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veramentus
functional psychiatry & psychotherapy

New Patient Intake Form

Name: _____ **Date of Birth:** _____ **Today's Date** _____

Describe the problems/symptoms that concern you:

Previous or Presenting Problems & Concerns (History of Present Illness)

Please check all the behaviors and symptoms that you consider problematic from the past or present:

Cognitive Function	At Present	In Past
- Difficulty with sustained concentration or focus	☐	☐
- Mind often wanders	☐	☐
- Readily distractible by external sounds or sights or internal daydreaming	☐	☐
- Delayed initiation of tasks (procrastinating)	☐	☐
- Difficulty following through	☐	☐
- Problems with planning	☐	☐
- Problems with organization	☐	☐
- Can get hyperfocused on a task and lose track of time	☐	☐
- Difficulty sitting still	☐	☐
- Difficulty waiting your turn	☐	☐
- Problems with short-term or long-term memory	☐	☐
- Racing thoughts	☐	☐

Previous or Presenting Problems & Concerns (History of Present Illness) Continued…

Please check all the behaviors and symptoms that you consider problematic from the past or present:

	At Present	In Past
Mood		
- Feeling sad or depressed	☐	☐
- Feeling bored or disinterested	☐	☐
- Low motivation	☐	☐
- Low energy	☐	☐
- Reduced enjoyment of pastimes or regular interests	☐	☐
- Isolating to self	☐	☐
- Feeling hopeless	☐	☐
- Feeling guilty, ashamed, or disappointed	☐	☐
- Problems regulating mood: can get easily/quickly angry, sad, or happy	☐	☐
- Mood swings	☐	☐
- Seasonal changes to mood, energy, or motivation	☐	☐

Anxiety		
- Chronic worrying about daily concerns	☐	☐
- Episodes of sudden anxiety with elevated heart rate, headache, muscle tension, or nausea	☐	☐
- Panic attacks (intense feeling of dread, hyperventilating, pounding heart rate)	☐	☐
.- Ruminating thoughts about unresolved experiences from the past, or future tasks/obligations	☐	☐
- Avoidance of social engagements from feeling intense judgement by others	☐	☐
- Repeating and undesirable Intrusive thoughts or Obsessive thoughts (can't let a thought go)	☐	☐
- Recurring extreme fear that something terrible will happen to you or a loved one	☐	☐
- Not feeling safe when going outside	☐	☐
- A specific phobia (type in):		

Previous or Presenting Problems & Concerns (History of Present Illness) Continued…

Please check all the behaviors and symptoms that you consider problematic from the past or present:

Behavior	At Present	In Past
- Increase or decrease in appetite	☐	☐
- Eating more or eating less	☐	☐
- Periods of talking too fast or too slow	☐	☐
- Periods of moving unusually slow or very fast with lots of energy (hyperactive)	☐	☐
- Reduced productivity at home or work	☐	☐
- Periods of being very productive and goal oriented	☐	☐
- Periods of engaging in risky or impulsive behaviors	☐	☐
- Tics (repetitious and jerky movements in face, neck, arms, hands)	☐	☐
- Extreme biting nails, picking skin, or pulling hair	☐	☐
- Repeating compulsive acts (washing hands, opening and shutting door, or having to do something 'just right')	☐	☐
- Repeating compulsive thoughts (counting steps, looking for symmetry, mentally repeating words, numbers, or specific song)	☐	☐

Sleep		
- Not feeling tired or reduced need for sleep	☐	☐
- Difficulty falling asleep	☐	☐
- Waking often during the night	☐	☐
- Difficulty staying asleep until desired time in morning	☐	☐
- Vivid or distressing dreams/nightmares	☐	☐
- Sleeping too much	☐	☐
- Difficulty getting out of bed after waking up	☐	☐
- Napping during the day	☐	☐
- Problems with daytime drowsiness, fatigue, or low energy	☐	☐

Previous or Presenting Problems & Concerns (History of Present Illness) Continued…

Please check all the behaviors and symptoms that you consider problematic from the past or present:

	At Present	In Past
Trauma		
- History of experiences or events you consider to be traumatic or very unsettling	☐	☐
- Flashbacks or nightmares of previous even	☐	☐
- Avoiding places, sights, sounds, or thoughts that remind you of past event	☐	☐
- Sudden changes in mood when being reminded of past event	☐	☐
- Feeling detached from yourself or surroundings when thinking of past event	☐	☐
Libido		
- Low sex drive, reduced interest in sex	☐	☐
- Hyper sex drive, excessive interest in sex	☐	☐
- Reduced ability to enjoy sex or pain during sex	☐	☐
- Problems with climaxing (too soon, delayed, not at all)	☐	☐
- Erectile issues	☐	☐
Perception		
- Hearing sounds/voices or seeing people/objects which are not there (or not confirmed by others)	☐	☐
- Delusional thoughts (having a strong belief or thought which is not consistent with reality)	☐	☐

Are your problems affecting any of the following?

☐ Handling everyday tasks	☐ work/school	☐ recreational/exercise
☐ personal interests	☐ relationships	☐ housing
☐ personal health	☐ finances	☐ sexual activities
☐ self-esteem	☐ hygiene	☐ parenting

Have you ever had thoughts of being better off dead or wanting to fall asleep and not wake up?

