Confidential SIMEDHealth, LLC - Psychology Intake Form

Legal Name	_____ (First) (Middle) (Last)
Date of Birth	
How would you identify your sexual orientation?	❑ Straight/Heterosexual ❑ Lesbian/Gay/Homosexual ❑ Bisexual ❑ Transsexual ❑ Asexual ❑ Other:_____
Current Marital Status	❑ Single, not in a relationship ❑ Single, in a relationship ❑ Married for _____ years ❑ Divorced for _____ years ❑ Widowed for _____ years
Spouse/Significant Other's Name	
What is your Spouse/ Significant Other's work status?	❑ Fulltime employment ❑ Part-time employment ❑ Unemployed ❑ Disabled
Have you had any prior marriages?	❑ No ❑ Yes If Yes, how many times have you been married? _____
Do you have children?	❑ No ❑ Yes If Yes, how many children do you have? _____

Please list all the people that you live with.

Name	***Age***	***Relationship***

What City & State were you born in?	
Who was responsible for raising you as a child? (Check all that apply)	❑ Biological Mother ❑ Step Mother ❑ Biological Father ❑ Step Father ❑ Sibling(s) ❑ Uncle ❑ Aunt ❑ Grandmother ❑ Grandfather ❑ Adopted family ❑ Foster family ❑ Other:_____
What was your father's occupation?	
What was your mother's occupation?	
Did your parents' divorce?	❑ No ❑ Yes If Yes, how old were you when they divorced? _____

Please list siblings and ages.

Name	***Age***

Do you have any history of being neglected and/or emotionally, sexually, or physically abuse?	❑ No ❑ Yes If Yes, Please describe when, where, and by whom? _____ _____ _____
What is your highest level of education?	❑ _____Grade ❑ G.E.D. ❑ High School Diploma ❑ Associates Degree ❑ Bachelor's Degree ❑ Master' Degree ❑ M.D./D.O ❑ J.D. ❑ Ph.D. ❑ Other: _____
Were you ever held back or failed any grades?	❑ No ❑ Yes If Yes, Please list which grades you failed or repeated: _____ _____ _____
Were you ever placed in any remedial or special education classes?	❑ No ❑ Yes If Yes, Please list when you were placed in those classes_____ _____ _____

Have you ever served in the military?	❑ No ❑ Yes If Yes, Please list branch and years of service: _____ _____
Are you currently employed?	❑ No ❑ Yes If Yes, Please list your job title and the name of employer: _____ _____
If you are working, when did you last work?	
If you are working, how many hours do you work per week?	_____ Hours Per week If you have any work restrictions please list them here: _____ _____
Have you ever been convicted of a felony?	❑ No ❑ Yes If Yes, Please provide specifics: _____ _____
Do you have any pending legal problems?	❑ No ❑ Yes If Yes, Please provide specifics: _____ _____
Have there ever been any times that you have not been able to obtain your prescription medications (e.g., problems with authorization, finances) or not taken them as prescribed (e.g., missing dosages, doubling up on dosages) to get a better effect?	❑ No ❑ Yes If Yes, Please describe what happened:_____ _____
Have you ever been hospitalized for any medical condition?	❑ No ❑ Yes If Yes, Please describe the reason for medical hospitalizations and dates: _____ _____
Have you ever received any previous <u>outpatient</u> mental health care (e.g., psychiatric evaluations, neuropsychological testing, psychotherapy, substance/ alcohol abuse counseling)?	❑ No ❑ Yes If Yes, Please describe the mental health care received and dates: _____ _____

