Dr. SADEK PSYCHIATRIC ASSESSMENT INTAKE

All information on this form is strictly confidential so please fill out accurately.

Today's Date y/m/d _____
LAST Name_____ First Name----------
Date of Birth y/m/d_____ Phone: _____
Family Doctor_____
Current Therapist/ Counselor_____
PRESENTING PROBLEM —in your own words, summarize in one to two brief sentences.

_____
_____
_____
_____

PURPOSE OF VISIT: Summarize your goals for this assessment in one to two brief sentences

_____
_____
_____

Please describe any **current stressful event** in your life (home. work family, social. etc)

_____
_____
_____
_____

Risk assessment	**Yes**	**No**
Do you have thoughts of harming yourself?	○	○
Do you have a plan (how -to) harm yourself?	○	○
Have you attempted to harm yourself in the past?	○	○
Do you have any relatives committed suicide?	○	○
Did you harm yourself or cut before?	○	○
Do you have thoughts of harming someone else?	○	○
Have you assaulted or threatened anyone recently?	○	○
Have you ever been in trouble because of your temper/violence?	○	○
Does drinking/drugging ever lead you to become violent?	○	○
Do you own a gun or a lethal weapon?	○	○
Are you here for insurance purpose or because of legal issues?	○	○

Your Medical History:

Weight Height Allergies **Yes**☐ **No** ☐ (please specify)
Blood Pressure:
Did you have an EKG done? Y○N○WHEN
Did you have blood work done? Y○ N○ when?

Past Surgeries, Hospitalizations: _____

Medical Problems (please check Y or N and specify with dates):

Diabetes **Yes**☐ **No** ☐
Heart problems **Yes**☐ **No** ☐
Seizure **Yes**☐ **No** ☐
Asthma **Yes**☐ **No** ☐
Thyroid problems **Yes**☐ **No** ☐
Kidney problems **Yes**☐ **No** ☐
Cancer **Yes**☐ **No** ☐
Neurological problem **Yes**☐ **No** ☐
Sleep disorder **Yes**☐ **No** ☐
Liver problem **Yes**☐ **No** ☐
Kidney problem **Yes**☐ **No** ☐
Head trauma **Yes**☐ **No** ☐

Current Medications: List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____
_____
_____
_____
_____
_____
_____

Did you see a psychiatrist in the past? **Yes**☐ **No**☐ **Name?**
Did you receive any therapy in the past? Yes☐ **No**☐ **when? Name?**
Were you admitted to a psychiatric inpatient unit? **Yes**☐ **No** ☐
When?_____

Select any medication that you ever took in this list

Prozac (fluoxetine) ☐ Zoloft (sertraline) ☐ Luvox (fluvoxamine) ☐
Paxil (paroxetine) ☐ Celexa (citalopram) ☐ Cipralex (escitalopram) ☐
Effexor (venlafaxine) ☐ Cymbalta (duloxetine) ☐ (bupropion) /
Wellbutrin ☐ Remeron (mirtazapine) ☐ Anafranil (clomipramine)☐
Tofranil (imipramine) ☐ Elavil (amitriptyline) ☐ Trintelix ☐
Fetzima☐

Tegretol (carbamazepine ☐ Lithium ☐ Epival (Divalproes) ☐
Lamictal (lamotrigine) ☐ Tegretol (carbamazepine) ☐ Topamax (topiramate) ☐

Seroquel (quetiapine) ☐ Zyprexa (olanzepine) ☐ Ziprasidone ☐
Abilify (aripiprazole) ☐ ☐ Clozaril (clozapine) ☐ Haldol (haloperidol) ☐
Risperidone ☐ Latuda (Lurazidone) ☐

Zopiclone ☐ Melatonin ☐ Lorazepam☐ clonazepam ☐
Desyrel (trazodone) ☐

Xanax (alprazolam) ☐ Ativan (lorazepam) ☐ Valium ☐
(diazepam) ☐

Vyvanse☐ Adderall (amphetamine salts) ☐ Concerta (methylphenidate) ☐ Biphentin ☐ Strattera (atomoxetine) ☐ Ritalin ☐ Dexedrine☐
OTC meds?

List Prescription, year and any side effects

Drugs and Alcohol History

Do you smoke?

If not currently drinking, have you consumed alcohol in the past? **Yes☐ No ☐**

Check if you have ever tried the following:

	Yes	No	Daily Amount	How Often	When did you use last?
Cocaine	○	○			
Heroin	○	○			
LSD or hallucingens	○	○			
Weed /MJH	○	○			
Alcohol	○	○			
Pain Killers not prescribed	○	○			
Tranquilizers	○	○			
Stimulants like Dexedrine	○	○			

Family History

I have _____Brothers and _____sisters. My parents are together Yes□ No □

I was adopted Yes□ No □ Parents split -----years ago.

