

University of Florida & Shands Adult Psychiatry
Outpatient Clinic Intake Form

Date _____

Name _____ Age _____

Address _____

Home phone _____ Work phone _____ Cell phone _____

What issue(s) bring(s) you to the Psychiatry Clinic?

What has been stressing you of late (e.g. Family, job, recent loss of loved ones, financial issues)?

Are you currently having any of the following problems (please circle)?

Depression? Loss of interest in activities? Feeling hopeless, worthless? Poor energy? Poor self-esteem? Change in appetite? Increased or decreased? Fatigue? Poor focus? Problems going to sleep? Thoughts of not being alive? Periods of euphoria or unusually good mood? Having very high energy for no reason? Going days without needing to sleep? Thoughts racing? Talking too fast? Acting impulsively (spending, speeding)?	Worrying excessively? Having tense muscles? So anxious you feel you cannot rest? Having panic attacks? Traumatic events that come back in nightmares, flashbacks? Feeling awkward in public? Thoughts that replay? Repetitive or compulsive behaviors? Phobias or fears? Grunts, tics, or jerks? Inattentiveness at work or school? If so, since what age? Hyperactive or fidgety?	Hearing voices? Seeing things? Feelings people were trying to watch or harm you? Concerns about alcohol use? Drug use? Concerns about eating too much? Eating too little? Memory problems? Getting lost easily? Forgetting how to do tasks? Problems finding words? Problems caring for yourself (cooking, dressing)?
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Past Psychiatric Care

Have you been ever diagnosed with a mental health condition by a medical provider (e.g. Depression, bipolar, schizophrenia, ADHD)? If so, please list.

Have you ever been seen by a psychiatrist or therapist/counselor? Please list and describe.

Date(s) seen? By whom?	For what problem?	What treatment (meds, ECT, therapy)?

Have you ever been hospitalized for psychiatric care? Please list and describe.

Date(s)	Where and for what?	What treatment (meds, ECT, therapy)?

Have you ever been treated with any of the following medications? Circle all that apply and list any good or bad effects of the medications.

Med	Good/bad effects	Med	Good/bad effects	Med	Good/bad effects
Abilify		Haldol		Ritalin	
Ambien		Klonopin		Saphris	
Adderall		Invega		Serax	
Anafranil		Lamictal		Seroquel	
Antabuse		Latuda		Serzone	
Ascendin		Lexapro		Soma	
Atarax		Librium		Sonata	
Ativan		Lithium		Stelazine	
Buspar		Lunesta		Strattera	

Campral		Luvox		Suboxone/ subutex	
Celexa		Marplan		Symmetrel	
Chloral hydrate		Mellaril		Tegretol	
Clonidine		Methadone		Thorazine	
Clozaril		Miltown		Tofranil	
Cogentin		Nardil		Topomax	
Concerta		Norpramine		Traxene	
Cymbalta		Orap		Trazodone	
Dalmane		Pamelor		Trileptal	
Depakote		Parnate		Valium	
Dexedrine		Paxil		Vibryd	
Doral		Prosom		Vistraril	
Effexor		Pristiq		Vivitrol	
Elavil		Prolixin		Wellbutrin	
Fanapt		Remeron		Xanax	
Geodon		Restoril		Zoloft	
Halcion		Risperdal		Zyprexa	

Any other psychiatric medications you have taken?

Past Medical Care

Do you have a primary care doctor? Name _____ Last Seen? _____

What medical illnesses do you have?

What surgeries have you had?

Please list all medications you are currently taking, including over-the-counter medications, herbals, and supplements.

Medication	Dosage	# times per day	For what condition	Who prescribes it

Describe any allergies you have (e.g. to medications, foods).

Are you currently having or have you recently had any of these physical symptoms?

