Elite DNA Therapy Services
a comprehensive approach

# Adult Intake Form

**Demographics**

Patient Name: _____ [ ] Male [ ] Female [ ] Unknown
Prefers to be called: _____ Prefers to be recognized as [ ] Male [ ] Female
Date of Birth: _____ Patient Social Security Number: _____
Ethnicity: _____ Preferred Language: _____
Current Diagnosis (if any): _____
Name (Person completing this form): _____ Relationship to Patient: _____
Home Address: _____ Primary Phone: _____
_____ Secondary Phone: _____

**Doctor Information**

Primary Physician: _____ Referring Physician: _____
Phone: _____ Phone: _____Specialty: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

**Insurance Information (Guarantor)**

Primary Insurance Type: _____ Secondary Insurance Type: _____
Member ID Number: _____ Member ID Number: _____
Group Number: _____ Group Number: _____
Policy Holder's Name: _____ Policy Holder's Name: _____
Policy Holder's DOB: _____ Policy Holder's DOB: _____
Policy Holder's Social Security Number: _____ Policy Holder's Social Security Number: _____

**Guardian Information** (Complete If Applicable)

Guardian Name: _____ Occupation: _____
Relationship to Patient: _____ Home Phone: _____
Date of Birth: _____ Cell Phone: _____
Social Security Number: _____ Work Phone: _____
Marital Status: _____ E-mail Address: _____

Guardian Name: _____ Occupation: _____
Relationship to Patient: _____ Home Phone: _____
Date of Birth: _____ Cell Phone: _____
Social Security Number: _____ Work Phone: _____
Marital Status: _____ E-mail Address: _____

*Elite DNA Therapy Services, LLC may contact guardian, emergency contact or guarantor for verify purposes or in case of emergency.

**Presenting Concerns**

Please describe your primary concerns. (How long have you noticed this?) _____

_____

Have you already tried to address these concerns? ___ Yes ___ No

Were the efforts effective? ___ Yes ___ No

If there was an event that caused you to seek treatment now; what is it? _____

**Current Symptoms Checklist**

[ ] Depressed mood
[ ] Unable to enjoy activities
[ ] Sleep pattern disturbance
[ ] Loss of interest
[ ] Decreased concentration/forgetfulness
[ ] Racing thoughts
[ ] Impulsivity
[ ] Excessive energy
[ ] Increased irritability
[ ] Crying spells
[ ] Excessive worry
[ ] Anxiety attacks
[ ] Avoidance
[ ] Repetitive behaviors
[ ] Thoughts of harming someone else
[ ] Increased risky behavior
[ ] Increased libido
[ ] Decreased need for sleep
[ ] Other: _____

Have you ever had feelings or thoughts that you didn't want to live? ___ Yes ___ No

Do you currently feel that you don't want to live? ___ Yes ___ No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? ___ Yes ___ No

Would anything make it better? ___ Yes ___ No

Have you ever thought about how you would kill yourself? ___ Yes ___ No

Is the method you would use readily available? ___ Yes ___ No

Have you planned a time for this? ___ Yes ___ No

Is there anything that would stop you from killing yourself? ___ Yes ___ No

Have you ever tried to kill or harm yourself before? ___ Yes ___ No

**Medical History** (Please complete fully and speak with our Intake Specialists if you have questions.)

Date of last complete physical exam: _____

Check All Box That Are Applicable:

[ ] Head Trauma
[ ] Seizures, onset age: _____
[ ] Vision Problems
[ ] Hearing Problems

Disabilities that may impact your treatment: _____

Medicine/Food Allergies: _____

Current Medical Problems/Diagnosis: _____

_____

Past Medical History (Ex: non-psych hospitalizations, illnesses, injuries or surgeries): _____

_____

Current Medications or Supplements (list dosages): _____

_____

Are you being treated or have been treated by other specialties or other professionals? ___ Yes ___ No

**For Women Only**

Are you currently pregnant or do you think you might be pregnant? ___ Yes ___ No __ Unsure

Are you planning to get pregnant soon? ___ Yes ___ No

Birth control method: _____

Please mark all **past** psychiatric medications.

**Antidepressants**

[ ] Prozac (fluoxetine)
[ ] Zoloft (sertraline)
[ ] Luvox (fluvoxamine)
[ ] Celexa (citalopram)
[ ] Lexapro (escitalopram)
[ ] Paxil (paroxetine)
[ ] Pristiq (desvenlafaxine)
[ ] Cymbalta (duloxetine)
[ ] Effexor (venlafaxine)
[ ] Wellbutrin (Bupropion)
[ ] Remeron (mirtazapine)
[ ] Viibryd (vilazodone)
[ ] Trintellix (vortioxetine)
[ ] Elavil (amitriptyline)
[ ] Anafranil (clomipramine)
[ ] Sinequan (doxepin)
[ ] Tofranil (imipramine)
[ ] Pamelor (nortriptyline)
[ ] Savella (milnacipran)
[ ] Fetzima (levomilnacipran)
[ ] Other: _____

**Anti-Anxiety (Anxiolytics)**

[ ] Xanax (alprazolam)
[ ] Buspar (buspirone)
[ ] Ativan (lorazepam)
[ ] Vistaril (hydroxyzine)
[ ] Klonopin (clonaxepam)
[ ] Valium (diazepam)
[ ] Librium (chlordiazepoxide)
[ ] Tranxene (clorazepate)
[ ] Serax (oxazepam)
[ ] Other: _____

