NAME: _____ DATE: _____

ADDRESS:_____

PHONE: _____ □ Cell □ Home □ Work

DOB: _____ Age: _____

What Pharmacy do you Use? _____ Street/City_____

Who is your Primary Care Physician? _____

Are you involved in an investigation or legal case currently? □ Yes □ No

Type of Suit:

□ Divorce □ Worker's Comp □ Child Custody □ Professional Board

□ Department of Family/Children Services □ Motor Vehicle □ Other _____

Name of Attorney: _____ _____ **Phone**: _____

CONSENT FOR COMMUNICATIONS

You have the right to request that we restrict how protected health information about you is used or disclosed. Most patients have family members and friends that occasionally become involved in their care. (For example, your spouse calls to confirm your appointment time; OR your adult child calls with questions about your medications.) Please list any restrictions to the information you have regarding how we can communicate with those you have listed below. (Example: Appointments only, financial matters only; Medications Only, etc. If there are no restrictions, please list "NONE" beside their name

Please list below any persons you will allow us to talk with about you. ***(If you prefer we do not speak with anyone, please write "NO ONE" across this section.***

Name	Relationship to you	Phone Number	Restrictions (See instructions below)

How would you like us to communicate with you?

□ Cell Phone #_____ Okay to leave voicemail? □ Yes □ No

□ Home Phone #_____ Okay to leave message on answering machine? □ Yes □ No

□ Mail (Address _____)

□ Email _____@_____

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the manner listed above and authorize Valdosta Psychiatric Associates staff to disclose information only to those individuals listed above and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information and/or Psychotherapy Information.

_____Date_____ _____

Signature of Patient/Legal Guardian (Minors 12-17 must sign) Witness:

Name:_____ **DOB:** _____

INTAKE QUESTIONNAIRE

Medical History (check all that apply)

□ Allergies/Seasonal	□ Anemia	□ Arthritis
□ Asthma	□ Back Pain (Chronic)	□ BPH
□ Cancer (type)_____	□ COPD/Emphysema	□ Diabetes □ Type I □ Type II
□ Disc Disease □ Lumbar □ Cervical	□ Fibromyalgia	□ GERD / Gastritis
□ Gout	□ Hearing Loss	□ Heart Disease
□ Hepatitis	□ Hernia	□ High Cholesterol
□ HIV	□ Hypertension	□ Hypotension
□ Hyperthyroidism	□ Hypothyroidism	□ Irritable Bowel Syndrome
□ Kidney Disease	□ Kidney Stones	□ Liver Disease
□ Lupus	□ Migraine Headaches	□ Obesity
□ Parkinson's Disease	□ Seizure Disorder	□ Sleep Apnea
□ Sexually Transmitted Disease	□ Stroke/TIA (History of)	□ Testosterone (Low)
□ Traumatic Brain Injury	□	□ No Medical Problems

Other Illnesses not listed above:_____

_____

_____

Surgical History

□ Appendectomy	□ Back □Lumbar □ Cervical	□ Bariatric Surgery	□ Brain
□ Cardiac Value	□ Cardiac Bypass	□ Ear/Nose/Throat	□ Gall Bladder
□ Gastric Bypass	□ Hernia Repair	□ Hip Replacement	□ Hysterectomy (Partial)
□ Hysterectomy (Total)	□ Kidney Stones Removed	□ Kidney Removed	□ Knee Replacement
□ Prostate	□ Rotator Cuff	□ Shoulder	□ Tubal Ligation
□ Wrist	□	□	□

Other Surgeries not listed above: _____

Medications

Please list all medications you take daily including dosages and how often:

Allergies

Please list any drug or non-drug allergies you have:

Name: _____ **DOB: _____**

Habits

Do you smoke cigarettes currently? □ Yes □ No How much per day? _____

Have you smoked in the past? □ Yes □ No

Do you use Oral Tobacco? □ Yes □ No

Do you Drink Alcohol? □ Yes □ No How much per week? _____

Please check all stressors you are experiencing currently

□ Economic/Financial	□ Education/School	□ Family Conflict	□ Grief/Loss
□ Legal Problems	□ Medical Illness	□ Work	□ Living Situation
□ Social Environment	□ Substance Abuse	□ Marital Conflict	□ Family Disruption due to divorce or separation
□ Personal Injury	□ Relationship		

Please give a brief description of the reason you are here today: _____

_____

_____

_____

_____

Please check any symptoms you are now experiencing

□ Anxiety
□ Anger
□ Appetite Disturbance
□ Behavior Problems
□ Decreased Concentration
□ Decreased Energy
□ Decreased Pleasure and Interest in things
□ Depressed Mood
□ Feelings of hopelessness, helplessness or worthlessness
□ General Stress
□ Grief/Loss
□ Uncontrolled Fear or Phobia
□ Unexplained or chronic pain
□ Thoughts of hurting someone else
□ Hallucinations (hearing voices, seeing things)
□ Falling Asleep during the daytime
□ Impulsiveness
□ Insomnia (trouble fall sleep or staying asleep)
□ Irritability
□ Isolating (staying away from others)
□ Mania (unusually hyperactive, talkative)
□ Memory Impairment
□ Nightmares
□ Panic Attacks
□ Sexual Dysfunction
□ Thoughts of hurting myself
□ Rapid weight loss or weight gain

