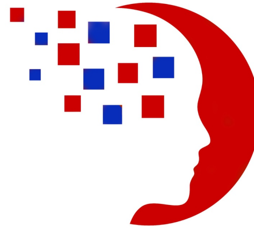
Date ____________



WADSORTH PSYCHIATRIC SERVICES, PLLC

6520 226th Place SE, Suite 203 Issaqua,WA 98027
Office: (425)222-1000 Fax: (206)770-7477
www.psychsvc.com

Patient Information

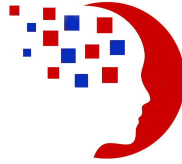
Patient Name ___________________________________ Date of Birth ____________ Age _______
Address ____ City/State/Zip _____________________
Primary phone# _________________ Secondary phone# ___________________
Legal sex: Male ______ Female _____ Other ______ Decline to answer ________
SS# ______ - ____ -_______ Email: ____
Employer _______________________________ Occupation ________________________________
Preferred Pharmacy _____________________ Location _________________ Phone# ______________

Emergency Contact ____
Relationship _____________________________ Phone number ___________________

Are we allowed to leave a message on your voicemail or send you a text? _______________________

Primary Insurance: ________________________________
Group # ____
ID#____
Name of Insured ____________________________________ Date of Birth ______________________
Secondary Insurance: ________________________________
Group # ____
ID#____
Name of Insured ____________________________________ Date of Birth ______________________

Name of person responsible for account: ____
Relationship to patient: ___________________________Date of Birth___________________________
SS# ______ - ____ -_______ Phone number. ___________________________
Address ____
City/State/Zip ____



Wadsworth Psychiatric Services, PLLC

PATIENT INTAKE QUESTIONNAIRE

Patient's Name: ____ Date: ____________________

Person completing this form: □ Patient or Other (give name): ___________________________________

Who referred you to Wadsworth Psychiatric Services?
Name: ____
What kind of help are you seeking? ____
Length of time symptoms: ____
Severity of symptoms: Mild ____________ Moderate _______________ Severe _________________

SYMPTOM CHECK LIST: Please circle (use blank space to add items not listed)

Agitated	Desperate	Distracted	Impaired Performance	Fearful
See things	Obsessions	Crying Spells	Hear Voices	Suspicious
Hopeless	Rapid Speech	Aggressive	Avoid People	Withdrawn
Racing Thoughts	Headaches	Chest Pain	Irritable	Nightmares
Mood Swings	Anxious	Sexual Difficulties	Homicidal	Depressed
Restless	Confused	Feel "out of control"	Worry a lot	Sad
Helpless	Guilt	Trouble Concentrating	Sleep Changes	Anxiety Attacks
Angry/Aggressive	Self-harm	Personality Changes	Overeating	Undereating

SLEEP CHANGES? DESCRIBE:

____

____

Energy Level: □ Tire easily □ Average energy □ High energy

DESCRIBE CURRENT STRESSORS: ____

____

PREVIOUS PSYCHIATRIC TREATMEMNT:

Previous psychiatric conditions you have been treated for ______________________________________

____

____

(CHECK ALL PRIOR Psychiatric/Psychological Treatment or Counseling)
□ None
□ Inpatient Care
When/Where: ____

Please identify where treated or who provided the following treatment:
□ Individual OP Therapy: ____
□ Family Therapy/Marital: ____
□ Partial/Day Hospital: ____
□ Medication Management: ____

CHEMICAL ABUSE/DEPENDENCY HISTORY
Have you ever felt you should cut down on your drinking? □ NO □ YES
Have people annoyed you by criticizing your drinking? □ NO □ YES
Have you ever felt bad or guilty about your drinking? □ NO □ YES
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
□ NO □ YES

Is there a patient history of alcohol, marijuana, street drugs, and/or medication abuse/dependence?
□ NO □ YES, If yes please explain:
____

Drug Abused/Experimented	**Age of Onset**	**Dose/Amt**	**How Often?**	**Last Used**

Do you smoke? □ NO □ YES If yes, how much? ________________
Trying to Quit? □ NO □ YES
Amount of caffeine consumed in a day: ______________________
Has there been exposure to toxic substances? ___________________

MEDICAL HISTORY:
Family Physician: Name: ____
Phone:____
Address: ____
Date of your last complete physical exam? ____
Problems? ____

Accidents/Surgeries:

____

List current medical diagnosis you are being treated for

MEDICATIONS CURENTLY IN USE:
(Prescribed or over-the-counter) □ None Used

Name of Med	**Dosage**	**Frequency**	**Last Dose**

PSYCHIATRIC MEDICATIONS TAKEN IN THE PAST:

