Vivek Agnihotri, M.D.
Zinia S. Thomas, M.D.
745 Old Frontenac Square; Suite 201
St. Louis, MO 63131
Tel: 314-395-8940; Fax: 314-395-8941
info@spectrumpsychiaty.com

ADULT INTAKE & PERSONAL HISTORY FORM

Name: ____ Social Security #:________________________

Gender: ____ F ____ M Date of birth: ________ Age: ________

Form completed by (if someone other than client): ____

Address: ___________________________ City: ________________ State: ______ Zip: __________

Phone (home): _______________________ (cell): _____________________

Person Responsible for Payment ______________________________________ Soc. Sec #____________

Relationship ____

Signature of Person Responsible for Payment **X**______________________________ Date: __________

Must be signed for services to begin

Pharmacy Information
Name: _______________________ Address: _________________________ Phone: ________________

Emergency Information *In case of emergency, contact:*
Name: ______________________________ Relationship: ________________ Phone: ______________

Referral Source
How did you hear about our office (or from whom)? ____
____

Primary reason(s) for seeking services: (*please describe*)

____
____

Development

Are there special, unusual, abuse or other traumatic circumstances that affected your development? **Y N**

If Yes, please describe: ____
____

Social Relationships

Marital Status _______________________

Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

Sexual orientation: _________________ Comments: ____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _______________________________________

Legal

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: __________________

____

Are you presently on probation or parole? **Y N** If Yes, please describe: _________________________

Past History

Traffic violations: ____ Yes ____ No DWI, DUI, etc.: ____ Yes ____ No

Criminal involvement: ____ Yes ____ No Civil involvement: ____ Yes ____ No

Education

Fill in all that apply: Years of education: ______ Currently enrolled in school? ____ Yes ____ No

__ High school grad/GED

__ College:________________#of years: __________ Graduated: __Yes__No Major: _____________

Other training: ____

Special circumstances (e.g., learning disabilities, gifted): ____

Employment

Occupation: ___________________________ Employer:____________________________

____

Currently: ____ FT ___ PT ____ Temp ____ Laid-off ____ Disabled ___ Retired

__ Social Security ____ Student ____ Other (describe): _____________________________________

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

Primary Care Physician: _____________________________________ Phone:______________________

Address: ____

List any medical diagnoses: ____

List any recent health or physical changes: ____

List any surgeries: ____

Current prescribed medications & dosages (*please include over-the- counter medications)*:

____

____

____

Are you ALLERGIC to any medications? ____

If Yes, describe reaction: ____

Family history of medical problems: ____

____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	___	___	___	___	___	___	___	___
Barbiturates	___	___	___	___	___	___	___	___
Valium/Xanax	___	___	___	___	___	___	___	___
Cocaine/Crack	___	___	___	___	___	___	___	___
Heroin/Opiates	___	___	___	___	___	___	___	___
Marijuana	___	___	___	___	___	___	___	___
PCP/LSD/Mescaline	___	___	___	___	___	___	___	___
Inhalants	___	___	___	___	___	___	___	___
Caffeine	___	___	___	___	___	___	___	___
Nicotine	___	___	___	___	___	___	___	___
Over the counter	___	___	___	___	___	___	___	___
Prescription pain meds	___	___	___	___	___	___	___	___
Other drugs	___	___	___	___	___	___	___	___

Substance Abuse Questions

Describe when and where you typically use substances: ________________________________

____

Describe any changes in your use patterns: ________________________________

____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

____

How do you believe your substance use affects your life? ________________________________

Who or what has helped you in stopping or limiting your use? ________________________________

Have you ever needed detoxification/rehabilitation for alcohol or drugs? ______ Yes ____ No

If Yes, describe with dates and locations: ________________________________

____

Family Psychiatric/ Substance Abuse History

Please list and describe any family members who have/had any psychiatric issues or problems with substance abuse. *(i.e.: bipolar disorder, depression, anxiety, ADHD, substance abuse, autism)*

____

____

____

____

Prior Psychiatric Treatment History

Current Therapist/Clinician: ___________________________________ Phone:____________________

Address: ____

Prior Psychiatric Hospitalizations? NO YES please describe (hospital, dates, reason) _______________

____

Prior Suicide Attempts? ____

Current Psychiatric Medications & Dosage: ____

____

Prior trials of Psychiatric Medications: ____

____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder

____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks

____ Phobias/fears
____ Recurring thoughts
____ Sexual addiction
____ Sexual difficulties
____ Sick often
____ Sleeping problems
____ Speech problems
____ Suicidal thoughts
____ Thoughts disorganized
____ Trembling
____ Withdrawing
____ Worrying
____ Other (specify): _________
____

Please check if there have been any recent changes in the following:

___ Sleep patterns
____ Eating patterns
____ Behavior
____ Energy level
___ Physical activity level
____ General disposition
____ Weight
____Nervousness/tension

Describe changes in areas in which you checked above or any other changes noticed: _______________

____

Any additional information that would assist us in understanding your concerns or problems: _________

____

____

____

What are your hopes/goals for treatment?____

____

____

____