VIVEK AGNIHOTRI, M.D. LLC

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ADULT INTAKE & PERSONAL HISTORY FORM

Name: _____ Social Security#: _____

Gender: ☐F ☐ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home):_____(cell): _____ Email.:_____

Person Responsible for Payment _____ Soc. Sec #_____

Relationship _____

Signature of Person Responsible for Payment **X**_____ Date: _____

Must be signed for services to begin

Pharmacy Information

Name: _____ Address: _____ Phone: _____

Are you ALLERGIC to any medications? _____

If Yes, describe reaction: _____

Emergency Information *In case of emergency, contact:*

Name:_____Relationship:_____Phone: _____

Referral Source

How did you hear about our office (or from whom)? _____

Education

Fill in all that apply: Years of education:_____Currently enrolled in school? ☐Yes ☐No

☐High school grad/GED ☐ College Name:_____#of years: _____ Graduated: ☐Yes ☐No

Major:_____Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Occupation: _____ Employer:_____

Currently: ☐FT ☐ PT ☐ Temp ☐Laid-off ☐Disabled ☐Retired ☐Social Security ☐Student

☐ Other (describe): _____

Primary reason(s) for seeking services: (*please describe*)

_____

_____

_____

_____

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Prior Psychiatric Treatment History

Current Therapist/Clinician:_____ Phone:_____

Address: _____

Prior Psychiatric Hospitalizations? ☐NO ☐YES please describe (hospital, dates, reason)

_____

Prior Suicide Attempts? _____

Current Psychiatric Medications & Dosage: _____

_____

Prior trials of Psychiatric Medications: _____

_____

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Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- ☐ Aggression
- ☐ Alcohol dependence
- ☐ Anger
- ☐ Antisocial behavior
- ☐ Anxiety
- ☐ Avoiding people
- ☐ Chest pain
- ☐ Cyber addiction
- ☐ Depression
- ☐ Disorientation
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug dependence
- ☐ Eating disorder
- ☐ Elevated mood
- ☐ Fatigue
- ☐ Gambling
- ☐ Hallucinations
- ☐ Heart palpitations
- ☐ High blood pressure
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Memory impairment
- ☐ Mood shifts
- ☐ Panic attacks
- ☐ Phobias/fears
- ☐ Recurring thoughts
- ☐ Sexual addiction
- ☐ Sexual difficulties
- ☐ Sick often
- ☐ Sleeping problems
- ☐ Speech problems
- ☐ Suicidal thoughts
- ☐ Thoughts disorganized
- ☐ Trembling
- ☐ Withdrawing
- ☐ Worrying
- ☐ Other (specify): _____

Please check if there have been any recent changes in the following:

- ☐ Sleep patterns
- ☐ Eating patterns
- ☐ Behavior
- ☐ Energy level
- ☐ Physical activity level
- ☐ General disposition
- ☐ Weight
- ☐ Nervousness/tension

Describe changes in areas in which you checked above, or any other changes noticed:

_____

_____

_____

Medical/Physical Health

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Primary Care Physician: _____ Phone: _____

Address: _____

List any medical diagnoses: _____

List any recent health or physical changes: _____

List any surgeries: _____

Family Medical/Psychiatric History

Please list any diseases/genetic illness occurring among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents), (please esp. include any family members who have/had any psychiatric issues or problems with substance abuse.

_____

_____

_____

_____

Social Relationships

Marital Status:_____if ☐married or in ☐relationship how many years _____

Children: ☐ yes ☐ no if yes how many, ages, male or female _____

Who lives in your household? _____

Assessment of current relationship (if applicable): ☐Good ☐Fair ☐ Poor

Sexual orientation:_____Comments: _____

Development

Are there special, unusual, abuse or other traumatic circumstances that affected your development? ☐**Yes** ☐**No**

If Yes, please describe: _____

_____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Legal

Are you involved in any active cases (traffic, civil, criminal)? ☐ Yes ☐ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Are you presently on probation or parole? ☐**Yes** ☐**No** If Yes, please describe: _____

_____

Past Legal History

Traffic violations: ☐Yes ☐ No DWI, DUI, etc.: ☐ Yes ☐ No

Criminal involvement: ☐ Yes ☐ No Civil involvement: ☐ Yes ☐ No

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	NO	Yes	NO
Alcohol					☐	☐	☐	☐
Barbiturates					☐	☐	☐	☐
Valium/Xanax					☐	☐	☐	☐
Cocaine/Crack					☐	☐	☐	☐
Heroin/Opiates					☐	☐	☐	☐
Marijuana					☐	☐	☐	☐
PCP/LSD/Mescaline					☐	☐	☐	☐
Inhalants					☐	☐	☐	☐
Caffeine					☐	☐	☐	☐
Nicotine					☐	☐	☐	☐
Over the counter					☐	☐	☐	☐
Prescription pain meds					☐	☐	☐	☐
Other drugs					☐	☐	☐	☐

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Substance Abuse Questions

Describe when and where you typically use substances: _____

_____

Describe any changes in your use patterns: _____

_____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

_____

How do you believe your substance use affects your life? ___

_____ Who or what has helped you in stopping or limiting your use? _____

Have you ever needed detoxification/rehabilitation for alcohol or drugs? ☐Yes ☐ No

If Yes, describe with dates and locations: _____

_____

Any additional information that would assist us in understanding your concerns or problems: _____

_____

_____

What are your hopes/goals for treatment? _____

_____

_____