Round Rock| South Austin| Central Austin| Cedar Park| Georgetown| Waco| Killeen| Amarillo
Phone: (512) 244-4272 | Fax: (512) 244-2895 | www.austinpaindoctor.com

New Patient Intake

Patient's Name: Date of Birth:

Date of Visit: Location of Care:

Please take a few minutes to fill out this medical intake to facilitate your appointment today.

Past Psychiatric History

Outpatient Treatment? ☐ Yes | ☐ No
If yes please describe:

When	By Whom?	Nature of Treatment

Psychiatric Hospitalization? ☐ Yes | ☐ No
If yes please describe:

When	Where?	Reason

Past Psychiatric Medications? ☐ Yes | ☐ No
If yes please describe:

Name of Medication	Dose	How often do you take it?	What is it for?	Who prescribes it?

Are you currently seeing a Mental Health Provider? ☐ Yes | ☐ No
Provider Name: _____
Diagnosis: _____

What brings you to counseling at this time? Is there something specific, such as a particular event?
Be as detailed as you can. : _____

Are you having any thoughts of hurting yourself? ☐ Yes | ☐ No

Symptoms Checklist:

	Y	N		Y	N
Depressed Mood	☐	☐	Change In Appetite	☐	☐
Racing Thoughts	☐	☐	Excessive Energy	☐	☐
Excessive Worry	☐	☐	Excessive Guilt	☐	☐
Unable to Enjoy Activities	☐	☐	Increased Irritability	☐	☐
Impulsivity	☐	☐	Fatigue	☐	☐
Anxiety Attacks	☐	☐	Crying Spells	☐	☐
Sleep Patter Disturbance	☐	☐	Decreased Libido	☐	☐
Increase Risky Behavior	☐	☐			
Avoidance	☐	☐			
Loss of Interest	☐	☐			
Increased Libido	☐	☐			
Hallucinations	☐	☐			
Concentration / Forgetfulness	☐	☐			
Decrease Need for Sleep	☐	☐			
Suspiciousness	☐	☐			

Have you been treated for depression, anxiety, bipolar Illness, or ADD? ☐ Yes | ☐ No

Do you have any history of substance abuse such as alcohol marijuana, cocaine, methamphetamine, heroin, pain medications, or other? ☐ Yes | ☐ No

Do you use Illicit Substances? ☐ Yes | ☐ No

Do you have gambling problems? ☐ Yes | ☐ No

Have you ever been to a substance abuse treatment program, either inpatient or outpatient? ☐ Yes | ☐ No

Have you ever been arrested for DWI, public Intoxication, or possession of controlled substance? ☐ Yes | ☐ No

Do you have a family history of substance abuse or psychiatric illness? ☐ Yes | ☐ No

Have you ever had an adverse reaction to opioid pain medication including overdose, tolerance, or withdrawal? ☐ Yes | ☐ No