Psychiatric Assessment Intake

Today's Date:

Name			
Date of Birth (dd-Mon-yyyy)		Gender	Age
Email address:		Personal Health Number	
Phone #	Family Doctor	Pharmacy	
Home Address (with Postal Code)			
Occupation			

Please list anyone living with you		
Spouse	Age	Occupation
Children	Age	
	Age	
	Age	

Family History-Please Check all that apply even if not formally diagnosed

	Please identify who in the family (if anyone) has experienced any of the following:
Depression	
Bipolar Disorder	
Schizophrenia	
ADHD	
Concentration Problems	
Hyperactivity	
Anger Outbursts	
Severe Agitation	
Nervous Breakdown	
Anxiety	
Panic Attacks	
Phobias	
Obsessive Worrying	
Compulsions	
Attempted Suicides	
Completed Suicides	
Alcoholism	
Drug Abuse/Use	
Abuse as an Abuser or Victim	

Medical History

Past Surgeries or Hospitalizations: list procedure/reason for admission and age it occurred

Have you experienced any abuse (Physical, Emotional, Sexual: Please describe in detail including age and length of time in which it occurred)

Psychiatric History

Psychiatric Hospitalizations (dates, locations, reason for admission, and length of stay):

Past Psychotherapy/Counselling (dates, length of time, and focus of treatment):

Previous treatment by a Psychiatrist (dates, lengths of time, and focus of treatment):

Medications

Current Medications and Dose (length of time, purpose, results, side effects? who prescribed the medication?) Include herbal supplements/vitamins

Drug and Alcohol Use/History

Cigarettes/Tobacco/Vaping:

1. Do you currently smoke, chew or vape? YES____ NO____

If yes: Number of years ____ Number of packs/day ____ Last time using ____

If no: Have you used these products in the past? YES____ NO____

Caffeine:

1. Do you drink coffee or other caffeinated drinks? YES ____NO____

If yes: Number of cups/beverages per day ____ Type of beverage _____

Alcohol:

1. Do you drink alcohol currently or have you within the last year? YES____ NO____

If yes: How many times per week? ____ Type of Beverage _____

Average amount consumed per week ____ How long have you been drinking? ____

Drug Use:

1. Do you currently use any drugs or illicit substances? YES ____ NO ____

If yes: Type of drug_____

How much/How Often/How long? _____

Risk Assessment

	YES	NO
Do you have thoughts of harming yourself		
Do you have a plan for how you would harm yourself		
Have you attempted to harm yourself in the past		
Do you have thoughts of harming someone else		
Have you assaulted or threatened anyone recently		
Have you ever been in trouble because of your temper/violence		
Does drinking/using drugs ever lead you to become violent		
Do you own a gun or lethal weapon		
Have you ever considered/planned to harm yourself or others with this gun or lethal weapon		