Student Health and Wellness Center
Confidential Psychiatry Intake Form

Potential billing costs: SHW Behavioral Health appointments are not billed to insurance and are of no cost to students, however, labs and prescribed medications are subject to insurance coverage costs. Please ask our front desk team, your provider, or refer to our Costs of Services sheet if you have any questions or concerns about billing.

Welcome to Student Health & Wellness Center.

Name: _____Age: _____ Pronoun(s) used: _____
How would you prefer to be addressed?_____
Program/School/ Postdoctoral field: _____
Estimated Graduation/Completion date: _____
What would you like us to know about your identities? (sexual orientation, abilities, gender, gender identity, culture(s), race, religion etc.) _____
_____
_____

Please briefly describe the reason(s) for your visit today:

_____
_____
_____
_____

GAD-7: Over the **last 2 weeks**, how often have you been bothered by the following problems (circle)

	Not at all	Several	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
3. Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
4. Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
5. Being so restless it is hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritable	0 ☐	1 ☐	2 ☐	3 ☐
7. Feeling afraid as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐
Column totals	____ +	____ +	____ +	____

Total score _____

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

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

Please continue on the next page

PHQ-9: Over the *last 2 weeks*, how often have you been bothered by the following problems (circle)

	Not at all	Several	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling asleep, staying asleep, sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐
Column totals	____ +	____ +	____ +	____

Total score _____

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

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

Please list *Current* behavioral health medications with dosage and response/side effects:

_____

_____

_____

Please list *Previous* behavioral health medications with dosage and response/side effects:

_____

_____

_____

Please list any additional prescribed, over the counter, or herbal/alternative medications with dosage:

_____

_____

_____

Substance Use (Indicate number per day):

Nicotine: Cigarettes: _____per day e-cigarettes: _____per day Other:_____☐None
Caffeine: specify type(s) and quantity per day:_____ ☐None
Alcohol: _____drinks per day _____day(s) of the week of (specify type)_____ ☐None
Cannabis: ☐smoke ☐vape ☐edible_____per day_____days of the week ☐None
Other (opiate/hallucinogens/cocaine etc):_____ ☐None
Previous substance use treatment:_____ ☐None
Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?
☐Yes ☐No

In the last year have you drunk alcohol or used drugs more than you meant to? ☐Yes ☐No

Are the guns in your home secured?

☐Yes ☐No ☐I don't have guns

History

Have you had a prior psychiatric hospitalization?:☐Yes ☐No
Do you have a current or past history of an eating disorder?☐Yes ☐No
Do you feel safe in your current romantic relationship(s):☐Yes ☐No ☐N/A
Please answer if you have a <u>history</u> of the following:

Seizures?	☐NO	☐YES	If yes please describe: _____
Head trauma?	☐NO	☐YES	If yes please describe: _____
Thyroid disease?	☐NO	☐YES	
Vitamin D deficiency?	☐NO	☐YES	
Anemia?	☐NO	☐YES	
Headaches?	☐NO	☐YES	
Asthma?	☐NO	☐YES	
Hypertension?	☐NO	☐YES	
Heart Arrhythmias?	☐NO	☐YES	
Sleep apnea?	☐NO	☐YES	
Bleeding disorder?	☐NO	☐YES	
Glaucoma?	☐NO	☐YES	
Liver disease?	☐NO	☐YES	
Kidney disease?	☐NO	☐YES	

Contraception: What method are you <u>currently</u> using?

☐Condom ☐IUD ☐Pill ☐Patch ☐Nexplanon ☐Ring ☐Tubal ligation ☐Rhythm ☐Plan B ☐N/A
☐_____

Please continue on the next page

Please check any physical symptom(s) that you are experiencing currently:

☐ Weight gain
☐ Weight loss
☐ Change in appetite
☐ Chest pain
☐ Abnormal heart rhythm
☐ Blurred vision
☐ Snoring
☐ Pain
☐ Tremor
☐ Headache
☐ Dizziness
☐ Fatigue
☐ Nausea
☐ Constipation
☐ Diarrhea
☐ Pregnant/trying to conceive
☐ Breastfeeding

Other:
_____