



PSYCHIATRIC INTEGRAL INTAKE

Andre Marquis, Ph.D. and David Leavitt, M.D.

Client's Name _____ Age _____ Date First Seen _____

Home Phone (_____) _____ (message: Y/N) Work Phone (_____) _____ (message: Y/N)

Address _____ City _____ Zip _____

Date of Birth _____ Gender (M/F) Referral Source _____

Emergency Contact: Name _____ Phone (_____) _____

(Please use the back side of this form if you need more space to respond to *any* of the questions. Please attach medical records as appropriate.)

PRELIMINARY ISSUES AND PREVIOUS TREATMENT

What is the primary concern or problem for which you are seeking help?

What makes it better? What makes it worse?

Are there any *immediate* challenges or issues that need our attention? Yes/No If yes, please describe.

Have you had previous psychiatric treatment, counseling or psychotherapy? Yes/No From when to when? With whom?

If you've had treatment, what was it like for you? What most helpful? Least helpful?

What do you expect from your psychiatric treatment here?

EXPERIENCE: Individual-Interior

How would you describe your general mood/feelings in the past 2 weeks?

What emotions do you tend to feel most strongly?

Please mark any of the following feelings or experiences you've had recently, or have had sometimes in the past:

- Difficulty concentrating
- Little interest or pleasure in doing things
- Poor or excessive appetite
- Excessive tiredness
- Feeling hopeless
- Feeling helpless
- Intense feelings of guilt
- Having much more energy than normal
- Thoughts racing through your head
- Needing less sleep than normal
- Thoughts that you would be better off dead
- Desire to harm yourself
- Desire to harm someone else
- Hearing or seeing things not actually there
- Thoughts that seem strange but that you can't seem to stop
- Anxiety attacks that happen for no apparent reason
- Constant or excessive worry about things
- Fear that someone is trying to harm you

Please describe more about any of the feelings or experiences above that you've had:

What are some of your strengths?

What are some of your weaknesses?

How do you respond to stressful situations, or when you experience intense emotions?

How do you make decisions (for example, do you use logic and reason, or do you trust your gut and heart)?

Have you ever attempted to seriously harm or kill yourself or anyone else? Yes/No If yes, please describe.

Are you presently experiencing suicidal thoughts, or thoughts of wanting to harm someone else? Yes/No If yes, please describe.

Have there been any serious illnesses, births, deaths, or other losses in your family that affected you? Yes/No If yes, please describe.

What is your most painful memory?

Have you ever been a victim of, or witnessed, verbal, emotional, physical, and/or sexual abuse? Yes/No If yes, please briefly describe. Do you feel you are still affected by it?

In general, how satisfied are you with your life?

Not at all 1 2 3 4 5 6 7 Very

In general, how do you feel about yourself (self-esteem)?

Very bad 1 2 3 4 5 6 7 Very good

In general, how much control do you feel you have over your life and how you feel?

None at all 1 2 3 4 5 6 7 A lot

BEHAVIOR: Individual-Exterior

Have you ever been hospitalized for a psychiatric illness (i.e., depression/feeling suicidal/nervous breakdown)? Yes/No What were your hospitalized for? From when to when?

Illnesses you have now or have had in the past:	Past (X)	Present (X)	Comments (briefly describe your illness and whether it is causing problems now)
Seizures			
Thyroid Disease			
Head Injury			
Other _____			
Other _____			
Other _____			
Other _____			
Other _____			
Other _____			

Allergic reactions to medications:

Medication:

What happened:

Surgeries:

What:

When:

What prescription medications are you taking now?

****Please bring your bottles with you to your appointment***

Medication:	What It Is For:	When Started:	Dosage Per Day:

What vitamins / minerals / herbs / supplements are you taking now?

****Please bring your bottles with you to your appointment****

Product Name / Brand:	What It Is For:	When Started:	Dosage Per Day:

What medications have you taken in the past for any psychiatric illness? (i.e., depression, anxiety, insomnia, etc.)

Medication:	What It Was For:	Duration of Use:	Response (Did it help? Side effects?)

