3. Core Intake Form

Client Full Name:

Client Date Of Birth:

Client Address:

Client Mobile Phone Number:

Client ID Number:

Presenting Problem

What is the reason you are seeking medication management?:

Have you previously suffered from this?:

If yes, enter previous prescriber seen, describe treatment::

Aggravating Factors:

Relieving Factors:

I have problems in the following areas:

- [ ] Marriage/Relationship/Family
- [ ] Friendship/Peer Relationships
- [ ] Job/School Performance
- [ ] Physical Health
- [ ] Eating habits/Bingeing/Purging/Starving
- [ ] Sexual Functioning/Gender Issues
- [ ] Ability to Concentrate/Distractibility/Attention Span
- [ ] Ability to Control Temper
- [ ] Strange Thoughts/Strange Experiences
- [ ] Repetitive Behaviors / Obsessions / Compulsions
- [ ] Hyperactivity/Tics
- [ ] Memory

- [ ] Impulse Control / Stealing / Hair Pulling / Gambling
- [ ] Current Symptoms

(check all that apply)

- [ ] Anxiety
- [ ] Appetite Issues
- [ ] Avoidance
- [ ] Crying Spells
- [ ] Depression
- [ ] Excessive Energy
- [ ] Fatigue
- [ ] Guilt
- [ ] Hallucinations
- [ ] Impulsivity
- [ ] Irritability
- [ ] Libido Changes
- [ ] Loss of Interest
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Relationship issues
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

Exercise Frequency & type:

Current medications? Previous medications?:

Any allergies to any medications?:

Previous diagnoses/mental health treatment:

Do you have any history of trauma?:

Do you currently have suicidal thoughts? Have you had suicidal thoughts in the past?:

Suicide & Crisis Lifeline: If your life or someone else's is in imminent danger, please call 911. If you are in crisis and need immediate help, please call: 988

Family History

Family member psychiatric conditions::

Present Situation

Work:

Married, Divorced, Single?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?

(check all that apply)

- [ ] Alcohol
- [ ] Tobacco
- [ ] Marijuana
- [ ] Hallucinogens (LSD)
- [ ] Heroin
- [ ] Methamphetamines
- [ ] Cocaine
- [ ] Stimulants (Pills)
- [ ] Ecstasy

- [ ] Methadone
- [ ] Tranquilizers
- [ ] Pain Killers

If yes to any, list frequency/dates of use:

List current illicit drug use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Have you ever abused prescription drugs? If yes, which ones?:

Anything else you would like your prescriber to know?:

Emergency Contact

Name:

Relationship to client::

Phone Number:

Pharmacy

Please enter the name, phone number and address of your pharmacy:

Name, Phone Number, Address:

Primary Care Physician

It is very important that I communicate with your primary care physician and your psychiatrist (if you have one) after your consultation. Please take a few moments to provide your doctor's contact information.

Name, Phone Number, Fax Number, Address:

Are you currently seeing a Mental Health therapist?

Therapist Name, Email Address, Fax number:

Referral

- [ ] Psychology Today

- [ ] Northwell Referral
- [ ] Nassau Psychology PC
- [ ] PCP/Referring Physician
- [ ] Other

Indicate other referral::

Additional Information