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NEW CLIENT INTAKE FORM

Date: ___ / ___ / ___

BASIC INFORMATION

Name: _____

Gender: male female Age: _____ Date of birth: ___ / ___ / ___

Preferred phone: _____ cell home work other

Permission to leave detailed messages on this phone? yes no

Alternate phone: _____ cell home work other

Permission to leave detailed messages on this phone? yes no

Mailing address: _____

Street address, if different: _____

Email address: _____

Current occupation: _____

Employer: _____

Relationship status:

single married / partner separated divorced widowed

Emergency contact: _____ Relationship: _____

Phone: _____

Referred by: _____ Phone: _____

Current therapist: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

May we exchange information with your treating clinicians to coordinate your care?

Therapist: yes no PCP: yes no

Pharmacy: _____ Phone: _____

Address: _____

Person responsible for payment, if other than client: _____

Relationship: _____ Phone: _____

Address: _____

PRIOR PSYCHIATRIC HISTORY

Have you ever been diagnosed with a mental illness? yes no

If yes, please specify the diagnosis or diagnoses you have been given:

Do you feel the diagnosis is accurate? yes no not sure

Have you received outpatient psychiatric treatment in the past? yes no

If yes, when was your last appointment (approximately)? _____

Have you ever been admitted to an inpatient psychiatric unit? yes no

If yes, how many times? _____

At which hospital(s) were you admitted? _____

When was your most recent hospitalization (approximately)? _____

What was the main reason for that hospitalization? _____

Have you ever attempted suicide? yes no

If so, when and how? _____

Please list any psychiatric medications you have taken in the past, and indicate if any were especially helpful or caused problems:

Have you ever received treatment for substance abuse or other addictions? yes no

If yes, please specify: _____

How often did you have a drink containing alcohol in the past year?

Never Monthly or less 2-4 times per month

2-3 times per week 4 or more times per week

How many drinks do you have on a typical day when you are drinking?

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

How often did you have 6 or more drinks on one occasion in the past year?

Never Less than monthly Monthly Weekly Daily or almost daily

Any history of withdrawal symptoms from not drinking (e.g., tremors, seizures)? yes no

Has alcohol ever caused problems for you? yes no

If yes, please specify: _____

How many caffeinated beverages (coffee, soda, etc.) do you drink on an average day? _____

Do you or have you ever smoked? yes no

Packs per day: _____ Years smoked: _____ Date quit: _____

Have you ever used any of the following recreationally?

Marijuana Cocaine Heroin Ecstasy / Molly LSD Mushrooms

Speed PCP Ketamine Opiates (e.g., Oxycontin, Percocet)

Benzodiazepines (e.g., Xanax, Valium) Other: _____

Has your use of any of the above caused problems for you? yes no

Do you currently use any of these on a regular basis? yes no

If so, which one(s)? _____

Why are you seeking help at this time?

What are your goals for treatment?

MEDICAL HISTORY

Previously diagnosed medical conditions:

Any history of head injury? yes no

Do you have any allergies? yes no

If so, indicate what kind of reaction for each substance or medication:

EDUCATION

Degree(s) earned: _____

Any learning problems in school? yes no

Any behavioral or hyperactivity problems at school? yes no

FAMILY INFORMATION

	Name	Living with you?	Important Medical History	Age Deceased	Current Age
Spouse or partner					
Children					
Mother					
Father					
Siblings					

Is there anyone else living with you not mentioned above? yes no

If so, please indicate name and relationship:

Does or did anyone in your family have psychiatric illness (i.e. depression, anxiety, substance abuse, or other diagnoses)? yes no

If so, please specify their relationship(s) and diagnosis:

Do you have difficulties in any of your relationships? yes no

If so, please describe:

SYMPTOM CHECKLIST

Check the column that best describes how often you experience each of the following:

	Never	Rarely	Sometimes	Often
Depressed mood				
Difficulty sleeping				
Overeating				
Decreased appetite				
Difficulty concentrating				
Low energy				
Low self-esteem				
Wanting to harm yourself				
Harm to self				
Premenstrual symptoms				
Mood swings				
Unusually high energy				
Excessive risk-taking				
Difficulty controlling anger				
Wanting to harm others				
Hearing things not there				
Seeing things not there				
Anxiety				
Feeling panicked				
Intense fears (planes, heights, etc)				
Fear of social situations				
Fear of leaving the house				
Fear of being sick				
Fear of dying				
Physical pain				
Doing or thinking things over and over				
Frequent nightmares				
Memory problems				
Feeling detached from others				
Sexual difficulties				
Fear of being overweight				
Vomiting / purging				
Addictive behavior				