Clinical Intake Form for Ages 6 and up
EVMS Psychiatry & Behavioral Sciences

MRN:	
Date:	
Time:	

******If you currently experience suicidal or homicidal thoughts, please dial 911 or go to your nearest emergency room. ******

Services Available	**Services Unavailable**
Adult Psychiatric Care and Consults Child (6+) and Adult Neuropsychological and Cognitive Testing Electroconvulsive Therapy (ECT) Evaluation and Treatment Transcranial Magnetic Stimulation (TMS)	Substance Abuse & Addiction Psychiatry Child / Adolescent / Geriatric Psychiatric Care Social Work / Case Management / Wraparound Services

Name *(First M.I. Last)*:	☐ **M**	☐ **F**	**DOB:**
Address *(Street, Apt#)*:	**City, State, & ZIP:**		
Phone: May a message be left? ☐ Yes ☐ No	**Email:**		
Contact Name (if different):	**Relationship to Above:**		
Referred By:	**PCP:**		
Primary Insurance:	**Insurance Phone & ID No.:**		
Secondary Insurance:	**Insurance Phone & ID No.:**		

Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed

Services you are seeking:
(Please choose only ONE)

☐ Individual Therapy ONLY ☐ Medication Evaluation and Management ONLY ☐ Individual Therapy and Medication Management ☐ Child (6+) or Adult Psychological Testing (ADHD, IQ, etc.)	☐ ECT ☐ TMS ☐ Adult ASD Evaluation (child services not available) ☐ Evaluation only (Second opinion on Diagnosis, etc.) ☐ One-time consultation

Reason(s) for seeking treatment:	☐ Abuse/Trauma	☐ Bipolar Disorder	☐ Grieving	☐ Psychosis
	☐ Anxiety/Panic/Stress	☐ Concussion/TBI/Seizure/Stroke	☐ Learning Problems	☐ Relationship Issues
	☐ Attention Problems	☐ Depression	☐ Memory Problems or MCI	☐ Stress
	☐ Behavioral Problems	☐ Eating Disorder (height _____ weight _____)	☐ Neurological Problems	☐ Other _____

How long have you experienced the problems checked off above?			
Is this your first time requesting treatment by a psychiatrist and/or a psychologist?		☐ Yes	☐ No
If no, when was the last time you were seen and who were you seen by?			
Have you had any previous psychiatric hospitalizations?	☐ Yes ☐ No	If yes, when?	
Have you ever attempted suicide?	☐ Yes ☐ No	If yes, when?	
Do you drink alcohol (beer/wine/liquor)?	☐ Yes ☐ No	**How often?:** ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Consistently	
Do you use recreational drugs (marijuana/cocaine/heroin)?	☐ Yes ☐ No	**How often?:** ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Consistently	
Are you currently involved in any legal proceedings (lawsuits, divorce, personal injury, child custody, etc.)?		☐ Yes	☐ No
Do you have any pending disability claims OR do you plan to file a disability claim in the near future?		☐ Yes	☐ No
Any medical problems? If yes, please list the most severe:		☐ Yes	☐ No
Medications (Rx & OTC):			
Are you having difficulty attending work or with your day-to-day activities (ex: household chores)?		☐ Yes	☐ No
Do you have and/or utilize a support system (friends/family) to share your difficulties with?		☐ Yes	☐ No
Would you like to be fast-tracked into the Outpatient Training Clinic by a Resident or Intern?		☐ Yes	☐ No

Please complete the below items only if you are interested in Autism Spectrum Disorder (ASD) services. **Note that ASD services are for adults only.**

Do you have a formal diagnosis within the Autism Spectrum?	☐ Yes	☐ No
If so, please provide the diagnosis.		
Do you currently reside at a group home or residential treatment facility?	☐ Yes	☐ No
If yes, where do you currently reside?		
How do you best communicate with others: ☐ spoken language ☐ sign language ☐ written language ☐ communication device ☐ non-verbal		
Do you display aggressive behaviors? ex. throwing chairs, yelling, hitting others	☐ Yes	☐ No
How difficult is an office visit for you? ☐ have to leave in first 15 minutes ☐ can stay for 20-30 minutes ☐ can stay for an hour		

Office Use Only:

Accepted by:		**Scheduled for:**	_____, _____ at _____ AM / PM