

LOMA LINDA PSYCHIATRIC MEDICAL GROUP

Clinical Intake & Assessment Forms

1. Assessment Information (Adult)

Patient Name: _____ Date: _____

Address: _____

Highest Level of Education: ☐ High School ☐ College — Major: _____ Graduated? ☐ Yes ☐ No

Current Occupation / School: _____ Employer / School Name: _____

Persons Living in Your Home (Including Self)

Name	Age	Sex	Relationship

Significant Others Outside the Home

Name	Age	Sex	Relationship	Town/State

2. Symptoms Identification and Health History

Patient Name: _____ Date: _____

Presenting problem(s) and length of time experienced:

For each symptom below, note severity from 0 (none) to 4 (severe).

1. Crying spells *Score (0–4):* _____
2. Extreme tiredness *Score (0–4):* _____
3. Feelings of dread *Score (0–4):* _____
4. Feelings of hopelessness/helplessness *Score (0–4):* _____
5. Headaches *Score (0–4):* _____
6. Hearing voices *Score (0–4):* _____
7. Impulse control problems *Score (0–4):* _____
8. Loss of appetite *Score (0–4):* _____
9. Loss of interest in activities *Score (0–4):* _____
10. Loss of interest in sex *Score (0–4):* _____
11. Nervousness *Score (0–4):* _____
12. Nightmares *Score (0–4):* _____
13. Panic attacks *Score (0–4):* _____
14. Poor concentration *Score (0–4):* _____
15. Poor memory *Score (0–4):* _____
16. Sadness *Score (0–4):* _____
17. Sleep problems *Score (0–4):* _____
18. Suicidal thoughts & plans *Score (0–4):* _____
19. Suspiciousness *Score (0–4):* _____
20. Weight loss *Score (0–4):* _____
21. Worry all the time *Score (0–4):* _____
22. Other *Score (0–4):* _____

Allergies? ☐ Yes ☐ No If yes, list: _____

Health History: ☐ BP ☐ Diabetes ☐ Asthma ☐ Coronary ☐ Surgical ☐ Other: _____

Past Psychiatric History: ☐ Yes ☐ No Psychiatric Hospitalizations: ☐ Yes ☐ No How many: _____ Last: _____

Family Psychiatric History: ☐ Yes ☐ No If yes, who: _____

What: _____

3. Medication and Substance Use History

Patient Name: _____ Date: _____

Height: _____ ft _____ in Weight: _____ lbs

Current Medications

Medication & Directions	Reason Prescribed	Prescriber

Others:

Medications Previously Ineffective

Medication & Directions	Reason Prescribed	Prescriber

Others:

Substance Use

For each item, note frequency, quantity, form of use, age started/duration, and — if applicable — length of sobriety and relapse history.

Caffeine: ☐ Yes ☐ No Cups/day: _____

Smoke / Tobacco: ☐ Yes ☐ No ☐ Never Details: _____

Alcohol: ☐ Yes ☐ No ☐ Never Details: _____

Drugs: ☐ Yes ☐ No ☐ Never Details: _____

Family History

Drugs: ☐ Yes ☐ No If yes, who: _____

Alcohol: ☐ Yes ☐ No If yes, who: _____

Pharmacy

Pharmacy Name: _____ Phone: _____

Address: _____

4. Yale–Brown Obsessive Compulsive Scale (Y-BOCS) — Screening

Patient Name: _____ Date: _____

- ☐ Yes ☐ No Do you have thoughts that bother you or make you anxious that you can't get rid of, no matter how hard you try?
- ☐ Yes ☐ No Do you have a tendency to keep things extremely clean or wash your hands more often than most people?
- ☐ Yes ☐ No Do you check things over and over to excess?
- ☐ Yes ☐ No Do you have to straighten, order, or tidy things so much that it interferes with other things you want to do?
- ☐ Yes ☐ No Do you worry excessively about acting or speaking more aggressively than you should?
- ☐ Yes ☐ No Do you have great difficulty discarding things even when they have no practical value?

If you answered Yes to any of the above, complete the severity scale below (0 = none/always in control, 4 = extreme/no control).

