TRUENORTH PSYCHIATRIC NURSING CORP

863 Bowsprit Road, Ste 174 | Chula Vista, CA 91914
Phone: 619-614-8009 | Email: maja.ceranic.nusn@gmail.com

New Patient Intake Form

Patient Name: _____ Appointment Date: _____

WHAT BRINGS YOU IN?

Please briefly describe your main concerns and what you hope to get help with:

Current concerns - check all that apply:

- ☐ Depression / sadness
- ☐ Anxiety / worry
- ☐ Panic attacks
- ☐ Mood swings
- ☐ Irritability / anger
- ☐ Sleep problems
- ☐ Focus / attention
- ☐ Hyperactivity / impulsivity
- ☐ Obsessive thoughts
- ☐ Compulsive behaviors
- ☐ Trauma / flashbacks
- ☐ Nightmares
- ☐ Low motivation
- ☐ Loss of interest
- ☐ Appetite changes
- ☐ Fatigue / low energy
- ☐ Social discomfort
- ☐ Relationship stress
- ☐ Work / school stress
- ☐ Alcohol / substance concerns
- ☐ Suspicion / paranoia
- ☐ Hearing voices
- ☐ Seeing things others do not
- ☐ Other

If other, please describe: _____

SAFETY

Have you ever had thoughts of suicide or wishing you were dead? ☐ Yes ☐ No

Are you having suicidal thoughts now? ☐ Yes ☐ No

Have you ever attempted suicide or intentionally harmed yourself? ☐ Yes ☐ No

Have you ever had thoughts of seriously harming someone else? ☐ Yes ☐ No

If yes to any item above, briefly explain (include approximate dates if known):

PSYCHIATRIC TREATMENT HISTORY

Have you previously received mental health treatment? ☐ Yes ☐ No

Prior counseling / therapy? ☐ Yes ☐ No

Prior psychiatric medications? ☐ Yes ☐ No

Prior psychiatric hospitalization? ☐ Yes ☐ No

Prior substance-use treatment? ☐ Yes ☐ No

Please list important past diagnoses, hospitalizations, or treatments:

MEDICAL HISTORY - BRIEF

Primary medical conditions or significant past medical problems:

History of seizures? ☐ Yes ☐ No

Significant head injury? ☐ Yes ☐ No

Pregnant / possibly pregnant? ☐ Yes ☐ No

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CURRENT MEDICATIONS & ALLERGIES

Current prescription medications (name, dose, and how often):

Over-the-counter medications / vitamins / supplements:

Medication allergies or significant adverse reactions:

SUBSTANCE USE

Please check any substances currently or previously used:

- ☐ Alcohol
- ☐ Cannabis
- ☐ Nicotine / tobacco
- ☐ Stimulants
- ☐ Cocaine / crack
- ☐ Opioids / pain pills
- ☐ Benzodiazepines
- ☐ Other substances

Current alcohol/substance use - type, amount, and frequency:

Have you ever experienced withdrawal symptoms when cutting down or stopping? ☐ Yes ☐ No

Have substances caused problems with health, relationships, work/school, or legal matters? ☐ Yes ☐ No

If yes, briefly describe:

FAMILY & SOCIAL HISTORY

Family history of mental health or substance-use concerns (who and what condition):

Who do you currently live with?

Relationship status:

Current occupation / school:

Current stress level: ☐ Low ☐ Medium ☐ High

Main sources of support:

Major current stressors:

TRAUMA / SAFETY AT HOME

Have you experienced trauma or abuse that you believe is relevant to your care? ☐ Yes ☐ No

Do you currently feel safe at home and in your relationships? ☐ Yes ☐ No

Anything you would like your provider to know:

GOALS & PREFERENCES

What are your main goals for treatment?