BOSC
Mental Health

**Psychiatry Outpatient Intake Form**
Info@BOSCMENTALHEALTH.COM
**Upon completion, email to above address**

**Office: 786-643-3835**
**Fax: 305-470-7457**

Name _____ Date _____

Insurance _____ Age _____ Date of Birth _____

Member ID _____

Phone number _____ E-mail _____

Address _____

Pharmacy Name/address _____

Emergency contact _____ Relationship _____ Phone _____

Referred by _____

What are the issues for which you are seeking care?

_____

_____

**Have you ever had any of the following conditions? (Check all that apply)**

- ❑ Anemia
- ❑ Asthma
- ❑ Cancer
- ❑ Cardiac structural problems
- ❑ Chronic pain/Fatigue
- ❑ Diabetes
- ❑ Gastrointestinal problems
- ❑ Glaucoma
- ❑ Gynecological problems
- ❑ Hormone problems
- ❑ Head injury
- ❑ Heart murmur
- ❑ High or low blood pressure
- ❑ High cholesterol
- ❑ HIV positive or AIDS
- ❑ Immunological disease
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Lung disease
- ❑ Mouth, nose or throat problems
- ❑ Neurological problems
- ❑ Seizure
- ❑ Sleep apnea
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Urological problems

**Have you experienced any of the following symptoms in the past month? (Check all that apply)**

- ❑ Thoughts about harming self
- ❑ Thoughts about harming other/others
- ❑ Recurrent thoughts of death
- ❑ Suicide attempt
- ❑ Depressed mood
- ❑ More depressed in the winter
- ❑ Loss of interest in activities
- ❑ Excessive guilt
- ❑ Feelings of worthlessness
- ❑ Hopelessness
- ❑ Moving slower than usual
- ❑ Moving faster than usual
- ❑ Decreased concentration
- ❑ Increased appetite/weight gain
- ❑ Decreased appetite/weight loss
- ❑ Sleeping too much
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Nightmares
- ❑ Flashbacks
- ❑ Fatigue
- ❑ Feeling nervous or on edge
- ❑ Muscle tension
- ❑ Panic attacks
- ❑ Increased irritability
- ❑ Excessive energy
- ❑ Decreased need for sleep
- ❑ Sexual indiscretion
- ❑ Excessive spending
- ❑ Increased risky behavior
- ❑ Intrusive thoughts
- ❑ Impulsivity
- ❑ Rituals
- ❑ Fear of gaining weight
- ❑ Restricting calories
- ❑ Binging on food/compensatory behavior
- ❑ Hallucinations (auditory, visual, tactile)
- ❑ Delusions
- ❑ Paranoia
- ❑ Self-harm behavior
- ❑ Chronic feelings of emptiness
- ❑ Fear of abandonment
- ❑ Unstable relationships
- ❑ Difficulty controlling anger
- ❑ Frequent mood changes in course of a day
- ❑ Fear of embarrassment
- ❑ Social situations avoided
- ❑ Alcohol or substance abuse

Allergies _____

Medical/Surgical history: _____

_____

**Current medications and/or supplements** (prescribed or non-prescribed):

| Name | Dose | Frequency | Estimated start date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Primary care provider (PCP) :_____ Date of last physical: _____

Do you give consent to communicate with your PCP, if needed? ☐Yes ☐No

**For women**

Is there a chance that you might be pregnant? ☐Yes ☐No ☐Maybe

Are you planning to become pregnant in the next 6 months? ☐Yes ☐No ☐Maybe

**Psychiatric History**

Have you ever seen a psychiatrist? ☐Yes ☐No Name: _____

If yes, do you give consent to communicate with your psychiatrist, if needed? ☐Yes ☐No

Have you ever seen a psychologist, therapist or other mental health professional? ☐Yes ☐No

If yes, name/location of the services _____

Reasons services utilized & for how long? _____

Reasons for discontinuation _____

Have you ever had psychological evaluation? If yes, reason _____

**Past suicide attempt(s)?**

| Date | Age | Mean(s) used | Treatment received? | Hospitalized? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Non-suicidal self-harm?**

| Date | Age | Method(s) used | Treatment received? | Hospitalized? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Do you have access to firearm?** ☐Yes ☐No

**Past psychiatric diagnoses (Check all that apply)**

- ❑ Addiction
- ❑ Anxiety
- ❑ Attention deficit hyperactivity disorder (ADHD)
- ❑ Bipolar disorder
- ❑ Dementia
- ❑ Depression
- ❑ Eating disorder
- ❑ Impulse control disorder
- ❑ Obsessive-compulsive disorder (OCD)
- ❑ Panic disorder
- ❑ Personality disorder
- ❑ Post-traumatic stress disorder (PTSD)
- ❑ Psychosis
- ❑ Schizophrenia
- ❑ Other: _____

**Previous psychiatric medications**

| Name of Medicine | Highest daily dose | Total duration | Effective? (Yes/No) | Reason for discontinuation |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Past treatment/hospitalizations**

Please include substance abuse treatment/rehab, Partial Hospitalization (PHP), Intensive Outpatient (IOP), ECT, TMS.

| Location | Approximate Dates | Reason |
|---|---|---|
| | | |
| | | |
| | | |

**Family history of mental illness**

Please include any biological members of your family, maternal and/or paternal.

| Mental health diagnosis/addiction/genetic diagnosis | Relationship |
|---|---|
| | |
| | |
| | |
| | |
| **Suicide completed/attempted?** | **Relationship** |
| | |
| | |

**Substance use**

Do you currently smoke cigarettes/or vape e-cigs? ☐Yes☐No If yes, how many per day? _____

Do you use other tobacco products? ☐Yes☐No If yes, what type? _____

Do you drink alcohol? ☐Yes☐No If yes, how many days per week? _____

Do you use marijuana or other recreational drugs? ☐Yes ☐No

If yes, please specify _____ How frequently? _____

Have you ever abused prescription medication? ☐Yes☐No If yes, which one(s)? _____

Have you ever consumed recreational substances intravenously or shared needles? ☐Yes ☐No

Do you believe you struggle with substance use? ☐Yes ☐No

Does a family member/friend think you struggle with substance use? ☐Yes ☐No

Are you interested in receiving treatment/resources? ☐Yes ☐No

**Social History**

Where were you born? _____ Where did you grow up? _____

Who were you raised by? _____

Describe your childhood? History of Abuse/Violence _____

_____

What was your highest level of education? _____

Degree(s) earned: _____

What is your current occupation? _____

Are you currently married or in a relationship? ☐ Yes☐No Do you have children?:_____

What is your living situation? _____

Do you feel safe in your current environment? _____

From whom do you receive emotional support? _____

Current legal problems? ☐Yes☐No If yes, please specify _____

Are you involved with a religious or spiritual group? _____

What do you do for fun? _____

Military background/Branch/Years served

Is there anything else you would like us to know?

_____

_____

_____

What do you hope to accomplish in treatment?

_____

_____

_____