

ADULT MEDICAL/FAMILY HISTORY

To help us to fully evaluate your concerns, please fill out the following 9-page intake form to the best of your ability. We realize that there is a lot of information requested and you may not remember or have access to all of it, but please be as thorough as possible.

NOTE: This form is for patients 18 years old and older.

PATIENT IDENTIFICATION

Name _____ Age _____ Sex _____

Birth Date _____ Marital Status _____

Address _____

City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Personal Email Address (not shared, not work email) _____

Who do you currently live with? _____

REFERRAL SOURCE

Name _____ Phone _____ Fax _____

Address _____

City _____ State ____ Zip _____

Do we have permission to release information to the referral source when appropriate:

YES

NO

MAIN PURPOSE FOR THE CONSULTATION (please summarize the main problem)

ADULT MEDICAL/FAMILY HISTORY

WHY ARE YOU SEEKING EVALUATION? (What are your goals for this treatment?)

PLEASE LIST YOUR HISTORY OF PRIOR ATTEMPTS
TO CORRECT YOUR PROBLEM/PRIOR PSYCHIATRIC HISTORY.

MEDICAL HISTORY

Current medical problems and/or medications:

Current Supplements/vitamins/herbs:

Past medical problems/medications:

ADULT MEDICAL/FAMILY HISTORY

Other doctors/clinics seen regularly:

Any history of head trauma? (describe)

Any history of seizures or seizure-like activity?

Prior hospitalizations:

Prior abnormal lab tests/values?

Allergies/ drug intolerance?

CURRENT LIFE STRESSES: (include anything that is currently stressful for you such as relationships, job, school, finances, children)

ADULT MEDICAL/FAMILY HISTORY

YOUR PRENATAL AND BIRTH EVENTS: (Pregnancy complication, birth trauma, bleeding, medication, smoking, alcohol/drugs)

SLEEP BEHAVIOR: (trouble getting to sleep, trouble staying asleep, excessive snoring, sleepwalking, nightmares, recurrent dreams, excessive daytime sleepiness)

SCHOOL HISTORY

Last grade completed ____ Last school attended: _____

Average grades received _____ Specific learning disabilities _____

Any behavior problems in school?

Please attach copies of any psychological tests done in the past.

ADULT MEDICAL/FAMILY HISTORY

EMPLOYMENT HISTORY

(summarize the jobs you have held; most favorite, least favorite)

Any work-related problems?

What have your employers and supervisors said about your performance?

MILITARY HISTORY:

LIST ANY LEGAL PROBLEMS/DIFFICULTY WITH THE LAW.

ADULT MEDICAL/FAMILY HISTORY

ALCOHOL AND DRUG HISTORY

Please list the age you started, types of substances used through the years and any current usage. Describe how each of these substances made you feel; what benefit you got from them. This question includes alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants, (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers) barbiturates, hallucinogenic drugs (LSD, mescaline, mushrooms), PCP.

Did you ever experience withdrawal symptoms from alcohol or drugs?

YES NO

Has anyone ever told you they thought you had a problem with drugs or alcohol?

Have you felt guilty about your drug or alcohol use?

Have you felt annoyed when someone talked to you about your use of drugs/alcohol?

Have you ever used alcohol or drugs first thing in the morning?

Caffeine use per day (coffee, tea, sodas, chocolate)

Nicotine use per day, past and present (cigarettes, cigars, chewing tobacco)

ADULT MEDICAL/FAMILY HISTORY

SEXUAL HISTORY

(answer only if comfortable doing so)

Age at time of first sexual experience _____ Number of sex partners _____

History of sexually transmitted diseases _____

History of abortion _____

History of sexual molestation, abuse or rape _____

Any current sexual problems?

FAMILY HISTORY

Family structure: Who lives in your current household?

Please explain your relationship to each person (sister, brother, mother, child etc.)

NAME	RELATIONSHIP TO YOU

Current marital or relationship satisfaction (Satisfied, not satisfied, etc.):

Significant events (include marriages, separations, divorces, deaths, traumatic events):

Past marriages: _____

ADULT MEDICAL/FAMILY HISTORY

NATURAL MOTHER'S HISTORY

Age _____ Outside work _____

Highest school grade completed _____ Learning Problems _____

Behavioral Problems _____ Marriages _____

Medical Problems

Has mother or any maternal relatives had any learning problems or psychiatric problems including alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalization, physical or sexual abuse? If yes, please describe.

NATURAL FATHER'S HISTORY

Age _____ Outside work _____

Highest school grade completed _____ Learning Problems _____

Behavioral Problems _____ Marriages _____

Medical Problems

Has father or any paternal relatives had any learning problems or psychiatric problems including alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalization, physical or sexual abuse? If yes, please describe.

ADULT MEDICAL/FAMILY HISTORY

YOUR SIBLINGS: (names, ages, problems, strengths, relations with patient)

YOUR CHILDREN: (names, ages, problems, strengths, relations with patient)

BRIEFLY DESCRIBE YOUR RELATIONSHIPS WITH FRIENDS:

DESCRIBE YOURSELF/YOUR STRENGTHS:

End of Intake Form (9 total pages)

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