Fevers	Headache	Constipation	Hot/cold flashes
Chills	Chest pain	Acid reflux	Decreased sex drive
Night sweats	Shortness of breath	Joint pains	Problems reaching orgasm
Unexplained weight loss/gain	Heart palpitations	Muscle pains or tension	Easy bruising or bleeding
Weakness in arms/legs	Cough	Pain or difficulty urinating	Rashes
Numbness in arms/legs	Sore throat	Dental problems	
Episodes of passing out	Nausea or vomiting	Changes in vision	
Problems walking	Diarrhea	Changes in hearing	

For women-

Last menstrual period? _____

Usually regular? Yes/no

Do you use any birth control? Yes/no

If yes, please list. _____

Have you been pregnant before? Yes/no

If yes, how many times? _____

Miscarriages? Yes/no

Elective abortions? Yes/no

Any depression or unreal thoughts around pregnancies? Yes/no

Substance Use History

How often have you used the following substances?

	Last time used?	Approximately how often (# of times per week, month or year)?	How much do you use in a sitting if/when you do use?
Tobacco			
Alcohol			
Marijuana or K2/"spice"			
Cocaine			
Opiates (e.g. Heroin, morphine, Percocet,			

oxycodone, Tylenol #3, Dilaudid/hydromorphone)			
Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)			
PCP or LSD			
Mushrooms			
Others			

Family History

Please list blood relatives who have been diagnosed with the following conditions.

Alcoholism _____

Anxiety disorders _____

Bipolar disorder _____

Cancer _____

Depression _____

Diabetes _____

Drug abuse _____

Heart disease/high blood pressure/arrhythmias _____

Osteoporosis _____

Seizures _____

Schizophrenia _____

Strokes _____

Suicides _____

Thyroid disease _____

Social History

Where do you live? _____

Who lives with you? _____

How far did you go in school/highest level of education? _____

What is your current job/occupation? _____

What jobs have you had in the past?

Are you married? Yes/no

If so, for how long? _____

Have you been married in the past? Yes/no # of times? _____
Do you have children? Yes/no If so, how many, what are their ages? _____

What do you do in your free time to relax?

Do you have any religious beliefs? Yes/ No
How important are your religious/spiritual beliefs to your life? _____

Have you had any legal issues (arrests, charges, time in jail)? If so, please describe.

Have you ever been the victim of a violent crime? Yes/No
Have you ever been a victim of physical abuse? Emotional? Sexual abuse or rape? If so, please explain.

Safety

Do currently have thoughts of hurting yourself? Yes/no Please explain.

Have you tried to hurt yourself in the past? If so, please explain.

Do you currently have thoughts of hurting anyone else? Yes/no Please explain.

Have you tried to hurt anyone in the past? If so, please explain.

Do you own any guns or knives? _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name _____

Date _____

Provider _____

Patient ID # _____

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

add columns: + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

<p>10. If you checked off <i>any</i> problems, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

The Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

- 0 = would **never** doze
- 1 = **slight chance** of dozing
- 2 = **moderate chance** of dozing
- 3 = **high chance** of dozing

SITUATION	CHANCE OF DOZING (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL SCORE	

SCORE RESULTS:

- 1-6 Congratulations, you are getting enough sleep!
- 7-8 Your score is average
- 9 and up Very sleepy and should seek medical advice

Johns, M.W. (1991). A new method for measuring daytime sleepiness: The Epworth sleepiness scale. *Sleep, 14*, 540-545. Permission for single-use of the information contained in this material was obtained from the Associated Professional Sleep Societies, LLC, September 2006.

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try this:

general assessment series

Best Practices in Nursing
Care to Older Adults

A series provided by The Hartford Institute for Geriatric Nursing,
New York University, College of Nursing

EMAIL hartford.ign@nyu.edu HARTFORD INSTITUTE WEBSITE www.hartfordign.org
CLINICAL NURSING WEBSITE www.ConsultGerIRN.org

