ElliotHealthSystem

Behavioral Health Services
445 Cypress St.
Manchester, NH 03109
Tel: (603) 668-4079 Fax: (603) 663-8605

ADULT INTAKE

DATE	PATIENT'S NAME	DATE OF BIRTH AGE
OCCUPATION/SCHOOL (Grade)	PLACE OF EMPLOYMENT	
MARITAL/RELATIONSHIP HISTORY		
☐SINGLE ☐LIFE PARTNER ☐WIDOWED ☐DIVORCED ☐ MARRIED YEARS_____ NUMBER OF PREVIOUS MARRIAGES_____		

CURRENT H OUSEHOLD MEMBERS		
NAME	AGE	RELATIONSHIP TO PATIENT
CHILDREN NOT LIVING INSIDE THE HOME		

Briefly describe why the patient is here today:

_____

_____

_____

What does the patient hope to accomplish as a result of treatment at EBHS?

_____

_____

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no-one can be trusted; the world is completely dangerous?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
1 2. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings or people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "super alert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
1 9. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Please Check Frequency of Symptoms Over Past 2 Weeks	None	Several Days	Half of The Days	Nearly Everyday	Everyday
Persistent intrusive thoughts or images that run through his or her head					
Repetitive Hand Washing					
Repetitive Counting					
Repetitive Checking					
Repetitive Ordering					
Repetitive Praying					
Repeating Word s Silently					
Repetitive Questioning					
Picking or hair pulling					
Palpitations, chest pain or discomfort					
Not being able to stop or control worrying					
Trembling or Shaking					
Easily annoyed or irritable					
Nausea or upset stomach					
Fear of Dying					
Trouble relaxing					
Chills or hot flashes					
Dizziness, unsteadiness, lightheaded or faint					
Feelings of being detached from oneself					
Feelings of losing control or going crazy					
Avoids places that bring on these feelings					
Sensitive to tastes, smells, texture or noises					
Please Check Frequency of Symptoms over past 2 Weeks	**None**	**Several Days**	**Half of the days**	**Nearly Everyday**	**Everyday**
Fail to pay close attention to details in school work, work or other activities					
Has difficulty sustaining attention in tasks or leisure activities					
Fidget or squirms with hands or feet when having to sit for a long time					
Difficulty getting things in order when you have to do a task that requires organization					
Avoids or delays getting started on tasks					
Restless or overactive feelings					
Excitable, impulsive behaviors					
Demands must be met immediately					
Easily frustrated					
Mood changes quickly and drastically					

Name:_____

MEDICAL HISTORY **NONE** ☐ DOB:

Please list medical problems that the patient has or has had in the past (diabetes, heart disease, cancer, etc.):	
Condition	Onset (Year)
P lease list all surgeries that the patient has had:	Year
DATE OF LAST PHYSICAL EXAM:	

PSYCHIATRIC HISTORY **NONE** ☐

P lease list psychiatric problems that the patient has had in the past.		
Problem	Dates	Type of Treatment

Please list prior psychiatric hospitalizations		
Reason	Where?	When? (Year)

Please list previous medications.		
Medication/Doses	Dates	Response/Side Effects

ALLERGIES (PLEASE LIST):

CURRENT MEDICATIONS: Include all medications prescribed by physicians as well as over the counter medications including herbs and supplements. Please be accurate.

Medication	Prescriber	Dose and Frequency

Name:

D.O.B.:

SOCIAL H ISTORY

Was the patient adopted?	☐ Yes ☐ No	If yes, at what age?
Are the patient's parents divorced?	☐ Yes ☐ No	If yes, at w ha t age?
Where did the patient grow up?		
How far did the patient get in school? (Grade, High School, College, etc.):		
Was the patient eve r in a special class or provided with special services? If so , please describe:		
What kind of grades did the patient receive while in school?		
Was the patient ever held back in school? ☐ Yes ☐ No	If yes, in which grade?	
Religion:		

FAMILY HISTORY

Does anyone in the patient's biological family have a psychiatric illness or a problem with drugs? ☐ Yes ☐ No	
If yes, please list relationship to patient:	Psychiatric illness or addiction:

SUBSTANCE H ISTORY

	Current	Past	How much a day	How many years
Cigarettes	0	0		
Alcohol	0	0		
Marijuana	0	0		
Cocaine ("crack")	0	0		
LSD, mescaline, peyote	0	0		
"Downers," barbiturates, valium, Ativan, sedatives	0	0		
Narcotics (heroin, morphine, methadone, oxycontin)	0	0		
Amphetamines (Dexedrine, "speed," " uppers, " diet pills, stimulants)	0	0		
Solvents (glue, gasoline, chloroform, ether, paint)	0	0		
Other substances	0	0		
Has use of one of these substances ever led to problems at work, school, legal problems, social problems, or engagement in risky or hazardous behavior?				☐Yes ☐ No
Does the patient find that he/she needs more of the substance to ach ieve a " high " or desire d effect?				☐Yes ☐N o

MEDICAL HISTORY (PATIENTS UNDER THE AGE OF 18)

Name

D.O.B:

NAME OF MOTHER	DATE OF BIRTH AGE
MOTHER'S OCCUPATION	PLACE OF EMPLOYMENT
MOTHER'S MARITAL/RELATIONSHIP HISTORY	
☐SINGLE ☐LIFE PARTNER ☐WIDOWED ☐DIVORCED ☐MARRIED YEARS NUMBER OF PREVIOUS MARRIAGES	

NAME OF FATHER	DATE OF BIRTH AGE
FATHER'S OCCUPATION	PLACE OF EMPLOYMENT
FATHER'S MARITAL/RELATIONSHIP HISTORY	
☐SINGLE ☐ LIFE PARTNER ☐ WIDOWED ☐ DIVORCED ☐ MARRIED YEARS NUMBER OF PREVIOUS MARRIAGES	

BIOLOGICAL/STEP SIBLINGS OF PATIENT (Please use back of sheet if you need more space)

NAME	AGE	GRADE

PREGNANCY	
Did the mother experience any unusual illness, condition or accident such as German measles, RH incompatibility, false labor, etc.?	☐ Yes ☐ No
If yes, please describe:	
Was the mother taking prescription meds or using illegal substances during pregnancy?	☐ Yes ☐ No
If yes, please list:	
Length of pregnancy (weeks):	Duration of labor (hours):
Birth weight:	Was this a planned pregnancy? ☐ Yes ☐ No
Problems with pregnancy and delivery (breach birth, Caesarean, etc.)?	☐ Yes ☐ No
If yes, please describe:	
Did the baby experience any problems after delivery?	☐ Yes ☐No
If yes, please describe:	
FEEDING	
Did the child have any feeding problems?	☐ Yes ☐ No
If yes, please describe:	
DEVELOPMENTAL	

Did the child reach developmental milestones on time (walking, toilet training, talking, dressing and undressing self)?	☐ Yes ☐ No
Describe infant's temperament:	
Did the child have difficulty with strangers or separating from parents?	☐ Yes ☐ No
Please explain developmental concerns, if any:	

Signature of Patient _____ Date: _____

Signature of Guardian _____ Date: _____