Please list any other symptoms not listed above:

_____

_____

Name: _____ DOB: _____

Past Psychiatric History

Have you ever been treated by a psychiatrist or counselor in the past? □ Yes □ No

□ **Out Patient Treatment**

Provider:	Dates of Treatment:
Provider:	Dates of Treatment:
Provider:	Dates of Treatment:

What were you being treated for?_____

□ **Inpatient Treatment**

Facility Name:	Type of Admission	Date/Year
□	□ Voluntary □ Involuntary	
□	□ Voluntary □ Involuntary	
□	□ Voluntary □ Involuntary	

□ Reason for Admission:

□ Depression	□ Drug/Alcohol	□ Manic Episode	□ Psychotic Episode
□ Severe Anxiety	□ Suicidal Ideations	□ Suicide Attempt	□ Violence/Assaultive Behaviors

Family History

Has anyone in your family ever been treated for psychiatric condition or Substance Abuse? □ Yes □ No

□ Family History is unavailable

Family Member	Type of problem
□ Mother	
□ Father	
□ Spouse	
□ Brother	
□ Sister	
□ Son	
□ Daughter	
□ Maternal Grandmother	
□ Maternal Grandfather	
□ Paternal Grandmother	
□ Paternal Grandmother	
□ Aunt	
□ Uncle	
□ Other?	

Name: _____ DOB: _____

Father: □ Living □ Deceased (Age _____)
Brief Description of your Father: _____
_____
_____

Mother: □ Living □ Deceased (Age _____)
Brief Description of your Mother: _____
_____
_____

Siblings: □ # Living _____ □ # Deceased _____

If you were not raised by your biological parents, please explain:
_____
_____
_____
_____

What is your cultural background: (Hispanic, Italian, German, Irish, etc) _____

Substance Abuse History

Do you have a history of Substance Abuse? □ Yes □ No

Type of substance Used	Quantity Used	Frequency of Use

Have you experienced any of the following as a result of your drug or alcohol use?

□ Arrests	□ Consuming more than intended	□ Blackouts	□ DUI
□ Employment Issues	□ Family/Marital Conflict	□ Feeling guilty	□ Financial problems
□ Fighting	□ Health Problems	□ Increased Tolerance	□ Increased tolerance
□ Unintentional Overdose	□ Physical Health Problems	□ Seizures	□ Withdrawal Symptoms

List any other consequences not listed above: _____

Name: _____ DOB: _____

Education History

□ Currently in school – **Grade** _____	□ Less than a high school education	□ Graduated from high school
□ GED Obtained	**HIGHEST GRADE COMPLETED**? _____	□ Associates Degree
□ College Degree	□ Some College	□ Professional Degree
□ Technical Degree	□ Master's Degree	

Employment History

Employment Status:

□ Full-time □ Part-time □ Unemployed □ Retired □ Disabled □ Homemaker

Name of Employer: _____ How long at your current job?_____

Occupation: _____

Military Service History:

□ Never been in the military	□ Active Duty Military	□ Parent is active duty military
□ Spouse is Active Duty military	□ Retired from the military	□ Honorably discharged from military
□ Veteran	□ Medically discharged from military	□ Dishonorable discharge

Branch of Service:

□ Air Force	□ Army	□ Marines	□ Navy
□ National Guard	□ Reserves	□ Coast Guard	

General Social History:

Marital Status:

□ Single/Never married	□ Married	□ Divorced
□ Separated	□ Widowed	□ Partnership/Serious Relationship

Current level of satisfaction in the relationship is

□ not applicable.	□ very Satisfied.	□ somewhat satisfied.	□ dissatisfied.

Number of Marriages _____ **Number of Children: _____**

List the Names and Ages of Children

Name: _____ **DOB: _____**

Residential Status:

□ Own A home	□ Rent	□ Live w/parents	□ Foster Care
□ Homeless	□ Nursing Home Facility	□ Live w/roommate(s)	

Housing Conditions are:

□ Excellent	□ Good	□ Fair	□ Poor

List the members of your current household:

Social Supportive Network:

□ Supportive Family	□ Friends	□ Religious Congregation	□ Co-workers
□ Internet-based	□ Social Services	□ Sponsor	□

Cultural:

□ Caucasian	□ African-American	□ Hispanic	□ Asian
□ Native American	□ Bi-Racial	□ Indian	□

Sexual Orientation:

□ Heterosexual	□ Homosexual	□ Bi-Sexual	□ Transgendered

Religion

□ Denomination:	□ Participate in religious activities	□ Do not participate in religious activities