~ SPA ~
Salem Psychiatric Associates

821 Saginaw St. S.
Salem, OR 97302
503-589-4046

PATIENT INTAKE FORM

Patient Name: **Date:**
Age: **Birth Date:**

What are your goals for treatment?

Allergies:

Allergy	Reaction

Please list all medications you are prescribed: (feel free to attach medication sheet)

Name	Dose	Reason	Who Prescribes	Date Began

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Please list all psychiatric medications you have tried in the past:

Name	Dose	Reason	Who Prescribes	Date Began

Hospitalizations and surgeries (psychiatric, medical and substance abuse treatment):

Year	Hospital	Reason for Hospitalization

List any serious illnesses or injuries:

____

____

____

Pregnancies:

Date	Outcome

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Patient Name: **Date:**
Age: **Birth Date:**

Current birth control method if female:

Who is your Primary Care Physician:

Psychiatric Symptoms Checklist

Sleep: ☐ No problems ☐ Not enough ☐ Trouble getting up ☐ Nightmares ☐ Too much sleep
Appetite: ☐ No problems ☐ No Interest ☐ Increased appetite ☐ Carbohydrate craving
Energy: ☐ Normal ☐ Increased ☐ Low ☐ Up and down
Interest in Sex: ☐ Normal ☐ Increased ☐ Low
Concentration: ☐ Normal ☐ Somewhat difficult ☐ Poor ☐ Terrible
Memory: ☐ Good ☐ Some difficulty remembering ☐ Poor
Depressed or Sad: ☐ All the time ☐ Most days ☐ Some days ☐ Not at all
Suicidal thoughts: ☐ All the time ☐ Most days ☐ Some days ☐ Not at all
Past Suicidal Attempts: ☐ No ☐ Yes
If yes, please give details: ____________________

Anxiety: ☐ Panic attacks ☐ All the time ☐ Most days ☐ Some days ☐ Not at all
Anger/Irritation: ☐ All the time ☐ Most days ☐ Some days ☐ Not at all

Medical Symptoms

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐Nervousness
- ☐ Numbness
- ☐ Sweats

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

MEN only
- ☐ Breast lump
- ☐ Erection Difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

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MUSCLE/JOINT BONE
Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose Veins

SKIN

- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore than won't heal

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period ____________________
Date of last Pap Smear ________________________
Have you had a mammogram? __________________
Are you pregnant? _____________________________
Number of children ____________________________

Do any of your **blood** relatives have mental health problems?

Mother's Side: ______________________________ Diagnosis: ______________

____

Father's Side: ______________________________ Diagnosis: ______________

____

Brother's & Sister's Side:________________________ Diagnosis: ______________

____

Children: ______________________________ Diagnosis: ______________

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Has anyone in your family attempted or committed suicide? ________________________________

Family medical history:

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
						High Blood Pressure	
Sisters						Kidney Disease	
						Tuberculosis	
						Other	

Habits:
Caffeine: number of coffee/tea/caffeinated soda and chocolate per day ____________________

Number of days a week you consume alcohol ________________________________

Number of drinks at a time ________________________________

Do you use any street drugs? ________________________________

Do you take any medication that is not prescribed for you (such as opiates)? ________________

____

Tobacco Products: ____________________________ Amount per day: ____________

Is there anything else you would like us to know?

____

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