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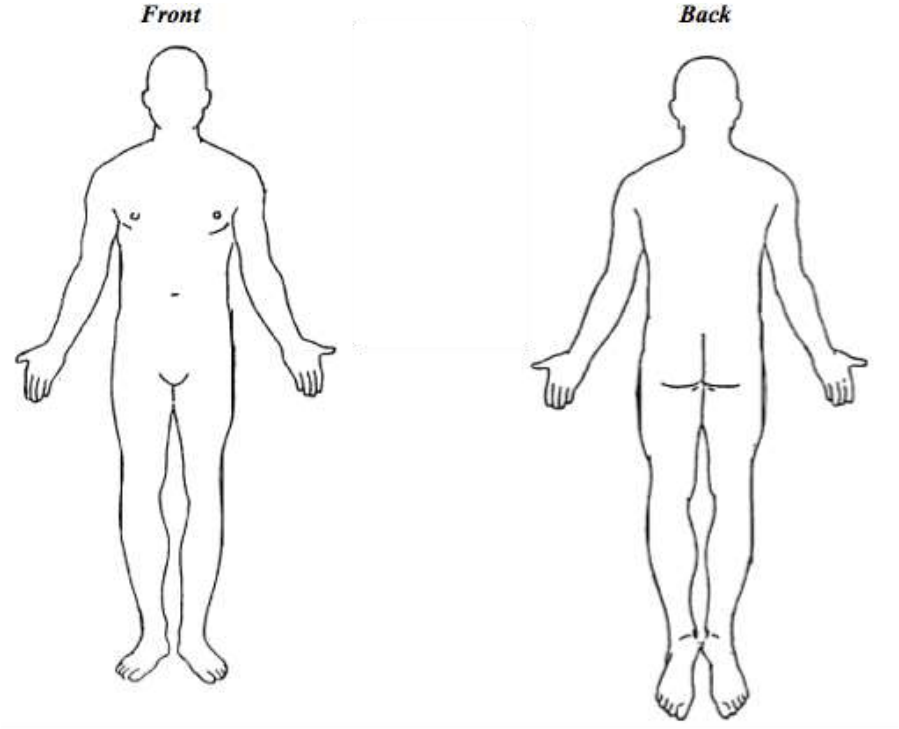
Please indicate if you or any family have been hospitalized, diagnosed, and / or treated for any of the following mental health issues.	***Problem***	***Person with the Mental Health Issue***
	❑ Alzheimer Dementia	
	❑ Alcoholism	
	❑ Anger / Violent outbursts	
	❑ Anorexia / Bulimia	
	❑ Anxiety / Panic Attacks / "Nervous Breakdown"	
	❑ Attention-Deficit/Hyperactivity Disorder (ADD/ADHD)	
	❑ Bipolar Disorder	
	❑ Depression	
	❑ Drug Abuse	
	❑ Drug Overdose	
	❑ Hallucinations / Delusional Thinking	
	❑ Inappropriate / Hypersexual Behaviors	
	❑ Obsessive-Compulsive Disorder (OCD)	
	❑ Post-Traumatic Stress Disorder (PTSD)	
	❑ Schizophrenia	
	❑ Suicide Attempt	
	❑ Other:	
Are you currently drinking caffeinated beverages such as coffee, tea, or colas?	❑ No ❑ Yes If Yes, how many drinks do consume in a day? _____	
Have you ever smoked cigarettes / cigars / pipes?	❑ No ❑ Yes If Yes, how many cigarettes / cigars / pipes did you smoke in a day? _____	
Are you currently smoking cigarettes / cigars / pipes?	❑ No ❑ Yes If Yes, how many cigarettes / cigars / pipes do smoke in a day? _____	
Have you ever used chewing tobacco?	❑ No ❑ Yes If Yes, how much chew did you use in a day? _____	
Are you currently using chewing tobacco?	❑ No ❑ Yes If Yes, how much do you chew in a day? _____	
Have you ever drank alcoholic beverages on a regular basis?	❑ No ❑ Yes If Yes, how much did you drink in a day? _____	
Are you currently drinking alcoholic beverages?	❑ No ❑ Yes If Yes, how many drinks in a day? _____	
Have you ever used illicit / street drugs such as marijuana, cocaine, crack, heroin, ecstasy, crank, LSD, speed, inhalants, etc?	❑ No ❑ Yes If Yes, which drugs have you used and for how long? _____	
Are you currently using illicit / street drugs such as marijuana, cocaine, crack, heroin, ecstasy, crank, LSD, speed, etc?	❑ No ❑ Yes If Yes, which drugs are you using and how much are you using in a day/week?	

Please mark the location on the diagram where and what type of pain you are having:

Achy Pain = ^^^^
Burning = XXXX
Numbness = 0000
Pins & Needles = ++++
Radiating Pain = ////



How did your chronic pain start?

