PACIFIC
PAIN & WELLNESS GROUP

23000 Crenshaw Blvd., Suite 100
Torrance, CA 90505
Tel: 310.437.7399 Fax: 424-250-9397

Outpatient Adult Psychiatry/Psychology Intake Form

This form must be filled out in its entirety before coming in for an appointment. Failure to do so may result in your appointment being rescheduled.

Note: You are able to enter your answers directly onto this form.

Name of person completing this section (if different than patient) and relationship to patient: Click here to enter text.

Patient Information

Name: Click here to enter text. **Date of Birth:** Click here to enter text.

Age:Click here to enter text. **Social Security Number**:Click here to enter text. ☐Will provide at time of apt
Sex: ☐Male ☐Female

Email: Click here to enter text.

Which doctor will you be seeing
☐Dr. Ananth ☐Dr. Solomon

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Address: Click here to enter text.
Home Phone: Click here to enter text.**Cell Phone**: Click here to enter text.

Ethnicity: Click here to enter text.

Who were you referred to our clinic by: Click here to enter text.
PCP: Click here to enter text.

Emergency Contact Name Click here to enter text.
Phone Click here to enter text.
Relationship: Click here to enter text.

*****For all New Patients*****

I understand if I cancel my new patient appointment after the 48 hour cancellation policy or no show/miss my appointment my card will be charged the full amount of the appointment. ☐ **Yes** ☐ **No**
Type or initial name or sign: Click here to enter text.

Pharmacy Information

Name of Preferred Pharmacy: Click here to enter text.

Pharmacy Address: Click here to enter text.
Pharmacy Cross Streets:Click here to enter text. & Click here to enter text.

Pharmacy City: Click here to enter text.

Pharmacy Phone: Click here to enter text. Pharmacy Fax:Click here to enter text.

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Patient Name: _____

Please answer the following Questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All the information you provide will be kept confidential.**

What problems are you having which prompted you to come to this clinic? (Be as thorough as possible)
Click here to enter text.

What are you goals/expectations for treatment?
Click here to enter text.

Past Psychiatric Treatment

Have you ever been hospitalized for psychiatric reasons? ☐No ☐Yes
If Yes, when and where? Click here to enter text.
Have you ever had outpatient treatment by a psychiatrist? ☐No ☐Yes
If yes, when and by whom? Click here to enter text.
Which psychiatric medications have you taken in the past and what were the benefits and/or side affects you had from them? ☐None List: Click here to enter text.

Are you taking any psychiatric medications now? ☐No ☐Yes
Current Medication List – Please list all medications prescribed/otc/and supplements

Medication Name	Dose	Frequency
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
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Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.

Are you allergic to any medications? ☐ No ☐ Yes
List medications and allergic reactions: Click here to enter text.

Have you undergone any surgical procedures? ☐ No ☐ Yes
Please list procedures & dates of surgery: Click here to enter text.

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Does your mind work overtime? ☐ No ☐ Yes
Do you have unexplained bursts of energy? ☐ No ☐ Yes
Do you often worry or feel nervous? ☐ No ☐ Yes
Do you have physical symptoms from anxiety? ☐ No ☐ Yes
Do you feel isolated? ☐ No ☐ Yes
Is anyone physically or emotionally abusing you? ☐ No ☐ Yes
How many hours do you get of sleep per night? ☐ 1-3 ☐ 4-6 ☐ 7-10
How many meals do you eat per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 +

Do you have problems with chronic physical pain? ☐ No ☐ Yes

Rate average pain level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have you ever suffered a severe head injury with loss of consciousness or concussion? ☐ No ☐ Yes
Describe:Click here to enter text.

What are things that bother you the most – describe.

☐Problems/losses within my family
☐Problems/loses among my friends community
☐educational problems
☐Occupational problems
☐Housing problems
☐Financial/economic problems
☐Can't get adequate health care
☐Problems with law, legal system
☐Discipline problems at work
☐Careless, high-risk behavior
☐ Other – explain Click here to enter text.