Has anyone in your family been diagnosed with or treated for:

	Yes (Who?)	No		Yes (who?)	No
Bipolar disorder	☐		ADHD	☐	
Schizophrenia	☐		Alcohol abuse	☐	
Anxiety	☐		Other substance abuse	☐	
Suicide	☐		Post-traumatic stress	☐	
Depression	☐		**Heart disease, medical?**	☐	

CHILDHOOD DEVELOPMENT

Where were you born? _____

	True	False	Unsure
1. My mom's pregnancy was complicated by her smoking or Use of street drugs or alcohol	○	○	○
2. My birth was difficult and complicated	○	○	○
3. I had a delay in talking	○	○	○
4. I had problems with becoming toilet trained	○	○	○
5. I had a delay in walking	○	○	○
6. My mother was not affectionate and caring for me	○	○	○
7. My father was not affectionate and caring for me	○	○	○
8. I was bullied as a child	○	○	○
9. I was sexually abused between ages 5 - 10	○	○	○
10. I was sexually abused between ages 11-15	○	○	○
11. I was physically abused	○	○	○
12. I was emotionally abused	○	○	○
13. I failed one grade or more at school (grade-----)	○	○	○
14. I had serious academic difficulties in school/ I	True	False	Unsure

went to special Ed or resource class	◯	◯	◯
15. Teachers did not like me	T◯e	F◯e	U◯re
16. I had very few friends in school	T◯e	F◯e	U◯re
17. I had many friends as a child	◯	◯	◯
18. I was a shy and timid child	T◯e	F◯e	U◯re
19. I did not got along well with my siblings	T◯e	F◯e	U◯re
20. I grow up in a poor family	T◯e	F◯e	U◯re
21. I always felt inferior to others	T◯e	F◯e	U◯re
22. I was ashamed of who I am while growing up	T◯e	F◯e	U◯re
23. It was difficult to separate from my parents	T◯e	F◯e	U◯re
24. I hated going to school	T◯e	F◯e	U◯re
25. School was a source of a stress for me	T◯e	F◯e	U◯re
26. I consider myself bisexual	T◯e	F◯e	U◯re
27. My parents separated when I was less than 10	T◯e	F◯e	U◯re
28. My parents separated when I was 11- 20	T◯e	F◯e	U◯re
29. I currently have many friends	T◯e	F◯e	U◯re
30. I finished grade 12	T◯e	F◯e	U◯re
31. I completed college	T◯e	F◯e	U◯re
32. I have a university degree	T◯e	F◯e	U◯re

Describe relationship with your parents
How do people describe you?
Highest education?
Where do you work?
How long have you been working in your current job?
Do you have partner? **Yes☐ No ☐ name of partner----------**
If Yes for how long?
Do you have children? **Yes☐ No ☐ How many and what age?**

	Please click the box that applies to you	**True**	**False**	**Unsure**
1.	I am often afraid that others will **abandon** or leave me, so I will make excessive efforts to avoid this abandonment (even when it's not real). If I am abandoned, I become very anxious or suicidal.	◯	◯	◯
2.	My **mood** can shift between extreme periods of depression, irritability, anxiety, or happiness within the same day.	◯	◯	◯
3.	I have engaged in self-harm or **suicidal** thinking, behaviours, or threats for years.	◯	◯	◯
4.	I cannot keep friends and my relationships are **unstable** lasting for short times, usually 6 month and rarely 2 years.	◯	◯	◯
5.	I find that I often do two or more of the following **impulsive acts**: drive recklessly, engage in unplanned or unsafe sex, abuse alcohol or drugs, and binge eat, gamble, or spend money recklessly.	◯	◯	◯
6.	I have long standing **chronic** issues with my anger. I frequently get very angry, and I have a hard time controlling this anger.	◯	◯	◯
7.	I often experience a sudden shift in the way I look at myself, my	☐	☐	☐

