

Dr. SADEK PSYCHIATRIC ASSESSMENT INTAKE

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

Today's Date y/m/d _____ GP: LAST Name _____ First Name ----- Date of Birth y/m/d _____ Phone: _____ email _____ Current Therapist/ Counselor _____ PRESENTING PROBLEM —in your own words, summarize in one to two brief sentences. _____ _____ _____
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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?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a plan (how -to) harm yourself?	<input type="checkbox"/>	<input type="checkbox"/>
Have you attempted to harm yourself in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any relatives committed suicide?	<input type="checkbox"/>	<input type="checkbox"/>
Did you harm yourself or cut before?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have thoughts of harming someone else?	<input type="checkbox"/>	<input type="checkbox"/>
Have you assaulted or threatened anyone recently?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been in trouble because of your temper/violence?	<input type="checkbox"/>	<input type="checkbox"/>
Does drinking/drugging ever lead you to become violent?	<input type="checkbox"/>	<input type="checkbox"/>
Do you own a gun or a lethal weapon?	<input type="checkbox"/>	<input type="checkbox"/>
Are you here for insurance purpose or because of legal issues?	<input type="checkbox"/>	<input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>	Cancer Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart problems Yes <input type="checkbox"/> No <input type="checkbox"/>	Neurological problem Yes <input type="checkbox"/> No <input type="checkbox"/>
Seizure Yes <input type="checkbox"/> No <input type="checkbox"/>	Sleep disorder Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver problem Yes <input type="checkbox"/> No <input type="checkbox"/>
Thyroid problems Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney problem Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney problems Yes <input type="checkbox"/> No <input type="checkbox"/>	Head trauma Yes <input type="checkbox"/> No <input type="checkbox"/>

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? _____ when? _____
 Did you receive any therapy in the past? Yes No when? _____ Name? _____
 Were you admitted to a psychiatric inpatient unit? Yes No Date? _____

Circle any medication that you ever took in this list and put the year and any side effects beside the name:

Prozac (fluoxetine) <input type="checkbox"/>	Zoloft (sertraline) <input type="checkbox"/>	Luvox (fluvoxamine) <input type="checkbox"/>
Paxil (paroxetine) <input type="checkbox"/>	Celexa (citalopram) <input type="checkbox"/>	Ciprallex (escitalopram)
Effexor (venlafaxine) <input type="checkbox"/>	Cymbalta (duloxetine) <input type="checkbox"/>	(bupropion) /
Wellbutrin <input type="checkbox"/>	Remeron (mirtazapine) <input type="checkbox"/>	Anafranil (clomipramine)
Tofranil (imipramine) <input type="checkbox"/>	Elavil (amitriptyline) <input type="checkbox"/>	Trintelix <input type="checkbox"/>
Fetzima <input type="checkbox"/>		
Tegretol (carbamazepine) <input type="checkbox"/>	Lithium <input type="checkbox"/>	Epival (Divalproes)
Lamictal (lamotrigine)	Tegretol (carbamazepine)	Topamax (topiramate)
Seroquel (quetiapine) <input type="checkbox"/>	Zyprexa (olanzepine)	Ziprasidone <input type="checkbox"/>
Abilify (aripiprazole) <input type="checkbox"/>	Clozaril (clozapine) <input type="checkbox"/>	Haldol (haloperidol)
Risperidone <input type="checkbox"/>	Latuda (Lurazidone) <input type="checkbox"/>	
Zopiclone <input type="checkbox"/>	Melatonin <input type="checkbox"/>	Lorazepam <input type="checkbox"/>
Desyrel (trazodone) <input type="checkbox"/>		clonazepam <input type="checkbox"/>
Xanax (alprazolam) <input type="checkbox"/>	Ativan (lorazepam) <input type="checkbox"/>	Valium
(diazepam) <input type="checkbox"/>		
Vyvanse <input type="checkbox"/>	Adderall (amphetamine salts) <input type="checkbox"/>	Concerta (methylphenidate) <input type="checkbox"/>
Biphentin <input type="checkbox"/>	Strattera (atomoxetine) <input type="checkbox"/>	Ritalin <input type="checkbox"/>
		Dexedrine <input type="checkbox"/>

Drugs and Alcohol History

Do you smoke? Yes No Did you have problem with alcohol previously? 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	ADHD	Yes (who?)	No
Bipolar disorder			Alcohol abuse		
Schizophrenia			Other substance abuse		
Anxiety			Post-traumatic stress		
Suicide			Heart disease, medical?		
Depression					

CHILDHOOD DEVELOPMENT

Where were you born?

