Cal Psychiatric Services

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Rev: 6/2015

HEALTH CARE INTAKE FORM

Personal Information

Name: _____ Date: _____
Address _____
Phone: _____ Email: _____
DOB: _____ Sex: _____
Primary Physician: _____ Phone: _____
Current Therapist: _____ Phone: _____

Complaint

What is your major complaint? _____
Start Date: _____ Have you previously suffered from this complaint ? _____
Previous therapist(s) seen complaint? _____
Aggravating Factors: _____
Relieving Factors: _____

- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Loss of Interest
- ☐ Sleep Changes
- ☐ Appetite issue
- ☐ Excessive Energy
- ☐ Impulsivity
- ☐ Panic Attacks
- ☐ Suspiciousness
- ☐ Avoidance
- ☐ Fatigue
- ☐ Irritability
- ☐ Racing Thoughts
- ☐ Crying Spells
- ☐ Guilt
- ☐ Libido
- ☐ Risky Activity

Medical History

Excessive frequency: _____ Exercise Type(s): _____
Allergies: _____
What medications are you currently using? _____
Previous diagnosis/mental health treatment : _____
Previous treated by: _____
Previous medications: _____
Dates treated: _____
Previous medical conditions: _____
Previous surgeries: _____

Family History

Were you adopted? _____ If yes, at what age? _____
How is your relationship with your mother? _____
How is your relationship with your father? _____
Siblings and their ages: _____
Are your parents married? _____
Did your parents divorce? _____ If yes how old were you? _____
Did your parents remarry? _____ If yes how old were you? _____
Who raised you? _____ Where did you grow up? _____
Family member mental condition(s): _____
Family member medical condition(s): _____
Treated with medication? _____
Medications: _____

Early Development

Where did you grow up? _____
How often did you move, and where? _____
How old were you when you left home? _____

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Personal Information (cont.)

Have any immediate family members died? _____ Who? _____
Have any committed suicide? _____ Who? _____
Describe any neglect you suffered, and by whom: _____
Trauma suffered and by whom: _____
Abuse suffered and by whom: _____
Highest education level completed: _____
Date completed and location _____
Have you ever served in the military _____ If yes, where? _____
Dates of service: _____ Highest rank achieved: _____

Present Situation

Work: ☐ Full time ☐ Part time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Are you married _____ If yes, date of marriage _____
Are you divorced _____ If yes, date of divorce _____
Prior marriages _____ If yes, how many? _____
What is your sexual orientation? _____ Are you sexually active? _____
How is your relationship with your partner? _____
Do you have any children? _____ Dates of birth _____
How is your relationship with your children? _____
List anyone else who lives with you: _____
Are you a member of a religion/spiritual group? _____
What is your level of involvement? _____
Have you ever been arrested? _____ When and why? _____

Have you ever tried to following (check all that apply)

☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)
☐ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants (pills)
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain killers

If yes to any, list frequency and dates of use: _____

Have you ever been treated for drunk alcoholic abuse?_____ If yes when? _____
For what substances? _____
Do you smoke cigarettes?_____ If yes, how many per day?_____
Do you drink caffeinated beverages? _____ If yes, how many per day?_____
Have you ever abused prescription drugs? _____ If yes, which ones? _____

Anything else you want the doctor to know