Yanira M. Olaya M.D., Inc.
Board Certified in General and Forensic Psychiatry

Intake Form

Name_____ DOB_____ SSN____-___-_____

Emergency Contact_____ Relation_____ Tel.#_____

Referred by_____ Primary Physician_____

What are the problem(s) you are seeking help for today?

_____

_____

Current Symptoms Checklist:

( )Depression	( )Racing thoughts	( )Excessive worry
( )Unable to enjoy activities	( )Impulsivity	( )Anxiety/Panic
( )Sleep pattern disturbances	( )Increase risky behavior	( )Avoidance
( )Loss of interest	( )Increased/decreased libido	( )Hallucinations
( )Concentration/forgetfulness	( )Decrease need for sleep	( )Suspiciousness
( )Change in appetite	( )Excessive energy	( )Excessive guilt
( )Increased irritability	( )Fatigue	( )Crying spellings

Suicide Risk

Have you ever tried to harm yourself in the past? ( )Yes ( )No

Have you had any recent thoughts, or do you currently have any thoughts of suicide? ( ) Yes ( )No

Medical History

Allergies_____ Weight_____ Height_____

List ALL current prescription medications and how often you take them:

_____

_____

Current over-the-counter medications or supplements:_____

Current/Past medical problems, hospitalizations or surgeries:_____

_____

_____

For Women:

Date of last menstrual period:_____ Are you currently, or do you think you are pregnant? ( ) Yes ( )No

Are you planning to get pregnant in the near future? ( ) Yes ( )No

Family History (Medical/Psychiatric Diagnoses, Substance Abuse or Self-Injury/Suicide):

_____

_____

Past Psychiatric History:

Outpatient Treatment ( )Yes ( )No. If yes, please describe when, by whom, and nature of treatment.

_____

_____

_____

Psychiatric Hospitalizations ( )Yes ( )No. If yes, describe for what reason, when and where. _____

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please circle.

Mood/Thoughts: Prozac, Zoloft, Luvox, Paxil, Celexa, Lexapro, Viibryd, Effexor, Cymbalta, Wellbutrin, Remeron, Serzone, Anafranil, Pamelor, Tofranil, Elavil, Tegretol, Lithium, Lamictal, Topamax, Seroquel, Zyprexa, Geodon, Abilify, Clozaril, Haldol, and Prolixin.

Sleep: Ambien, Lunesta, Sonata, Rozerem, Restoril, Desyrel/trazodone.

ADHD: Adderall, Concerta, Ritalin, Vyvanse, Focalin, Dexedrine, Strattera.

Anxiety: Xanax, Ativan, Klonopin, Valium, Restoril, Librium, Tranxene, Buspar, Vistaril, Benadryl, Propanolol.

Other: _____

Any negative/positive experiences with these medications?

_____

_____

Substance Use:

Do you (or others) think you have a problem with alcohol or drug use? ( ) Yes ( )No

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances and when/where were you treated? _____

Days/wk drinking alcohol: _____ Avg. number drinks/day: _____ Most drinks/day: _____

Do you have current/past problems with the use/abuse of illegal substances? If so, which substances?

_____

Have you abused prescription medication? If so, which medications? _____

How many caffeinated beverages do you drink a day? Coffee_____ Tea_____ Sodas _____

Tobacco/Cigarette History: _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( )No Where did you grow up? _____

List your siblings and their ages: _____

Did your parents' divorce? ( )Yes ( )No. If so, how old were you when they divorced? _____

If your parents divorced, whom did you live with? _____

Educational History: What is your highest educational level or degree attained? _____

Spiritual Life: Do you belong to a particular religion or spiritual group? _____