



Adler Psychiatry
4121 Montgomery Blvd NE,
Albuquerque, NM 87109
☎ (505) 807-0055 Office
📠 (505) 299-2649 Fax
www.AdlerPsychiatryNM.com

Welcome to Adler Psychiatry

Thank you for choosing Adler Psychiatry for your mental health needs. We are a small practice with all communication being completed electronically/online via Email/Text/Voicemail. Therefore it is critical that your email and phone number are correct. We ask that you complete this form ASAP to facilitate the onboarding/intake process for your appointment. If this information is not obtained in a reasonable timeframe, your appointment may need to be rescheduled. Please understand that it takes time to validate insurance, check your co-pay, and get your file ready for your visit. We recommend you take the time to fill this out as soon as you get it.

Thank you, and welcome to Adler Psychiatry.

Please enter the patient's information.

First Name: _____ Middle Initials: _____ Last Name: _____

Preferred Name _____

Date of Birth: _____ Gender Assigned at Birth: _____ Gender Identity _____ Preferred Pronouns _____
 Male
 Female

Marital Status:
 Single Married Domestic Partner Separated Divorced Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: _____

Emergency Contact _____

Emergency Contact Relationship _____ Emergency Contact Phone Number _____

Pharmacy Name _____ Pharmacy Phone Number _____

What is the main reason you are here today?

Have you ever been seen for this issue before?

Yes

No

If yes, please explain.

Past Psychiatric History:

Please enter any mental health issues you have currently, or in the past. Enter "None" if you have never been diagnosed with any of these issues.

Mental Health Issue	None	Currently	Past
No Previous Issues			
ADHD/ADD			
Alcohol Problems			
Anxiety			
Bipolar Disorder			
Depression			
Drug Problems			
Eating Disorder			
OCD			
Panic Attacks			
PTSD			
Schizophrenia			
Other (Please Explain)			

Explain any "other" issue

Have you ever been seen or treated by a psychiatrist or psychiatric mental health nurse practitioner?

Yes

No

Please list all previous psychiatric providers, with approximate dates of service.

	Name of Provider	Date
1		
2		
3		

Have you ever been seen or treated by a therapist or a counselor?

- Yes No

Please list all previous therapists or counselors, with approximate dates of service.

	Name of Provider	Date
1		
2		
3		

Have you previously tried any psychiatric medications?

- Yes No

PREVIOUSLY TAKEN PSYCHIATRIC MEDICATIONS

	Medication	Dose	How Taken	How long taken?	Effective?	Approximate Date	Side effects	omments
1								
2								

Have you ever been hospitalized for a mental health or psychiatric condition Voluntarily or Involuntarily?

- Yes No

Please list all psychiatric hospitalizations/intensive outpatient programs/partial hospitalization programs attended:

	Name of Hospital/Program	Date/Location
1		
2		
3		
4		

What other treatments and remedies have you pursued to treat mental health symptoms?

Psychiatric Review of Symptoms

Are you currently (within the past month) experiencing of the following?

- | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Feeling sad, empty, or irritable
_____ | <input type="checkbox"/> Loss of interest or pleasure in doing things you used to enjoy
_____ | <input type="checkbox"/> At least a few days in a row of feeling "up", or irritable and had a lot more energy than usual
_____ |
| <input type="checkbox"/> Visions or other things that other people did not see
_____ | <input type="checkbox"/> Hearing noises, sounds, or voices that other people did not hear
_____ | <input type="checkbox"/> Feel like people are following you, or trying to hurt you in some way
_____ |
| <input type="checkbox"/> Feel like you have special powers, such as reading other peoples minds
_____ | <input type="checkbox"/> While watching TV or listening to music, feel like it was referring directly to you
_____ | <input type="checkbox"/> During the last several months frequently been worried about number of different things in your life
_____ |
| <input type="checkbox"/> Difficulty controlling or stopping my worrying
_____ | <input type="checkbox"/> Feel very anxious or fearful about specific objects, places, or social situations
_____ | <input type="checkbox"/> Sudden urges of intense fear that come on for no apparent reason
_____ |
| <input type="checkbox"/> Frequent unwanted thoughts, urges, or images
_____ | <input type="checkbox"/> Feel like you have to complete physical acts associated with unwanted thoughts, urges, or images to avoid or reduce them
_____ | <input type="checkbox"/> Feel like you lose time, forget important details about yourself, or find evidence that that you took part in events you can't remember
_____ |
| <input type="checkbox"/> Feel like people or places familiar to you are unreal, or that you are detached from your body, or watching yourself
_____ | <input type="checkbox"/> Worry about my physical health more than most people
_____ | <input type="checkbox"/> Get sick more than most people
_____ |
| <input type="checkbox"/> Feel unhappy with my appearance
_____ | <input type="checkbox"/> Restrict or avoid particular foods so much that it negatively affects my health or weight
_____ | <input type="checkbox"/> Inadequate or poor quality sleep
_____ |
| <input type="checkbox"/> often experience excessive sleepiness
_____ | <input type="checkbox"/> Frequent irrepressible need to sleep or sudden lapses into sleep
_____ | <input type="checkbox"/> You or your partner noticing that you stop breathing or gasp for air during sleep
_____ |

