Alliance Psych Services
Farid Karimi, MD. PC
11235 **Distinctive Dr**
Orland Park, IL 60467
Office 708-479-5555 / **Fax** 708-479-5055

Initial Intake Form

Please complete all information on this form and bring it to the first visit. This information will be used for assessment and treatment planning purposes so that we may better serve your needs.

Name_____Date_____
Date of Birth_____ Primary Care Physician_____

What are the problems you are seeking help for?

1._____
2._____
3._____

What are your treatment goals?

1._____
2._____
3._____

Current Symptoms Checklist: (check all that apply)

☐ Depressed mood	☐ Racing Thoughts	☐ Excessive Worry
☐ Unable to enjoy activities	☐ Impulsivity	☐ Anxiety / Panic Attacks
☐ Sleep Pattern Disturbance ↑ or ↓	☐ Increased Risky Behavior	☐ Avoidance
☐ Loss of Interest	☐ Increased Libido	☐ Hallucinations
☐ Forgetfulness	☐ Decreased Need for Sleep	☐ Suspiciousness
☐ Change in Appetite ↑ or ↓	☐ Excessive Energy	☐ Decreased Libido
☐ Excessive Guilt	☐ Increased Irritability	☐ _____
☐ Fatigue	☐ Crying Spells	☐ _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No
If yes, how often do you have thoughts of not wanting to live? _____
_____
When was the last time you had these thoughts? _____
Do you feel hopeless and/or worthless?_____
Has anything happened recently to make you feel this way?_____
_____
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? _____
Have you ever tried to kill or harm yourself before? _____
_____

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Psychiatric History **Patient Name**: _____

Outpatient Treatment ☐ Yes ☐ No If yes, describe when, by whom, and nature of treatment:

_____

_____

Psychiatric Hospitalization ☐ Yes ☐ No If yes, describe for what reason, when, and where:

_____

_____

Psychiatric Medications: If you currently take or have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they are/were.

Antidepressants

Prozac (fluoxetine) _____ Zoloft (sertraline) _____
Luvox (fluvoxamine)_____ Paxil (paroxetine)_____
Celexa (citalopram)_____ Lexapro (escitalopram)_____
Effexor (venlafaxine)_____ Cymbalta (duloxetine)_____
Wellbutrin (bupropion)_____ Remeron (mirtazapine)_____
Serzone (nefazodone)_____ Anafranil (clomipramine)_____
Pamelor (nortriptyline) _____ Tofranil (imipramine)_____
Elavil (amitriptyline)_____ Other_____

Mood Stabilizers

Tegretol (carbamazepine)_____ Lithium_____
Depakote (valproate)_____ Lamictal (lamotrigine)_____
Topamax (topiramate)_____ Other_____

Antipsychotics/Mood Stabilizers

Seroquel (quetiapine)_____ Zyprexa (olanzapine)_____
Geodon (ziprasidone)_____ Abilify (aripiprazole)_____
Clozaril (clozapine)_____ Haldol (Haloperidol)_____
Prolixin (fluphenazine) _____ Other_____

Sedatives/Hypnotics

Ambien (zolpidem)_____ Sonata (zaleplon)_____
Rozerem (ramelteon)_____ Restoril (temazepam)_____
Desyrel (trazodone)_____ Other_____

Antianxiety Medications

Xanax (alprazolam)_____ Ativan (lorazepam)_____
Klonopin (clonazepam)_____ Valium (diazepam)_____
Tranxene (clorazepate)_____ Buspar (buspirone)_____
Other_____

ADHD Medications

Adderall (amphetamine)_____ Concerta (methylphenidate)_____
Ritalin (methylphenidate)_____ Strattera (atomoxetine)_____
Other_____

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Family Psychiatric History **Patient Name**: _____

Has anyone in your family been diagnosed with or been treated for:
Bipolar Disorder □ Yes □ No _____ Depression □ Yes □ No_____
Alcohol Abuse □ Yes □ No _____ Schizophrenia □ Yes □ No _____
Anxiety □ Yes □ No_____ Drug Abuse □ Yes □ No_____
_____