Past Medical History:

☐Diabetes	☐Heart Disease	☐Blood pressure	☐Cancer
☐Asthma	☐Emphysema	☐Liver disease	☐Kidney disease
☐Depression	☐Anxiety	☐Ulcers	☐Heart Attack
☐Stroke	☐Heart Palpations	☐Heart Surgery	☐Pace maker implant
☐Cancer	☐Lung Disease	☐Asthma	☐Emphysema
☐Chronic cough	☐Bronchitis	☐Pneumonia	☐Tuberculosis
☐Shortness of breath	☐Seizures	☐Epilepsy	☐Fainting
☐ Vertigo/Dizziness	☐ Motor difficulties	☐ Serious head injuries	☐ Recurring headaches
☐ Arthritis	☐ Muscle cramps	☐ Muscle stiffness	☐ Weakness
☐ Tremors	☐ Numbness	☐ Difficulty walking	☐ Uncontrolled movements
☐ Kidney disease	☐ Thyroid disease	☐ Hormone problems	☐ Blood Disease

☐Other Click here to enter text.

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Alcohol drug and tobacco use ☐ Check if none

Alcohol ☐ current use: date of last use Click here to enter text.

Problems related to use? ☐ No ☐ Yes

Legal, financial, health, relationship) List:Click here to enter text.

Treatment required? ☐No ☐ Yes

Describe: Click here to enter text.

Illicit drug and/or prescription drug abuse (continued on next page)

Substance	Date of last use	Problems related to use	Treatment required
Benzodiazepines (valium, Xanax, Ativan)	Click here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No
Caffeine	Click here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No
Marijuana	Click here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No
Cocaine	Click here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No
Designer drugs (Club drugs: G,X)	Click here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No
Hallucinogens (LSD, Mushrooms)	Click here to enter text.	☐ Yes ☐ No	☐ Yes ☐No
Inhalants (gasoline, glue, aerosol)	Click here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No
Methamphetamines (Speed, ice, Ritalin)	Click here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No
Opiates/Methadone (Vicodin, OxyContin, heroin)	Click here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No
Other	Click here to enter text.	☐ Yes ☐ No	☐ Yes ☐ No

Social History

Where were you born? Click here to enter text.

Where did you grow up? Click here to enter text.

Did your parents stay together while you were growing up? ☐Yes ☐No

How old were you when they separated? Click here to enter text.

Father's occupation while you were growing up: Click here to enter text.

Mother's occupation while you were growing up: Click here to enter text.

Where there any complications at your birth (Premature birth, major medical problems?)

☐No ☐ Yes Describe: Click here to enter text.

Are you/were you a victim of any form of physical/sexual/emotional abuse?

Physical abuse: ☐ No ☐ Yes Age of occurrence: Click here to enter text.

Sexual abuse: ☐ No ☐ Yes Age of occurrence: Click here to enter text.

Emotional abuse: ☐ No ☐ Yes Age of occurrence: Click here to enter text.

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Did you graduate from high school? ☐ No ☐ Yes Last grade attended: Click here to enter text.

What type of jobs have you had in the past? Click here to enter text.
Are you currently employed? ☐ No ☐ Yes If yes, where: Click here to enter text.

Are you currently involved in a romantic relationship? ☐No ☐ Yes
Spouse's/partner's first name: Click here to enter text.
How long have you been together? Click here to enter text.
How would you describe your relationship? Click here to enter text.
What is your spouse's/partner's occupation? Click here to enter text.
Have you been involved in any previous significant intimate/romantic relationships? ☐ No ☐ Yes
Describe: Click here to enter text.

What are some things you enjoy doing (hobbies, sports, past times)? Click here to enter text.

Have you ever been convicted of any crimes, incarcerated in prison, or placed on probation?
☐No ☐Yes Describe: Click here to enter text.

Family History
Is there any history of mental illness or substance abuse among your blood relatives?
☐No ☐Yes
If yes, describe – Father's side: Click here to enter text.
Mother's side: Click here to enter text.

Social Supports
Is there anyone your trust or confide in during times of trouble? ☐ No ☐ Yes
Name supports: Click here to enter text.

Do you have any religious ties or involvement in a church? ☐ No ☐ Yes
Describe: Click here to enter text.

Current living situation
Do you live in a: ☐ House ☐ Apartment ☐ Manufactured Home ☐ other
☐ Own or ☐ Rent
Do you live alone? ☐ Yes ☐ No If not, who else lives with you: Click here to enter text.
Do you have planes to move in the near future? ☐ Yes ☐ No Where: Click here to enter text.
Do you have any pets? ☐ Yes ☐ No List: Click here to enter text.

How many children do you have
Click here to enter text. Boys Click here to enter text. Girls

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How many siblings do you have

Click here to enter text. Brothers Click here to enter text. Sisters

Advanced Directives

Do you have a psychiatric advanced directive? ☐ Yes ☐ No

Reviewed by:_____

Date:_____ **Patient Name:** Click here to enter text.