1. How much of your time is occupied by obsessive thoughts? 0 None · 1 <1 hr/day · 2 1–3 hr/day · 3 3–8 hr/day · 4 >8 hr/day
2. How much do obsessive thoughts interfere with social, work, or other functioning? 0 None · 1 Slight · 2 Manageable · 3 Substantial · 4 Extreme
3. How much distress do your obsessive thoughts cause you? 0 None · 1 Mild · 2 Moderate · 3 Severe · 4 Near-constant
4. How much effort do you make to resist the obsessive thoughts? 0 Always · 1 Most of the time · 2 Sometimes · 3 Often · 4 Never
5. How much control do you have over your obsessive thoughts? 0 Complete · 1 Much · 2 Some · 3 Little · 4 None
6. How much time do you spend performing compulsive behaviors? 0 None · 1 <1 hr/day · 2 1–3 hr/day · 3 3–8 hr/day · 4 >8 hr/day
7. How much do compulsive behaviors interfere with social, work, or other functioning? 0 None · 1 Slight · 2 Manageable · 3 Substantial · 4 Extreme
8. How anxious would you feel if prevented from performing your compulsive behaviors? 0 None · 1 Mild · 2 Moderate · 3 Prominent · 4 Extreme
9. How much effort do you make to resist the compulsions? 0 Always · 1 Most of the time · 2 Sometimes · 3 Often · 4 Never
10. How much control do you have over the compulsions? 0 Complete · 1 Much · 2 Some · 3 Little · 4 None

Clinician total score: _____ / 40

5. Mood Disorder Questionnaire (MDQ)

Patient Name: _____

Date: _____

Section One

☐ Yes ☐ No Have any of your blood relatives been diagnosed with Manic-Depressive illness or Bipolar Disorder?

☐ Yes ☐ No Have you ever had far more energy than usual, slept very little, and engaged in activities that may have been risky or dangerous?

Has there ever been a period when you were not your usual self and...

☐ Yes ☐ No You felt so good or hyper that others thought you weren't your normal self, or you got into trouble?

☐ Yes ☐ No You were so irritable that you shouted at people or started fights or arguments?

☐ Yes ☐ No You felt much more self-confident than usual?

☐ Yes ☐ No You were much more talkative or spoke much faster than usual?

☐ Yes ☐ No You got much less sleep than usual and didn't really miss it?

☐ Yes ☐ No Thoughts raced through your head or you couldn't slow your mind down?

☐ Yes ☐ No You were so easily distracted that you had trouble concentrating or staying on track?

☐ Yes ☐ No You had much more energy than usual?

☐ Yes ☐ No You were much more active or did many more things than usual?

☐ Yes ☐ No You were much more social or outgoing — e.g., phoning friends in the middle of the night?

☐ Yes ☐ No You were much more interested in sex than usual?

☐ Yes ☐ No You did things that were unusual for you, or that others might have thought were excessive, foolish, or risky?

☐ Yes ☐ No You spent so much money that it caused problems for you or your family?

Section Two

☐ Yes ☐ No If you answered Yes to more than one item above, did several of them happen during the same period of time?

Section Three

How much of a problem did any of these cause you (e.g., unable to work; family, money, or legal problems; serious arguments or fights)?

☐ No problem

☐ Minor problem

☐ Moderate problem

☐ Serious problem

6. Patient Health Questionnaire (PHQ-9)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by the following? Score each: 0 = Not at all, 1 = Several days, 2 = More than half the days, 3 = Nearly every day.

1. Little interest or pleasure in doing things *Score (0–3):* _____
2. Feeling down, depressed, or hopeless *Score (0–3):* _____
3. Trouble falling or staying asleep, or sleeping too much *Score (0–3):* _____
4. Feeling tired or having little energy *Score (0–3):* _____
5. Poor appetite or overeating *Score (0–3):* _____
6. Feeling bad about yourself — or that you are a failure, or have let yourself or your family down *Score (0–3):* _____
7. Trouble concentrating on things, such as reading or watching television *Score (0–3):* _____
8. Moving or speaking so slowly that others could have noticed, or the opposite — being fidgety or restless *Score (0–3):* _____
9. Thoughts that you would be better off dead, or of hurting yourself in some way *Score (0–3):* _____

If you circled any problems above, how difficult have they made it to do your work, take care of things at home, or get along with others?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Clinician total score: _____ / 27

7. Medication Consent Form

Patient Name: _____ Date: _____

(Completed separately by each prescriber responsible for this patient's ongoing care.)

Information Provided to the Patient

The undersigned provider certifies that the following has been discussed with the patient:

1. The nature of the patient's condition.
2. The reasons for the recommended medication, including the likely course with and without it, and that consent may be withdrawn at any time.
3. Reasonable alternative treatments, if any.
4. The type, dose, frequency, route, and expected duration of the medication.
5. Common side effects, and any side effects of particular concern for this patient.
6. For medications taken beyond three months: possible additional effects, including persistent involuntary movements of the face, mouth, hands, or feet (tardive dyskinesia), which may be irreversible and may appear even after the medication is stopped.
7. Whether written medication information was provided: ☐ Yes ☐ Patient declined

Provider Signature / Date

Printed Name

Patient Acknowledgment and Consent

By signing below, I acknowledge that: I have participated in discussing and planning my medication treatment; the information above has been explained to me and I understand it; I may discuss further questions with my prescriber at any time; nothing here prevents a prescriber from acting in an emergency; and I may withdraw this consent at any time by telling a member of the treatment team.

Name and Signature