CHRISTYKANE PhD

Dr. Christy Kane LLC Heath Intake From

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name		Date:
Date of Birth		
Primary Care Physician		

Do you give permission for ongoing regular updates to be provided to your primary care physician?
Client/Responsible Party Signature_____
Have you seen a Therapist/Counselor Before? If Yes Dates:
What are the problem(s) for which you are seeking help?
1)
2)
3)
What are your treatment goals?
1)
2)
3)

Current Symptoms Checklist (check each symptoms present

( ) Depressed mood	( ) Racing thoughts	( ) Excessive worry
( ) Unable to enjoy activities	( ) Impulsivity	( ) Avoidance
( ) Sleep pattern disturbance	( ) Increase risky behavior	( ) Hallucinations
( ) Loss of interest	( ) Increased libido	( ) Suspiciousness
( ) Concentration/forgetfulness	( ) Decrease need for sleep	( ) _____
( ) Change in appetite	( ) Excessive energy	( ) _____
( ) Excessive guilt	( ) Increased irritability	( ) _____
( ) Fatigue	( ) Crying spells	( ) _____
( ) Decreased libido	( ) Anxiety attacks	( ) _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you currently feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? ____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

Past Medical History

Allergies
Current Weight_____Height_____

List all current prescription medications and how often you take them. If none write none.

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements:
Current medical issues:
Past medical problems, non-psychiatric hospitalization, or surgeries:
Have you ever had an EKG? ( ) Yes ( ) No. If yes, when_____
Was the EKG ( ) Normal. ( ) Abnormal or. ( ) unknown?
For Women Only: Date of Last menstrual period_____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you currently taking birth control? ( ) Yes ( ) No If yes brand_____
Do you have any concerns about your physical health that you would like to discuss with your provider? ( ) Yes ( ) No

Personal and Family Medical History

Disease	Client	Which Family Member
Thyroid Disease		
Anemia		
Liver Disease		
Chronic Fatigue		
Kidney Disease		
Diabetes		
Asthma/respiratory problems		
Stomach or intestinal problems		
Cancer (type)		
Fibromyalgia		
Heart Disease		
Epilepsy or seizures		
Chronic Pain		
High blood pressure		
High Cholesterol		
Liver Problems		
Head trauma		
Other:_____		

Is there any additional personal or family medical history? ( ) Yes ( ) Not If yes, please explain
Where there any complications with your birth?
Were there any childhood developmental issues?

Past Psychiatric History: Outpatient treatment ( ) Yes ( ) No If yes, please describe when, by whom, and nature of treatment.

Reason	Date Treated	By Whom

Psychiatric Hospitalization ( ) Yes ( ) No If yes, please describe for what reason, when and where.

Reason	Date Hospitalized	Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Psychotropic	Dates	Dosage	Response/Side-Effects

Your Exercise Level

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

How many minutes per day do you exercise? _____

What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder ( ) Yes ( ) No Schizophrenia ( ) Yes ( ) No

Depression ( ) Yes ( ) No Post-traumatic stress ( ) Yes ( ) No

Anxiety ( ) Yes ( ) No Alcohol abuse ( ) Yes ( ) No

Anger ( ) Yes ( ) No Other substance abuse ( ) Yes ( ) No

Suicide ( ) Yes ( ) No Violence ( ) Yes ( ) No

If yes, who had each problem? _____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment?
_____

Substance Use;

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No If yes, which ones?
_____

Have you ever abused prescription medication? ( ) Yes ( ) No If yes, which ones and for how long?
_____

Check if you have ever tried the following:

Drug	Yes NO	If yes, how long and when did you last use?
Methamphetamine		
Cocaine		
Stimulants (pills)		
Heroin		
LSD or Hallucinogens		
Marijuana		
Pain killers (not as prescribed)		
Methadone		
Tranquilizer/sleeping pills		
Alcohol		
Ecstasy		
Other		

How many caffeinated beverages do you drink a day? Coffee_____Sodas_____Energy Drinks_____ Tea_____

Tabacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No How many packs per day on average? _____ How many years? _____
In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No
What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History

Were you adopted? ( ) Yes ( ) No Where did you grow up? _____
List your siblings and their ages: _____
What was your father's occupation? _____
What was your mother's occupation? _____

Family Background and Childhood History-1

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him: _____
Has anyone in your immediate family died? _____
Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom: _____ _____

Education History:

Highest Grade Completed? _____ Where? _____
Did you attend college? _____ Where? _____Major? _____
What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
Have you ever served in the military? _____ If so, what branch and when? _____

Relationship History

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed
How would you identify your sexual orientation?
would you identify your sexual orientation? ( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual ( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

Signature and Date

Signature
Date
Guardian Signature (if under the age of 18)
Office Review

Signature and Date-1

Full Legal Name:
Cell Phone:
Home Phone:
Home Address:
Emergency Contact:
Work Phone Number: