ever make yourself engage in risky behavior (e.g., fasting, over-exercising, vomiting, laxative use, taking diet pills) in order to avoid gaining weight or maintain your current weight?
5. Do you weigh yourself more than once a day?
6. Do you avoid eating around other people?
7. Are you ashamed, critical, and disgusted with your body?
8. Are your thoughts preoccupied with food, counting calories, and/or your body?
9. Do you currently fast or use crash diets?
10. Do you eat large amounts of food when you are not hungry?

Family Psychiatric History:

Has anyone in your family been diagnosed with 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
Anger ( ) Yes ( ) No Other substance abuse ( ) Yes ( ) No
Suicide ( ) Yes ( ) No Violence ( ) Yes ( ) No
If yes, who had what
problems?____
____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated and what medications and how effective was the treatment?
____
____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances?
____
If yes, where were you treated and when?
____

____
____

How many days per week do you drink any alcohol? ____________
What is the least number of drinks you will drink in a day? _______
What is the most number of drinks you will drink in a day? _______
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? ______
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a
hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones?
____

Have you abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how
long____

____
____

Check if you have ever tried the following:
Yes No If yes, how long and when did you last use?
Methamphetamine ( ) ( ) ____
Cocaine ( ) ( ) ____
Stimulants (pills) ( ) ( ) ____
Heroin ( ) ( ) ____
LSD or Hallucinogens ( ) ( ) ____
Marijuana ( ) ( ) ____
Pain killers (not as prescribed) ( ) ( )
____
Methadone ( ) ( ) ____
Tranquilizer/sleeping pills ( ) ( )
____
Alcohol ( ) ( ) ____
Ecstasy ( ) ( ) ____
Other ____
How many caffeinated beverages do you drink a day? Coffee _______ Sodas ________ Tea

____
Tobacco History?
How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No How many packs per day on average? ___________ How many years?_________
In the past? ( ) Yes ( ) No. How many years did you smoke? ________ When did you quit? _____________
Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No. In the past? ( ) Yes ( ) No
What kind? __________ How often per day on average? ______ How many years? ____________

Family Background and Childhood History:
Where did you grow up? ____
List your siblings and their ages:
____
____
What was your father's occupation?
____
What was your mother's occupation?
____
Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? __________________
If your parents divorced, who did you live with?
____
Describe your father and your relationship with him
____
____
Describe your mother and your relationship with her:____

Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes
If yes, describe your faith or belief:
____

Do you identify with a certain cultural background?
____
____
____

Have you ever experienced something
traumatic?____
____Re
lationship History:
Are you currently: ( ) Married ( ) Divorced ( ) Single ( ) Widowed
How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long?
____
Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer
What is your spouse or significant other's occupation?
____
Describe your relationship with your spouse or significant other:
____
____
Have you had any prior marriages? ( ) Yes ( ) No. If so, how many?
____
How long? ____
Do you have children? ( ) Yes ( ) No. If yes, list ages and gender identity:
____
____
Legal: Have you ever been arrested? _______ Do you have any pending legal problems?
____