Has any family member ever attempted or committed suicide? □ Yes □ No
If yes, whom? _____

Substance Use History

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

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

Have you ever abused prescription medications? □ Yes □ No
If yes, which ones? _____

Have you ever felt you out to cut down on your drinking and/or drug use? □ Yes □ No
Have you ever had a drink or used drugs first thing in the morning? □ Yes □ No
Do you think you may have a problem with alcohol or drug use? □ Yes □ No

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	□	□	_____
Cocaine	□	□	_____
Stimulants	□	□	_____
Heroin	□	□	_____
LSD or Hallucinogens	□	□	_____
Marijuana	□	□	_____
Alcohol	□	□	_____
Methadone	□	□	_____
Ecstasy	□	□	_____
Other	□	□	_____

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Patient Name: _____

How many caffeinated beverages do you drink a day? Coffee_____ Soda _____Tea_____

Do you currently smoke cigarettes? □ Yes □ No How many per day?_____ How many Years?_____

Did you smoke cigarettes in the past? □ Yes □ No How long? _____ When did you quit? ____

Do you currently use tobacco products other than cigarettes? □ Yes □ No
What kind, how often, and for how many years? _____

Did you use tobacco products other than cigarettes in the past? □ Yes □ No
What kind, how often, and for how many years? _____

Your 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 problems: _____
_____
_____

Past medical problems, non-psychiatric hospitalizations, or surgeries: _____
_____

For women only: Date of last menstrual period: _____ Are you currently pregnant or think you might be pregnant? □ Yes □ No
Are you planning to get pregnant in the near future? □ Yes □ No

How many times have you been pregnant? _____ How many live births? _____
Date and place of last physical exam: _____

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Patient Name: _____

Family History:
Were you adopted? □ Yes □ No Where did you grow up? _____
How many times did you move? _____

When you mother was pregnant with you, were there any complications during the pregnancy or birth?_____

List your siblings and their ages: _____
_____

Your father is □ Alive □ Deceased □ Unknown **Your mother is** □ Alive □ Deceased □ Unknown Did your parents divorce? □ Yes □ No If yes, how old were you when they divorced? _____

Describe your father and your relationship with him: _____
_____

Describe your mother and your relationship with her: _____
_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____
If yes, who and when? _____

Family Medical Issues:

□ Diabetes	□ Stroke	□ Liver Disease	□ High Blood Pressure	□ Heart Disease
□ Dementia	□ Cancer	□ Kidney Disease	□ Pancreatic Disease	□ Seizures

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? □ Yes □ No
If yes, please describe when, where and by whom: _____

Educational History:

Highest grade completed _____ Degree _____
School last attended _____ City _____
What was your attitude toward school? _____
Describe any difficulties with school _____

Occupational History:

Are you currently: □ Working □ Not working by choice □ Unemployed □ Disabled □ Retired
What is/was your occupation? _____
How long in current position? _____
Where do you work: _____

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Military History: **Patient Name: _____**

Have you ever served in the military? □ Yes □ No If yes, what branch and when? _____
Honorable discharge □ Yes □ No Other type of discharge: _____

Relationship and Current Family History:

Are you currently: □ Married □ Divorced □ Separated □ Single □ Widowed

How long? _____

If not married, are you currently in a relationship? □ Yes □ No If yes, how long?_____

Describe your relationship with your spouse or significant other: _____
_____

Have you had any prior marriages? □ Yes □ No If yes, how many? _____ How Long? _____

Do you have children? □ Yes □ No If yes, list ages and gender: _____
_____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____
_____

Legal History:
Have you ever been arrested? _____Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? □ Yes □ No
If yes, what is the level of your involvement? _____
Do you find you involvement helpful during stressful times? □ Yes □ No

Emergency Contacts:
_____ Relationship _____Contact #_____
_____ Relationship _____Contact #_____

_____ _____
Patient / Guardian Signature Date

The above Initial Intake has been reviewed with client as part of the Initial Evaluation.

Reviewed by: _____ _____
Date