**Typical Antipsychotics**

[ ] Thorazine (chlorpromazine)
[ ] Haldol (haloperidol)
[ ] Other: _____

**Atypical Antipsychotics/Mood Stabilizers**

[ ] Abilify (aripiprazole)
[ ] Clozaril (clozapine)
[ ] Latuda (lurasidone)
[ ] Zyprexa (olanzapine)
[ ] Seroquel (quetiapine)
[ ] Risperdal (risperidone)
[ ] Geodon (ziprasidone)
[ ] Haldol (haloperidol)
[ ] Prolixin (fluphenazine)
[ ] Saphris (asenapine)
[ ] Rexulti (brexpiprazole)
[ ] Invega (paliperidone)
[ ] Fanapt (iloperidone)
[ ] Other: _____

**Mood Stabilizers**

[ ] Lithium
[ ] Tegretol (carbamazepine)
[ ] Neurontin (gabapentin)
[ ] Lamictal (lamotrigine)
[ ] Trileptal (oxcarbazepine)
[ ] Topamax (topiramate)
[ ] Depakote (valproate)
[ ] Other: _____

**Sedatives/Sleep Aides**

[ ] Ambien (zolpidem)
[ ] Sonata (zaleplon)
[ ] Rozerem (ramelteon)
[ ] Restoril (temazepam)
[ ] Desyrel (trazodone)
[ ] Lunesta (eszopiclone)
[ ] Belsomra (suvorexant)
[ ] Other: _____

**ADHD Medications**

[ ] Adderall (amphetamine)
[ ] Adderall XR
[ ] Evekeo (amphetamine)
[ ] Zenzedi (amphetamine)
[ ] Adzenys XR (amphetamine)
[ ] Concerta (methylphenidate)
[ ] Ritalin (methylphenidate)
[ ] Daytrana (methylphenidate)
[ ] Metadate (methylphenidate)
[ ] Dyanavel XR
[ ] Strattera (atomoxetine)
[ ] Quillivant XR
[ ] Kapvay (clonidine)
[ ] Tenex/Intuniv (gunanfacine)
[ ] Mydayis (mixed amphetamine salt)
[ ] Cotempla XR (methylphenidate)
[ ] Other: _____

**Family History** (Please indicate if any family members have been diagnosed or experience any of the following)

| | Mother | Father | Sibling | Maternal Grandparents | Paternal Grandparents | Other |
|---|---|---|---|---|---|---|
| Depression | | | | | | |
| Anxiety | | | | | | |
| Substance abuse | | | | | | |
| Learning disability | | | | | | |
| ADHD | | | | | | |
| Bipolar disorder | | | | | | |
| Psychosis/Schizophrenia | | | | | | |
| OCD | | | | | | |
| Suicidal behavior | | | | | | |
| Self-harm/cutting | | | | | | |
| Seizure disorder | | | | | | |
| Autism spectrum | | | | | | |
| Intellectual disability | | | | | | |
| Abuse | | | | | | |
| Thyroid problem | | | | | | |
| Other | | | | | | |

**Psychiatric History**

Have you ever received any of the following services or feelings?

- Individual Therapy: ___ Yes ___ No
- Family Therapy: ___ Yes ___ No
- Group Therapy: ___ Yes ___ No
- Psychological Testing: ___ Yes ___ No
- Inpatient (Hospital or Residential): ___ Yes ___ No
- Past Suicidal Ideation: ___ Yes ___ No
- Aggressive Behavior or Homicidal Ideation/Behavior: ___ Yes ___ No
- Previous Diagnosis: ___ Yes ___ No

**Substance Abuse**

Is substance abuse a primary treatment concern? ___ Yes ___ No __ Unsure

Have you ever been treated for alcohol or drug use or abuse? ___ Yes ___ No __ Unsure

Have many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ___ Yes ___ No

Have people annoyed you by criticizing your drinking or drug use? ___ Yes ___ No

Have you ever felt bad or guilty about your drinking or drug use? ___ Yes ___ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves? ___ Yes ___ No

Do you think you may have a problem with alcohol or drug use? ___ Yes ___ No

Have you used any street drugs in the past three months? ___ Yes ___ No

Have you ever abused prescription medication? ___ Yes ___ No

**Tobacco History**

Have you ever smoked cigarettes? ___ Yes ___ No

Do you currently smoke cigarettes? ___ Yes ___ No

How many packs per day on average? _____

**Trauma History**

Have you ever experienced or witnessed any kind of abuse? ___ Yes ___ No

- Emotional abuse: ___ Yes ___ No
- Physical abuse: ___ Yes ___ No
- Sexual abuse: ___ Yes ___ No
- Neglect: ___ Yes ___ No

**Educational History**

What is the highest-grade level / degree of education you have completed? _____

**Work History**

Are you currently: [ ] Working [ ] Student [ ] Unemployment [ ] Disabled [ ] Retired

- How long have you been in your present position? _____
- What is/was your occupation? _____
- Where do you work? _____
- What are your hours? _____

**Relationship History and Current Family**

Relationship Status:

[ ] Married for: _____ [ ] Single for: _____

[ ] Divorced for: _____ [ ] Widowed: _____

[ ] Partnered for: _____

How would you identify your sexual orientation? _____ [ ] Prefer Not to Answer

Are you sexually active? ___ Yes ___ No

Have you had any prior marriages? ___ Yes ___ No

Do you have children? ___ Yes ___ No

What are their ages and whom do they live with? _____

_____

Whom do you currently live with? _____

**Legal History**

Have you ever been arrested? ___ Yes ___ No

Have you ever been incarnated/ jail? ___ Yes ___ No

Do you have any pending legal problems? ___ Yes ___ No

**Spiritual Life**

Do you belong to a religion or spiritual group? ___ Yes ___ No ___Prefer not to answer

Are there any cultural factors that could impact patient's treatment? ___ Yes ___ No

Any other information you wish the provider to know: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Print Name of Patient or Patient Representative | Relationship to Patient

_____ _____

Signature of Patient or Patient Representative | Date