Do you have a primary care physician? Yes/No If yes, who is it? _____ Office phone number _____

Please estimate your: Height _____ Weight in lbs _____

When was your last physical? _____ Were there any noteworthy results (diseases, blood pressure, etc.)? Yes/No If so, please describe: _____

Please mark any of the following behaviors that are true of you:

- I eat too much
- I eat too little
- I neglect friends and family
- I tend to neglect myself and my own needs
- I have difficulty being kind and loving to myself
- I act in ways that end up hurting myself or others
- I tend to lose my temper easily
- I can't control some of my behaviors
- I sometimes spend more money than I can afford to
- I cry frequently

Are there any other behaviors you are concerned about? Yes/No If yes, please describe:

Please mark if you sometimes have the following difficulties:

- Headaches
- Menstrual problems
- Dizziness
- Heart palpitations or tremors
- Jitters
- Tingling/numbness
- Blackouts

Do you have other physical pains or difficulties? Yes/No If yes, what are they?

In general, how would you rate your physical health?

Very unhealthy 1 2 3 4 5 6 7 Very healthy

Describe your current sleeping patterns (When do you sleep? How many hours per 24 hours? Do you have trouble falling asleep, staying asleep, or waking up in the morning?)

Describe your normal eating habits (types of food, and how much).

What experiences have you had with alternative and complementary therapies? (Please fill in below)

Type of Therapy:	(X)	Comments – (Please specify which modality in this category was used, for how long, & results)
Herbs		
Homeopathy		
Folk remedies		
Bodywork or Massage		
Chiropractic / Osteopathy		
Energy Work (i.e., healing touch, Reiki Johrei, QiGong)		
Prayer		
Self-help groups		
Acupuncture or Oriental medicine		
Ayurveda		
Exercise		
Yoga		
Chi/Qi Gong		
Hypnosis		
Relaxation		
Meditation		
Biofeedback		
Imagery		
Other _____		
Other _____		

Describe your drug and alcohol use (both past and present). Do you feel you currently are having problems with any substances?

Do you engage in some form of exercise (aerobic and/or strength building)? Yes/No If yes, please describe.

Do you have any communication impairments (sight, hearing, speech)? Yes/No If yes, please describe.

CULTURE: Collective-Interior

Describe your relationships, including friends, family, and co-workers.

What is important and meaningful to you? What matters the most to you?

In general, how satisfied are you with your friendships and other relationships?

Not at all 1 2 3 4 5 6 7 Very

In general, how comfortable are you in social situations?

Not at all 1 2 3 4 5 6 7 Very

In general, how satisfied are you with your religion/spirituality?

Not at all 1 2 3 4 5 6 7 Very

Which emotions were encouraged or commonly expressed in your *family of origin* (family you grew up with)?

Which emotions were discouraged or not allowed in your *family of origin*?

What emotions are most comfortable for you now? _____

What emotions are least comfortable for you now? _____

How do you identify yourself ethnically? How important is your ethnic culture to you?

Describe your sex life. How satisfied are you with your sex life?

Do you have a religious/spiritual affiliation and/or practice? Yes/No Please explain.

What beliefs do you have about religion/spirituality? How important to you are those beliefs?

Are you involved with any cultural activities or institutions? Yes/No If yes, please describe.

SOCIAL SYSTEMS: Collective-Exterior

List your *family of origin* (family you grew up with), beginning with the oldest, include parents and yourself.

Name	Age	Gender	Relationship to you (include "step" and "half" etc.)

List your *current family* or all the people you currently live with (begin with the oldest person and include yourself).

Name	Age	Gender	Relationship to you (include "step" and "half" etc.)

Family psychiatric history	(X)	List family members who have had these illnesses (siblings, parent, grandparent, children)
Depression		
Anxiety		
Head Injury		
Bipolar or Manic-depressive		
Schizophrenia		
Alcohol or Substance abuse		
Suicides		
Psychiatric hospitalizations		
Other _____		

Describe your current *physical* home environment. For example, describe the layout of your home, and other general conditions, such as, privacy, is it well-lighted?, do you have A/C?, heating?, etc.

Describe your current *social* home environment (What is it like at home? How do you get along with those who live with you?)

Do you have pets? Yes/No How important are they to you? _____

Describe your neighborhood. (Is it safe/dangerous, nice/unpleasant, quiet/loud, etc.?)

Are you currently employed? Yes/No If so, describe the type of work you do and the hours you usually work.

How satisfied are you with the type of work you do?

Not at all 1 2 3 4 5 6 7 Very

What is your yearly income? \$_____ per year. How satisfied are you with your standard of living?

Not at all 1 2 3 4 5 6 7 Very

Describe your work environment (include co-workers and supervisors who directly affect you).

Do you currently have a spouse or romantic partner? Yes/No Have you been married before? Yes/No If yes, please describe.

Do you have children? Yes/No If so, please list their names, ages, and any other important information about them.