CHECKLIST: Review of Systems

Patient Name: _____ Date of visit: _____

<p>CONSTITUTIONAL: Yes No <input type="checkbox"/> <input type="checkbox"/> Weight Loss <input type="checkbox"/> <input type="checkbox"/> Fatigue <input type="checkbox"/> <input type="checkbox"/> Fever</p> <p>EYES: Yes No <input type="checkbox"/> <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> <input type="checkbox"/> Eye Pain <input type="checkbox"/> <input type="checkbox"/> Double Vision <input type="checkbox"/> <input type="checkbox"/> Cataracts</p> <p>EAR, NOSE, THROAT: Yes No <input type="checkbox"/> <input type="checkbox"/> Difficulty Hearing <input type="checkbox"/> <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> <input type="checkbox"/> Vertigo <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> <input type="checkbox"/> Nasal Stuffiness <input type="checkbox"/> <input type="checkbox"/> Frequent Sore Throat</p> <p>CARDIOVASCULAR: Yes No <input type="checkbox"/> <input type="checkbox"/> Murmur <input type="checkbox"/> <input type="checkbox"/> Chest Pain <input type="checkbox"/> <input type="checkbox"/> Palpitations <input type="checkbox"/> <input type="checkbox"/> Dizziness <input type="checkbox"/> <input type="checkbox"/> Fainting Spells <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> <input type="checkbox"/> Difficulty lying Flat <input type="checkbox"/> <input type="checkbox"/> Swelling Ankles</p> <p>ENDOCRINE: Yes No <input type="checkbox"/> <input type="checkbox"/> Loss of Hair <input type="checkbox"/> <input type="checkbox"/> Heat/Cold Intolerance</p>	<p>RESPIRATORY: Yes No <input type="checkbox"/> <input type="checkbox"/> Cough Easy <input type="checkbox"/> <input type="checkbox"/> Coughing Blood <input type="checkbox"/> <input type="checkbox"/> Wheezing <input type="checkbox"/> <input type="checkbox"/> Chills</p> <p>GASTROINTESTINAL: Yes No <input type="checkbox"/> <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> Change in BMs <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Jaundice <input type="checkbox"/> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> <input type="checkbox"/> Black or Bloody BM</p> <p>GENITOURINARY: Yes No <input type="checkbox"/> <input type="checkbox"/> Burning/Frequency <input type="checkbox"/> <input type="checkbox"/> Nighttime <input type="checkbox"/> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> <input type="checkbox"/> Abnormal Discharge <input type="checkbox"/> <input type="checkbox"/> Bladder Leakage</p> <p>ALLERGIC/IMMUNOLOGIC: Yes No <input type="checkbox"/> <input type="checkbox"/> Hives/Eczema <input type="checkbox"/> <input type="checkbox"/> Hay Fever</p> <p>PSYCHIATRIC: Yes No <input type="checkbox"/> <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> <input type="checkbox"/> Mood Swings <input type="checkbox"/> <input type="checkbox"/> Difficult Sleeping</p>	<p>HEMATOLOGY/LYMPH: Yes No <input type="checkbox"/> <input type="checkbox"/> Easy Bruising <input type="checkbox"/> <input type="checkbox"/> Gums Bleed Easily <input type="checkbox"/> <input type="checkbox"/> Enlarged Glands</p> <p>MUSCULOSKELETAL: Yes No <input type="checkbox"/> <input type="checkbox"/> Joint Pain/Swelling <input type="checkbox"/> <input type="checkbox"/> Stiffness <input type="checkbox"/> <input type="checkbox"/> Muscle Pain <input type="checkbox"/> <input type="checkbox"/> Back Pain</p> <p>SKIN: Yes No <input type="checkbox"/> <input type="checkbox"/> Rash/Sores <input type="checkbox"/> <input type="checkbox"/> Lesions <input type="checkbox"/> <input type="checkbox"/> Itching/Burning</p> <p>NEUROLOGICAL: Yes No <input type="checkbox"/> <input type="checkbox"/> Loss of Strength <input type="checkbox"/> <input type="checkbox"/> Numbness <input type="checkbox"/> <input type="checkbox"/> Headaches <input type="checkbox"/> <input type="checkbox"/> Tremors <input type="checkbox"/> <input type="checkbox"/> Memory Loss</p> <p>FEMALES ONLY: Date Last Mammogram _____ Normal ___ Abnormal ___ Date last PAP _____ Normal ___ Abnormal ___ Age Onset Periods _____ Age Onset Menopause _____ Periods Regular? Yes ___ No ___ Number _____ Pregnancies _____</p>
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<http://compliance.med.ufl.edu/compliance-tips/review-of-systems-ros-in-em-services/>