_____
_____

On a scale of 0-10 with 0 = no pain and 10 = the worst pain imaginable rate:

_____/10 = Current Pain Levels
_____/10 = Lowest Pain Levels
_____/10 = Weekly Average Pain Levels
_____/10 = Highest Pain Levels

What makes your pain worse?

_____
_____

What makes your pain better?

_____
_____

Please check off any symptoms you may have experienced over the past month:

- ❑ Abnormal menstrual cycle / spotting
- ❑ Abdominal bloating / gas
- ❑ Anger Outbursts
- ❑ Body tension
- ❑ Blackouts
- ❑ Breathing difficulties
- ❑ Constipation
- ❑ Crying Spells
- ❑ Decreased attention/concentration
- ❑ Dizziness
- ❑ Decreased libido (interest in sex)
- ❑ Depressed mood
- ❑ Diarrhea
- ❑ Electrical shock sensation in head/brain
- ❑ Erectile difficulties
- ❑ Excessive energy
- ❑ Excessive guilt
- ❑ Excessive worry
- ❑ Excessive sweating
- ❑ Fatigue / poor energy
- ❑ Flashbacks of traumatic events
- ❑ Feelings of internal restlessness
- ❑ Forgetfulness
- ❑ Grandiose thoughts
- ❑ Hallucinations
- ❑ Hot flashes
- ❑ Hopelessness/Helplessness
- ❑ Impulsivity
- ❑ Inability to enjoy activities
- ❑ Increased irritability
- ❑ Increase risky behavior
- ❑ Increased libido (interest in sex)
- ❑ Inability to express emotion
- ❑ Loss of interest
- ❑ Muscle soreness
- ❑ Panic attacks
- ❑ Racing/erratic heartbeat
- ❑ Racing thoughts
- ❑ Repetitive cleaning/organizing/counting
- ❑ Ringing in ears
- ❑ Seizures
- ❑ Shaking (hands, feet, whole body)
- ❑ Skin rashes
- ❑ Social avoidance
- ❑ Spending Sprees
- ❑ Suspiciousness
- ❑ Thoughts of killing oneself
- ❑ Thoughts of killing another person
- ❑ Unexplained lapses of time
- ❑ Vision changes (blurry, double vision, etc.)

Have you experienced any recent changes in your appetite?	❑ No ❑ Yes -- If Yes, which have you experienced: ❑ No appetite ❑ Decreased appetite ❑ Increased appetite ❑ Increased cravings for certain foods ❑ Nausea/Vomiting when eating or thinking of food ❑ Other: _____
Have you experienced any recent changes in your weight?	❑ No ❑ Yes -- If Yes, which have you experienced: ❑ Weight gain of _____ lbs. in _____ months ❑ Weight loss of _____ lbs. in _____ months ❑ Other: _____
Have you experienced any recent changes in your sleep habits?	❑ No ❑ Yes -- If Yes, which have you experienced: ❑ Difficulty getting to sleep ❑ Difficulty staying asleep ❑ Waking up earlier than normal ❑ Night Sweats ❑ Restless sleeping ❑ Daytime sleepiness ❑ Daytime napping ❑ Nightmares ❑ Other: _____
Do you need any help walking or getting from place to place?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? _____ _____
Do you need any help bathing, grooming, or dressing yourself?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? _____ _____
Do you need any help preparing meals for yourself?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? _____ _____
Do you need any help cleaning your residence?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? _____ _____
Do you need any help doing your laundry?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? _____ _____
Do you need any help paying your bills or managing your finances?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? _____ _____
Do you need any help getting, organizing, or taking your medications?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? _____ _____
Do you need any help with shopping?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? _____ _____
Do you need any help caring for others who live with you such as children, medically ill spouses, or parents?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? _____ _____
If you are working, do you need any help doing your job?	❑ No ❑ Yes -- If Yes, what type of help do you need and who helps you? _____ _____

Certification of Accuracy

I certify that the answers provided in this 6 page Confidential Southeastern Health Psychology Intake Form are accurate to the best of my knowledge.

_____ _____

Patient's Signature Date

_____ _____

Signature of Legal Guardian Date