



PSYCHIATRIC PRE-APPOINTMENT INTAKE FORM

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1 PRESENTING CONCERNS

What brings you to Horizon: _____

Top Concern #1: _____

Top Concern #2: _____

Top Concern #3: _____

When did symptoms begin: _____

2 CURRENT SYMPTOMS

- | | |
|--|---|
| ☐ Anxiety | ☐ Compulsive behaviors |
| ☐ Depression | ☐ Trauma symptoms |
| ☐ Panic attacks | ☐ Nightmares |
| ☐ Mood swings | ☐ Flashbacks |
| ☐ Irritability | ☐ Paranoia/suspiciousness |
| ☐ Racing thoughts | ☐ Hallucinations |
| ☐ Difficulty concentrating | ☐ Elevated mood |
| ☐ Memory problems | ☐ Decreased need for sleep |
| ☐ Sleep problems | ☐ Impulsivity |
| ☐ Loss of interest/pleasure | ☐ Substance-use concerns |
| ☐ Low energy/fatigue | ☐ Grief/loss |
| ☐ Appetite changes | ☐ Other |
| ☐ Obsessive thoughts | |

3 PSYCHIATRIC HISTORY

Previous diagnoses: _____

Previous psychiatric provider(s): _____

Prior psychiatric hospitalization(s): _____

Prior therapy / IOP / PHP / residential treatment: _____

4 MEDICATION HISTORY

Current psychiatric medications / dose: _____

Other medications / supplements: _____

Previous psychiatric medications / response: _____

Medication allergies / reactions: _____



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5 MEDICAL HISTORY

- | | |
|---|--|
| ☐ Hypertension | ☐ Kidney disease |
| ☐ Heart disease | ☐ Liver disease |
| ☐ Diabetes | ☐ Chronic pain |
| ☐ Thyroid disorder | ☐ Sleep apnea |
| ☐ Seizures | ☐ Neurologic condition |
| ☐ Head injury/concussion | ☐ Pregnancy/breastfeeding |
| ☐ Migraines | ☐ Other |
| ☐ Asthma/lung disease | |

6 SUBSTANCE USE

Alcohol amount/frequency: _____

Cannabis amount/frequency: _____

Nicotine/vaping: _____

Other substances: _____

Prior detox/rehab/treatment: _____

7 SAFETY SCREENING

- ☐ Current suicidal thoughts
- ☐ Current self-harm thoughts
- ☐ Past suicide attempt/self-harm
- ☐ Thoughts of seriously harming another person
- ☐ Feel unsafe at home
- If you are in immediate danger, call 911 or go to the nearest emergency department. In the U.S., call or text 988.

8 FAMILY / SOCIAL HISTORY

Family psychiatric/substance-use history: _____

Relationship / children: _____

Occupation / school: _____

Living situation: _____

Major stressors: _____

Trauma history (optional): _____



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9 TREATMENT GOALS & SIGNATURE

What would you most like to improve: _____

Other goals / concerns: _____

Completion of this intake form does not establish a diagnosis or guarantee a particular medication or treatment.

Patient Name: _____

Signature: _____

Date: _____