life, or my **identity**, and completely change my goals, values, and career focus.	○	○	○
8. I worry about what others think of me, or I have suspicious ideas, or can become paranoid (believe that others hate me); or experience episodes under stress when I "**dissociate**" or feel that I, other people, or the situation is somewhat unreal.	○	○	○
9. I always feel "**empty**" and unfulfilled.	○	○	○
Over the past 2 weeks, how often have you been bothered by the following problems? Please click the box that applies to you. Click True if it happens majority of the time, more days than not:			
10. Little interest or pleasure in things you used to enjoy like going to a movie or going on a trip	○	○	○
11. Feeling down, depressed, sad or hopeless	○	○	○
12. Trouble falling asleep, staying asleep, or sleeping too much	○	○	○
13. Feeling tired or having little energy	○	○	○
14. Poor appetite or losing weight or overeating	○	○	○
15. Feeling guilty or feeling bad about yourself – or that you're a failure or have let yourself or your family down	○	○	○
16. Trouble concentrating on things such as reading newspaper, or watching television	○	○	○
17. Moving or speaking slowly that other people could notice or the opposite being very restless	○	○	○
18. Thoughts that you would be better off dead or wanting to kill yourself	○	○	○
Over the past 6 months or more, how often have you been bothered by the following problems? Please click the box that applies to you. Click true if happens majority of the time, more days than not:	True	False	Unsure
19. *Feeling nervous, anxious, or on edge and worrying too much about different things*	○	○	○
20. Not being able to stop or control worrying	○	○	○
21. Being so restless that it is hard to sit still	○	○	○
22. Becoming easily annoyed or irritable	○	○	○
23. Trouble sleeping	○	○	○
24. Fatigue	○	○	○
25. Feeling tension in muscles. Example tense neck, shoulders, back)	○	○	○
26. Having difficulty with concentration	○	○	○
Please click true if the statement applies to you	True	False	Unsure
27. I was arrested or charged more than once	○	○	○
28. I set fires on purpose as a child	○	○	○
29. I stole many times	○	○	○
30. I broke in to people's houses	○	○	○
31. I started many physical fights	○	○	○
32. I bullied other kids when I was younger	○	○	○
33. I do not care about the law, I have my own laws	○	○	○
34. I do not plan ahead	○	○	○

35. I am cruel to animals	○	○	○
36. I ran away from home or school in younger years	○	○	○
37. I was a defiant and spiteful child	○	○	○
38. I never respected authorities	○	○	○
39. I was an angry and resentful child	○	○	○
40. I drink heavily now	○	○	○
41. I use street drugs	○	○	○
Please click true if the statement applies to you for the majority of your life and since you were a child	Yes, True Frequent	No	Unsure
42. **DETAILS** often missed or makes careless mistakes *in schoolwork, work, other activities*	○	○	○
43. **EASILY distracted** by stimuli *(e.g. noise, movement, day dreaming a lot)*	○	○	○
44. **TASK AVOIDANCE** *(that requires attention such as homework, completing reports, forms)*	○	○	○
45. **INSTRUCTIONS** missed because mind elsewhere Or not listening when spoken to directly	○	○	○
46. **LOSE** things (e.g. wallet, keys, books, toy, homework)	○	○	○
47. **SUSTAINING attention** is problematic *(during reading, lectures or other activities)*	○	○	○
48. **ORGANIZATIONAL problems** *(messy, disorganized work, difficulty organizing time)*	○	○	○
49. **Fails to FINISH** *activities, schoolwork, chores or duties in the workplace* or not following through on instructions.	○	○	○
50. **FORGETFUL** in daily activities (e.g. doing homework, remembering appointments, paying bills)	○	○	○
1. Total /9			
Hyperactivity Impulsivity.	Yes, true Frequently	No	Unsure
51. **RUNS** about or climbs excessively in inappropriate situation	○	○	○
52. **ANSWERS blurted** before question is complete or blurt out rude comments	○	○	○
53. **PLENTY of talk** in social situation or play	○	○	○
54. **INTERRUPTS OR INTRUDES on others** (e.g. butts in conversations or games, cut through traffic)	○	○	○
55. **DIFFICULTY awaiting turn** (e.g. waiting to speak in turn, waiting on line	○	○	○
56. **GOING non-stop** or cannot unwind and relax	○	○	○
57. **IMPATIENCE** with prolonged seating (leaves seat in classroom or long meeting)	○	○	○
58. **RESTLESS**; always fidgets or squirms (e.g. taps legs or fingers)	○	○	○
59. **LOUD** or noisy	○	○	○

a. Total /9			
Click True if the statement applies to you	True	False	Unsure
60. I hear voices during the day	○	○	○
61. I feel I am not in control of my thoughts or actions	○	○	○
62. People want to kill me	○	○	○
Click True if the statement applies to you	True	False	Unsure
63. I binge eat on very large amount of food that I cannot control	○	○	○
64. I eat alone	○	○	○
65. I eat when not physically hungry	○	○	○
66. I feel guilty and disgusted after I eat	○	○	○
67. I eat more rapidly than usual	○	○	○
68. I eat until I am uncomfortably full	○	○	○
69. Are you troubled by repeated or unexpected “attacks” during which you suddenly are overcome by intense fear or discomfort for no apparent reason	○	○	○
70. If yes, during an attack did you experience 3 of the following symptoms: sweating, shaking, shortness of breath, pounding heart, dizziness, chest pain, numbness, fear of dying, fear of losing control, nausea	○	○	○
71. Are there things you feel you must do excessively or thoughts you must think repeatedly to feel comfortable or ease anxiety?	○	○	○
72. Do you have to check things over and over or repeat actions many times to be sure they are done properly?	○	○	○
73. Are you concerned about orderliness or symmetry?	○	○	○
74. Do you wash yourself or things around you excessively	○	○	○
75. Do you worry excessively about dirt, germs, or chemicals?	○	○	○
76. Do you have unwanted ideas, images, or impulses that seem silly, nasty, or horrible?	○	○	○