☐ Yes ☐ No

Have you ever had suicidal thoughts with or without a plan? ☐ Yes ☐ No

Did you have a plan? ☐ Yes ☐ No

If yes to any of the above, please describe:

Have you ever had homicidal thoughts? ☐ Yes ☐ No

Did you have a plan? ☐ Yes ☐ No

If yes to any of the above, please describe:

Have you ever had thoughts, made statements, or attempted to hurt yourself? ☐ Yes ☐ No

If yes, please describe:

Have you ever had thoughts, made statements, or attempted to hurt someone else? ☐ Yes ☐ No

If yes, please describe:

Have you ever been physically hurt or threatened by someone else? ☐ Yes ☐ No

If yes, please describe:

Past Mental Health Treatment

Yes	No	Type of Treatment	Date or Age	Provider/Program	Reason for Treatment
☐	☐	Outpatient Counseling			
☐	☐	Medication (Mental Health)			
☐	☐	Psychiatric Hospitalization			
☐	☐	Drug/Alcohol Treatment			

Family Mental Health History

Illness	Who	Illness	Who
ADHD/Hyperactivity		Eating Disorder	
Alcohol/ Drug abuse		Obsessive Compulsive	
Anger/ Abusive		Panic Attacks	
Anxiety		Schizophrenia	
Bipolar		Sexually Abused/ Abusive	
Depression		Suicide	

Current Medications ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Previous Medications ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list medication and reaction:

Please list all current over-the-counter medications (including vitamins, supplements, herbal remedies, etc.):

Women's Health

Date of Last Menstruation: _____ Birth Control Method: _____

Number of Pregnancies : _____ Deliveries: _____

Family Medical History

Family Member	Diagnoses	Family Member	Diagnoses

Family, Marital, and Developmental History

- ☐ Parents legally married or living together
- ☐ Parents temporarily separated
- ☐ Parents divorced or permanently separated
- ☐ Mother remarried
- ☐ Father remarried

Substance Use History ☐ None

Substance Type	Current Use			Past Use		
	Yes	No	Frequency/Amount	Yes	No	Frequency/Amount
Tobacco/Nicotine	☐	☐		☐	☐	
Caffeine	☐	☐		☐	☐	
Alcohol	☐	☐		☐	☐	
Marijuana	☐	☐		☐	☐	
Cocaine/Crack	☐	☐		☐	☐	
Ecstasy	☐	☐		☐	☐	
Heroin/Methadone	☐	☐		☐	☐	
Amphetamines	☐	☐		☐	☐	
Pain Killers	☐	☐		☐	☐	
PCP/LSD/Shroom	☐	☐		☐	☐	
Steroids	☐	☐		☐	☐	
Tranquilizers	☐	☐		☐	☐	

Have you had withdrawal symptoms when trying to stop using any substances? ☐ Yes ☐ No

If yes, please describe:

Have you had withdrawal symptoms when trying to stop using any substances? ☐ Yes ☐ No

If yes, please describe:

Past Medical History

Date of last physical exam: _____

Have you experienced any of the following during your lifetime? (Please check all that apply.)

- ☐ allergies
- ☐ asthma
- ☐ blood clots
- ☐ cancer
- ☐ cataracts
- ☐ chest pain/angina
- ☐ chronic cough
- ☐ chronic pain
- ☐ congestive heart failure
- ☐ constipation
- ☐ diabetes
- ☐ diarrhea
- ☐ dizziness/fainting
- ☐ fever
- ☐ fibromyalgia
- ☐ GERD
- ☐ glaucoma
- ☐ headaches
- ☐ head injury
- ☐ hearing problems
- ☐ heart attack
- ☐ heart disease
- ☐ heart palpitations
- ☐ heart surgery
- ☐ hepatitis
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ HIV/AIDS
- ☐ IBS
- ☐ kidney disease
- ☐ kidney stones
- ☐ low blood pressure
- ☐ liver disease
- ☐ meningitis
- ☐ migraines
- ☐ nausea
- ☐ muscle pain
- ☐ night sweats
- ☐ osteoporosis
- ☐ pacemaker
- ☐ seizures
- ☐ serious accident
- ☐ shortness of breath
- ☐ STD
- ☐ stomach aches
- ☐ stomach ulcer
- ☐ stroke/CVI/TIA
- ☐ thyroid disease
- ☐ tuberculosis
- ☐ urinary problems
- ☐ weight loss/gain
- ☐ vision problems

Other, not listed above:

History of Surgeries, Motor Vehicle Accidents, or other physical trauma (procedure/incident and year):

Family Relationships

Interpersonal / Social / Cultural Information

Please describe your social support network (check all that apply)

- ☐ Family
- ☐ Neighbors
- ☐ Friends
- ☐ Co-workers
- ☐ Students
- ☐ Support / self-help group
- ☐ Community Group
- ☐ Religious / Spiritual (which one) _____

How important are spiritual matters to you?

☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

Please describe your pastimes, hobbies, what you enjoy doing:

Education

Are you currently attending school? ☐ Yes ☐ No

Highest Level of Learning:

☐ High School ☐ Graduate Degree

☐ Associate Degree ☐ Doctorate, Post Doc

☐ Undergraduate Degree Major/Area of Study _____

Military Service

☐ Yes ☐ No (If no, skip this section)

Branch _____ Date of Discharge _____ Type of Discharge: _____

Rank _____ Were you in combat? ☐ Yes ☐ No

Legal

Have you ever been convicted of a misdemeanor or felony (including DUI)? ☐ Yes ☐ No

If yes, please explain:

Are you currently involved in any divorce or child custody proceedings? ☐ Yes ☐ No

If yes, please explain: