Coastal Calm Psychiatry Associates LLC

Psychiatric Diagnostic New Patient Intake Form

Confidentiality Notice: All information provided is protected under HIPAA regulations.

Patient Demographics
Full Name: _____
Date of Birth: ___/___/___ Age: ___
Gender Identity: _____ Preferred Pronouns: _____
Address: _____ City/State/ZIP: _____
Phone: (___) _____-_____
Alternate Phone: (___) _____-_____
Email: _____ Emergency Contact: _____
Relationship to Emergency Contact: _____ Emergency Contact Phone: (___) _____-_____

How did you hear about us? _____

Chief Complaint & Presenting Problem
1. Reason for seeking psychiatric care today:
_____
_____

2. Duration of symptoms: ___ days/weeks/months/years
3. Severity (1-10): ___ (1 = mild, 10 = severe)

Psychiatric History
1. Previous psychiatric diagnoses (if any):
☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ PTSD ☐ ADHD
☐ Schizophrenia ☐ OCD ☐ Eating Disorder ☐ Other: _____

2. Previous psychiatric hospitalizations: ☐ Yes ☐ No
If yes, details: _____

3. Previous therapy/counseling: ☐ Yes ☐ No
If yes, provider name & duration: _____

4. Past suicide attempts or self-harm: ☐ Yes ☐ No
If yes, details: _____

5. Past aggressive/homicidal behavior: ☐ Yes ☐ No
If yes, details: _____

6. Previous Medication Trials (Check all that apply, specify "Other" as needed)

- Antidepressants:
  ☐ Fluoxetine (Prozac) ☐ Sertraline (Zoloft) ☐ Escitalopram (Lexapro)
  ☐ Bupropion (Wellbutrin) ☐ Venlafaxine (Effexor) ☐ Other: _____
  Response: ☐ Effective ☐ Partial ☐ Ineffective ☐ Side Effects: _____

- Mood Stabilizers/Antipsychotics:
  ☐ Lithium ☐ Lamotrigine (Lamictal) ☐ Quetiapine (Seroquel)
  ☐ Aripiprazole (Abilify) ☐ Risperidone ☐ Other: _____
  Response: ☐ Effective ☐ Partial ☐ Ineffective ☐ Side Effects: _____

- Anxiety Medications:
  ☐ Lorazepam (Ativan) ☐ Clonazepam (Klonopin) ☐ Diazepam (Valium)
  ☐ Buspirone ☐ Hydroxyzine ☐ Other: _____
  Response: ☐ Effective ☐ Partial ☐ Ineffective ☐ Side Effects: _____

- Stimulants (ADHD):
  ☐ Methylphenidate (Ritalin) ☐ Adderall ☐ Vyvanse
  ☐ Dexedrine ☐ Strattera ☐ Other: _____
  Response: ☐ Effective ☐ Partial ☐ Ineffective ☐ Side Effects: _____

- Sleep Aids:
  ☐ Trazodone ☐ Zolpidem (Ambien) ☐ Mirtazapine (Remeron)
  ☐ Melatonin ☐ Other: _____
  Response: ☐ Effective ☐ Partial ☐ Ineffective ☐ Side Effects: _____

- Other Psychiatric Medications:
  ☐ Prazosin (for PTSD nightmares) ☐ Naltrexone (for cravings)
  ☐ Other: _____
  Response: ☐ Effective ☐ Partial ☐ Ineffective ☐ Side Effects: _____

Additional Notes:
_____

Medical History

1. Current medical conditions:
  ☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Thyroid Disorder
  ☐ Seizures ☐ Chronic Pain ☐ Other: _____

2. Current medications (include dosages):
  - _____
  - _____

3. Allergies (medications/substances): _____

4. Substance Use History:
- Tobacco: ☐ Never ☐ Former ☐ Current (____ per day)
- Alcohol: ☐ Never ☐ Social ☐ Heavy (____ drinks/week)
- Cannabis: ☐ Never ☐ Occasional ☐ Frequent
- Stimulants (cocaine, meth, etc.): ☐ Never ☐ Past ☐ Current
- Opioids: ☐ Never ☐ Prescribed ☐ Misused
- Other substances: _____

Family Psychiatric History
☐ Depression ☐ Bipolar Disorder ☐ Schizophrenia ☐ Anxiety
☐ Substance Use Disorder ☐ Suicide ☐ Other: _____

Social & Developmental History
1. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered
2. Living Situation: ☐ Alone ☐ With Family ☐ With Roommates ☐ Homeless
3. Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Disabled
4. Trauma History (abuse, neglect, accidents, etc.): ☐ Yes ☐ No
   If yes, describe: _____
5. Legal History (arrests, pending charges): ☐ Yes ☐ No
   If yes, describe: _____

Current Symptoms Checklist
Mood Symptoms:
☐ Persistent sadness ☐ Irritability ☐ Mood swings ☐ Loss of interest
☐ Excessive guilt ☐ Hopelessness ☐ Suicidal thoughts

Anxiety Symptoms:
☐ Excessive worry ☐ Panic attacks ☐ Phobias ☐ OCD behaviors
☐ Hypervigilance ☐ Sleep disturbances

Psychotic Symptoms:
☐ Hallucinations ☐ Delusions ☐ Paranoia ☐ Disorganized thinking

Cognitive Symptoms:
☐ Poor concentration ☐ Memory issues ☐ Indecisiveness

Other Symptoms:

☐ Fatigue ☐ Appetite changes ☐ Weight changes ☐ Psychomotor agitation/retardation

Suicide & Homicide Risk Assessment

1. Current suicidal thoughts: ☐ Yes ☐ No
   If yes, frequency & plan: _____

2. Current homicidal thoughts: ☐ Yes ☐ No
   If yes, frequency & plan: _____

Treatment Goals

What do you hope to achieve from treatment?

_____
_____

Consent & Signature

I authorize the evaluation and treatment of the above-named patient and confirm that the information provided is accurate to the best of my knowledge.

Patient/Guardian Signature: _____ Date: ___/___/___
Provider Signature: _____ Date: ___/___/___

Clinic Name & Contact Information: _____