Using alcohol/cannabis/
caffeine/nicotine or illegal drugs

Bet, wager, or gamble in a way
that interferes with my life

Significant problems with
friends or family, at work, or
another setting due to persistent
patterns in my thoughts, mood,
or actions that began when I was
young

Repeatedly passed urine or
feces your clothes, your bed, the
floor, or another place it doesn't
typically belong

Difficulty
concentrating/focusing or getting
distracted easily since I was a
child

Forgetting familiar places,
names of close friends and
family to the point that it affects
my life

Have you ever had any suicide attempts?

Yes

No

If yes, when?

Do you self-harm?

No

Cutting

Burning

Other

If other, please specify:

Do you often have times that you become so upset that you make, or even act upon verbal or physical threats to hurt other people, animals, or property?

Yes

No

Have you ever been aggressive to people or animals, destroyed property, deceived other people, or stolen things?

Yes

No

Have you ever witnessed or experienced an event in which your life was in danger, or you thought your life was in danger?

Yes

No

Have you ever suffered physical, sexual, or emotional abuse or neglect?

Yes

No

Family Psychiatric History:

Please list any medical/psychiatric problems your biological relatives suffered.

Past Medical/Surgical History:

Do you get care anywhere other your PCP on a regular basis? If so, please list in text box.

Yes

No

Please list all active/chronic medical conditions:

Please list all past/pending surgeries:

Current Medications:

What medications are you currently taking? Please include any non psychiatric medications/herbs/supplements/vitamins etc.

	Name of Medication	Dose	How often do you take it?	How Long Have You Been Taking it?	Does it help?

Any issues with your medication(s)

Allergies:

Please list all medication, food, and other allergies, if none state "none".

Developmental History

Did your mother have any difficulties surrounding her pregnancy/delivery?

- Yes No

What were you like as a child?

When did you reach puberty and how did you feel about it?

Did you have any behavioral or learning problems during your early childhood?

- Yes No

When you started school did you have trouble relating socially or keeping up academically with your classmates because of your learning or behavioral problems?

- Yes No

Social History:

EDUCATION / VOCATION HISTORY

Education Situation/Level

- Currently enrolled in school without issues.
 Currently enrolled in school with issues. Homeschooled
 Graduated high school. Attended some high school
 Attended some middle school
 Attended some elementary school.
 College graduate (Undergrad) Master's Degree
 Doctoral Degree Attending college currently.
 No school attended. Frequent truancy. Other

Education Comments

WORK HISTORY

Current Employment

- Student Employed - FT Employed - PT Unemployed - minor Unemployed Self-Employed
 Disabled Retired Homemaker

Work Concerns (Select as many needed)

- No work concerns or negative consequences. Frequent tardiness. Frequent absenteeism.
- Inability to focus or pay attention to work. Issues getting along with co-workers/supervisor.
- Frequent write-ups. Not completing work. Other

Please explain any work concerns.

RELATIONSHIPS

Marital Status

Relationship with Spouse/Partner

- No spouse / partner (minor child) No spouse / partner - single Good Fair Poor Strained
- Separated Divorcing

Are you really uncomfortable with your birth assigned gender?

- Yes No

Are you sexually active?

- Yes No

Are there any particular urges, fantasies, or behaviors that repeatedly cause you to feel intensely aroused, and bother you or other people?

- Yes No

Relationship with Family

- Good Fair Poor Strained Non-existent

Relationships with Peers

- Good Fair Poor Strained Non-existent No peer interaction

CURRENT LIVING SITUATION

- Lives at home with parents. Lives with relatives. Lives in foster care.
- Lives alone. Lives with spouse/partner Single parent living with children.
- Currently Homeless Lives in Shelter Military living - spouse/partner deployed .
- Military living - spouse/partner NOT deployed .

Do you have children? If so, how many?

What do you do in your free time to relax?

Do you have a religious affiliation?