Name of Med	**Dosage**	**Reason Stopped**	**Last Used**

Medication Allergies: ____

REVIEW OF SYSTEMS

VISUAL □ No Problem □ State Problem: ____

HEARING □ No Problem □ State Problem: ____

RESPIRATORY
□ No Problem □ Asthma □ Hay Fever □ Congestion □ Short of Breath □ Emphysema □ Wheezing □ Tuberculosis □ Sputum production □ Cough up blood

CARDIOVASCULAR
□ No Problem □ High blood pressure □ Low blood pressure □ Chest pain □ Palpitations □ Prior heart attack □ fainting episodes

EXCRETORY
□ No Problem □ Urinary infections □ Bladder infections
□ Incontinence of ____Urine _____stool
□ Excessive night urination

NEUROLOGICAL
□ No problem □ Seizures □ Frequent headaches □ Migraine or Cluster headaches □ Dizziness
□ Tremors □ Memory problems □ One-Sided body Weakness □ Pins and Needles Sensations
□ Meningitis
Is there a history of a concussion or traumatic brain injury? NO or YES, If yes please describe giving circumstance and dates. Was there loss of consciousness? And how long did it last? ________________
____
____

REPRODUCTIVE
Sexual orientation (is helpful to your therapy) □ Heterosexual □ Homosexual □ Bisexual □ HIV+
□ Genital herpes □ Sexually transmitted diseases □ High risk for HIV/AIDS □ Sexual worries
□ Birth control issues

ENDOCRINE □ No Problem □ Diabetes □ Hypoglycemia □ Thyroid dysfunction □ Edema or Swelling

GASTROINTESTINAL
□ No Problem □ abdominal pain □ frequent nausea □ frequent vomiting
□ frequent diarrhea
Weight □ Loss □ Gain Amount? _________
□ Appetite □ Poor □ Ravenous □ frequent constipation

MUSKULOSKELETAL
□ No Problem □ Muscle impairment/tenderness □ Joint pain Back pain

CANCER
Describe (type & treatment):
____

FAMILY HISTORY/SOCIAL HISTORY

Describe current home living arrangements, including who is living in your home with you:
□ Live with Parents □ Spouse/Significant other □ Children □ Group Home
□ Nursing home/Assisted Living
Married ____ Yrs. Married ____ Separated ____ Divorced ___ Widowed ___ #Marriages ________
Do you have children? Yes or No, if yes how many? _______________
Has there been exposure to abusive behavior(s)? □ NO □ YES If yes, answer the following:
Current exposure? □ NO □ YES
Past exposure? If so, when? ____
Who was the abuser? ______________________
Type of abuse: □ Physical □ Sexual □ Verbal
Did it occur: □ within the family □ outside the family?

Have any other family members sought or received mental health treatment? □ NO □ YES

Relationship	Type of Problem	Treatment Needed

Is there a family history of alcohol or drug abuse/dependency? □ NO □ YES If yes, please describe:
____
____

Where were you born? ____
How would you describe your childhood? ____
Siblings? NO or YES, if yes please describe ____
Birth order? ____________
Who lived in the home? ____

Do you have or had any legal problems? Yes or No, if yes please explain
____
____

Education/Occupation/Cultural Background

Highest level of education
□ BA or BS Degree □ High School Diploma □ Elementary education, level completed ________
□GED □ Master's Degree □ Technical Degree □ Doctoral Degree

Have you been told you have learning difficulties/impairments?
□ NO □YES if yes, please describe:

What community resources do you need or use? (I.e. social groups, clubs, self-help groups, community, Church and social services)

What or on whom do you rely on in times of stress?

Are you a Veteran of Military Service? □Yes □ No If yes, what branch of service and describe and related problems:

Religious/Cultural Background:
□Protestant □Catholic □Jewish □Other (specify): ________________________________
How significant a role does religion play in your life?
□Very important □Somewhat important □Minor importance □Not important
Your cultural/ethnic background:

Are there any cultural/spiritual/ethnic needs which might impact treatment or that you want us to know about? □ Yes □ No If yes, please explain:

RISK ASSESSMENT:

	Past	**Present**
Have you ever had thoughts of hurting yourself?		
Have you ever had thoughts of committing suicide?		
Have you ever had a plan to commit suicide?		
Have you made threats to kill yourself?		
Have you ever made a suicide attempt?		
Have you ever mutilated yourself?		
Have you ever had thoughts of harming someone?		
Have you ever had plans to harm someone?		
Have you ever attempted to harm someone?		
Have you made any threats to harm someone?		

Is there anything you want to add that you feel would help your provider understand your current circumstances better? ____

Patient Name: ____
Signature of Patient or Guardian: ________________________________ Date: ______________