1. My mom’s pregnancy was complicated by her smoking or Use of street drugs or alcohol	True	False	Unsure
2. My birth was difficult and complicated	True	False	Unsure
3. I had a delay in talking	True	False	Unsure
4. I had problems with becoming toilet trained	True	False	Unsure
5. I had a delay in walking	True	False	Unsure
6. My mother was not affectionate and caring for me	True	False	Unsure
7. My father was not affectionate and caring for me	True	False	Unsure
8. I was bullied as a child	True	False	Unsure
9. I was sexually abused between ages 5 - 10	True	False	Unsure
10. I was sexually abused between ages 11-15	True	False	Unsure
11. I was physically abused	True	False	Unsure
12. I failed one grade or more at school (grade-----)	True	False	Unsure
13. I had serious academic difficulties in school/ I went to special Ed or resource class	True	False	Unsure
14. Teachers did not like me	True	False	Unsure
15. I had very few friends in school	True	False	Unsure
16. I had many friends as a child	True	False	Unsure
17. I was a shy and timid child	True	False	Unsure
18. I did not got along well with my siblings	True	False	Unsure
19. I grow up in a poor family	True	False	Unsure
20. I always felt inferior to others	True	False	Unsure
21. I was ashamed of who I am while growing up	True	False	Unsure

22. It was difficult to separate from my parents	True	False	Unsure
23. I hated going to school. It was a stress for me	True	False	Unsure
24. I consider myself a genius	True	False	Unsure
25. My parents separated when I was less than 10	True	False	Unsure
26. My parents separated when I was 11- 20	True	False	Unsure
27. I currently have many friends	True	False	Unsure
28. I finished grade 12	True	False	Unsure
29. I completed college or university degree	True	False	Unsure

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-----together 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. My mood can shift between extreme periods of depression, irritability, anxiety, or happiness within the same day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I have engaged in self-harm or suicidal thinking, behaviours, or threats for years.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I cannot keep friends and my relationships are unstable lasting for short times, usually 6 month and rarely 2 years.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I have long standing chronic issues with my anger. I frequently get very angry, and I have a hard time controlling this anger.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I always feel " empty " and unfulfilled.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Feeling down, depressed, sad or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Trouble falling asleep, staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Poor appetite or losing weight or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Feeling guilty or feeling bad about yourself – or that you're a	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

failure or have let yourself or your family down			
16. Trouble concentrating on things such as reading newspaper, or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Moving or speaking slowly that other people could notice or the opposite being very restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Thoughts that you would be better off dead or want to kill yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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. True if happens majority of the time:	True	False	Unsure
19. <i>Feeling nervous, anxious, or on edge and worrying too much about different things</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. <i>Not being able to stop or control worrying</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Being so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Feeling tension in muscles. Example tense neck, shoulders, back)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Having difficulty with concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please click true if the statement applies to you	True	False	Unsure
27. I was arrested or charged by police more than once	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. I set fires on purpose as a child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. I stole many times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I broke into people's houses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. I started many physical fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. I bullied other kids when I was younger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. I do not care about the law; I have my own laws	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. I do not plan ahead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. I am cruel to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. I ran away from home or school in younger years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. I blame others for my mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. I often argued with adults as a child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. <i>I was a defiant and spiteful child</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. <i>I never respected authorities</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. <i>I was an angry and resentful child</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please click true if the statement applies to you for the majority of your life and since you were a child more days than not. Say yes if the problem happens 4 days or more each week	Yes, Frequent	No	Unsure
42. DETAILS often missed or makes careless mistakes <i>in schoolwork, work, other activities</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. EASILY distracted by stimuli (<i>e.g. noise, movement, day dreaming a lot</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. TASK AVOIDANCE (<i>that requires attention such as homework, completing reports, forms</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. INSTRUCTIONS missed because mind elsewhere Or not listening when spoken to directly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. LOSE things (<i>e.g. wallet, keys, books, jackets, homework</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

47. SUSTAINING attention is problematic (<i>during reading, lectures or other activities</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. ORGANIZATIONAL problems (<i>messy, disorganized work, difficulty organizing time</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Fails to FINISH activities, schoolwork, chores or duties in the workplace or not following through on instructions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. FORGETFUL in daily activities (e.g. doing homework, remembering appointments, paying bills) Total /9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity Impulsivity. Same rules as above	Yes, Frequent	No	Unsure
51. RUNS about or climbs excessively in inappropriate situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. ANSWERS blurted before question is complete or blurt out rude comments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. PLENTY of talk in social situation or play	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. INTERRUPTS OR INTRUDES on others (e.g. butts in conversations or games, cut through traffic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. DIFFICULTY awaiting turn (e.g. waiting to speak in turn, waiting on line)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. GOING non-stop or cannot unwind and relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. IMPATIENCE with prolonged seating (leaves seat in classroom or long meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. RESTLESS ; always fidgets or squirms (e.g. taps legs or fingers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. LOUD or noisy Total /9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Click True if the statement applies to you	True	False	Unsure
60. I hear voices during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61. I feel I am not in control of my thoughts or actions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. People want to kill me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Click True if the statement applies to you for at least 3 months	True	False	Unsure
63. I binge eat on very large amount of food that I cannot control at least once a week for the past 3 month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64. I eat alone and when not physically hungry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65. I feel guilty and disgusted after I eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
66. I eat more rapidly than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67. I eat until I am uncomfortably full	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68. Are you troubled by repeated or unexpected “attacks” during which you suddenly are overcome by intense fear or discomfort for no apparent reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
69. If yes, during an attack did you experience 3 of: sweating, shaking, shortness of breath, pounding heart, dizziness, chest pain, numbness, fear of dying, fear of losing control,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70. <i>Are there things you feel you must do excessively or thoughts you must think repeatedly to feel comfortable?</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71. Do you have to check things over and over or repeat actions many times to be sure they are done properly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
72. Are you concerned about orderliness or symmetry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
73. Do you wash yourself or things around you excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

74. Do you worry excessively about dirt, germs, or chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75. Do you have unwanted ideas, images, that seem silly, nasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>