MILITARY HISTORY

Please tell us about your military history - (Select as many as needed)

- No military history. Military history - with combat. Military history - without combat.
- Retired military. Honorably discharged. Dishonorably discharged. Multiple tours of combat.
- Combat with excessive traumatic experiences.

LEGAL ISSUES

Any legal issues (arrests, charges, time in jail)? You can select more than one answer

- No legal history. Current legal issues. Previous legal issues. Legal issues involving jail/prison time.
- Legal issues involving probation. Currently on parole. Currently on probation. Other

Please tell us a little more detail about any legal issues listed.

Other Concerns and Goals:

Please briefly describe any concerns not otherwise addressed above. Please also briefly describe your treatment goals. (No need for much detail here. We will discuss in greater depth during our appointments.)

Physical Review of Symptoms

Please indicate whether or not you are experiencing any of the following symptoms.

Constitution:

- None of the selections apply
- Fever
- Chills
- Weight loss
- Malaise/fatigue
- Sweating
- Weakness

Please explain any selected answers.

Skin:

- None of the selections apply Rash Itching

Please explain any selected answers.

Head, Ear, Nose and Throat:

- None of the selections apply Hearing loss Ringing in the ears
 Ear pain Nosebleeds Congestion
 Sinus pain Noisy breathing Sore throat

Please explain any selected answers.

Eyes:

- None of the selections apply Blurred vision Double vision
 Light sensitivity Eye pain Eye discharge
 Eye redness

Please explain any selected answers.

Cardiovascular:

- None of the selections apply Chest pain Palpitations / Heart racing.
 Shortness of breath when lying down Leg pain Leg swelling
 Difficulty breathing that wakes you from sleep

Please explain any selected answers.

Respiratory:

- None of the selections apply Cough Coughing up blood
 Coughing up phlegm Shortness of breath Wheezing

Please explain any selected answers.

Abdominal pain:

- None of the selections apply Diarrhea Constipation
 Blood in stool Black tarry stool

Please explain any selected answers.

Gastrointestinal:

- None of the selections apply
- Heartburn
- Nausea
- Vomiting

Please explain any selected answers.

Genitourinary:

- None of the selections apply
- Urinary pain
- Urinary urgency
- Urinary frequency
- Blood in urine
- Flank pain

Please explain any selected answers.

Musculoskeletal:

- None of the selections apply
- Muscle pain
- Neck pain
- Back pain
- Joint pain
- Falls

Please explain any selected answers.

Endocrine/hematology/allergy:

- None of the selections apply
- Easy bruising/bleeding
- Environmental allergies
- Increased thirst

Please explain any selected answers.

Neurological:

- None of the selections apply
- Dizziness
- Headaches
- Tingling
- Tremor
- Sensory change
- Speech change
- Weakness
- Seizures
- Loss of consciousness

Please explain any selected answers.

Insurance Information

Do you have insurance?

- Yes
- No

What type of insurance do you have?

- Private Insurance
- Medicaid
- Medicare

Primary Insurance

Primary Insurance Company

Member ID / Policy #

Group Number

Client Relationship to Insured

Self Spouse Child Other

Insured Name

Insured Phone #

Insured Date of Birth

Insured Gender

Female Male

Insured Street Address

Insured City

Insured State

Zip Code

Please email to: cs@adlerpsychiatrynm.com a picture of the FRONT of your PRIMARY insurance card.

Please email to: cs@adlerpsychiatrynm.com a picture of the BACK of your PRIMARY insurance card.

Do you have a secondary insurance?

Yes

No

Secondary Insurance

Secondary Insurance Company

Member ID / Policy #

Group Number

Client Relationship to Insured

Self Spouse Child Other

Insured Name

Insured Phone #

Insured Date of Birth

Insured Gender

Female Male

Insured Street Address

Insured City

Insured State

Zip Code

Please email to: cs@adlerpsychiatrynm.com a picture of the FRONT of your SECONDARY insurance card.

Please email to: cs@adlerpsychiatrynm.com a picture of the BACK of your SECONDARY insurance card.

Please email to: cs@adlerpsychiatrynm.com a picture of the front of a picture ID - either Driver's License or State ID. If the patient is a minor, please attach the parents ID. No controlled substances will be prescribed without a picture ID.

Acknowledgement and Consent to Contact

By entering in this information, you acknowledge that it will be sent via secure email. You are giving us your consent to contact you via email, text messages, and by phone as needed. By signing this form you are giving us consent to this information and the ability to contact you.

Signature of Patient / Parent / Authorized Representative

Signature

Date