

COMPASSIONATE BEHAVIORAL HEALTH CARE, LLC

8360 W Oakland Park Blvd., Ste 107, Sunrise, FL 33351 | Tel: (954) 999-5312

compassionatebhc.com

PATIENT INTAKE FORM

Please use the dropdown menus, checkboxes, and fillable fields. If a question does not apply, select "Not applicable" or leave the field blank. Please provide details where requested.

Patient Information

Date:	DOB:	Gender:	
Full Name:			
Occupation:	Email:		
Address:			
City:	State:	ZIP:	Cell:
Relationship:	Pronouns:		
Education:	Race:		
Insurance:	Member ID:		
Preferred communication:			

Treatment Goals

Why are you seeking assistance now, and what would you like to achieve through your care?

Current Symptoms / Concerns

Select all symptoms or concerns that apply to you.

☐ Dizziness	☐ Fainting	☐ Chest pain
☐ Depression	☐ Anxiety/panic	☐ Sleep problems
☐ Racing thoughts	☐ Irritability	☐ Concentration
☐ Hallucinations	☐ Other	

Other/details:

SUBSTANCE USE & MEDICAL HISTORY

Alcohol & Substance Use

How often do you have a drink containing alcohol?

Medical issues related to drug/alcohol use within the last 12 months?

Details:

Legal or employment problems related to alcohol/drug use within the last 12 months?

Details:

Blackouts or flashbacks from drug/alcohol use within the last 12 months?

Details:

Attempted to cut back on drug/alcohol use and were unsuccessful within the last 12 months?

Details:

Withdrawal symptoms from drug/alcohol use within the last 12 months?

Details:

Method:

More than one drug:

Substances used — select all that apply.

☐ Alcohol	☐ Marijuana	☐ Benzodiazepines	☐ Opioids
☐ Stimulants	☐ Hallucinogens	☐ Other	☐ Nonmedical prescriptions

Medications & Allergies

Current prescription medications, over-the-counter medications, vitamins, or supplements (include dose/frequency if known).

Food allergies/sensitivities:

Drug allergies/reactions:

Medical History

Medical History

Select any medical conditions you have been diagnosed with.

☐ Asthma	☐ COPD	☐ Heart disease
☐ Heart attack	☐ CHF	☐ Thyroid disorder
☐ Diabetes	☐ Lupus	☐ Arthritis
☐ Blood clotting problems	☐ Hepatitis	☐ Seizures/Epilepsy
☐ Migraines	☐ Glaucoma	☐ Cancer
☐ IBS/colitis	☐ Other	

Accidents, surgeries, or traumatic events:

PSYCHIATRIC & PERSONAL HISTORY

Mental Health History

Select any that apply to your history.

☐ Wanted to be dead	☐ Tried to kill myself
☐ DUI	☐ Physically injured someone else
☐ Legal/incarceration	☐ Physical/sexual assault
☐ ER for panic	☐ Psychiatric hospitalization

Previous psychiatric diagnoses — select all that apply.

☐ Depression	☐ Bipolar Disorder	☐ Generalized Anxiety Disorder
☐ Panic Disorder	☐ OCD	☐ PTSD
☐ Social Anxiety	☐ Schizophrenia	☐ Schizoaffective Disorder
☐ Autism Spectrum Disorder	☐ ADHD	☐ Eating Disorder
☐ Personality Disorder	☐ Learning Disorder	☐ Complex PTSD/Trauma
☐ Other		

Psychiatric hospitalization history:

Family mental health history:

Current Problem Areas

☐ Job/Career	☐ School	☐ Finances
☐ Physical health stress	☐ Parenting	☐ Abuse/violence
☐ Divorce/family	☐ Depression	☐ Suicidal thoughts
☐ Anxiety/panic	☐ Racing thoughts	☐ Isolation
☐ Hopelessness	☐ Obsessions/compulsions	☐ Sleep
☐ Eating/appetite/weight	☐ Self-esteem	☐ Concentration
☐ Irritability	☐ Anger outbursts	☐ Impulsiveness
☐ Alcohol/drug use	☐ Grief/loss	☐ Hallucinations
☐ Self-injury	☐ Harm to others	☐ Other

Growing Up

How would you describe your growing-up years?

☐ Loving/safe/secure	☐ Not so good	☐ Yelling/fighting
☐ Bullying	☐ Academic struggles	☐ Violence
☐ Loss	☐ Moved a lot	☐ Parents not around
☐ Accidents/traumas	☐ Felt unsafe/afraid at home	

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SLEEP, MEDICATION & LIFESTYLE

Sleep

Select any sleep-related concerns that have applied to you for 4–5 days or more.

☐ Trouble falling/staying asleep	☐ Daytime sleepiness
☐ Snoring	☐ Sleep apnea/disorder
☐ Do fine on <4–5 hours	☐ Wake choking/gasping
☐ Frequent naps	☐ Fall asleep very quickly
☐ Leg kicking/jerking	☐ Restless legs
☐ Vivid dreams/nightmares	☐ Talk/walk in sleep
☐ Mind races at bedtime	

Past Psychiatric Medications

Antidepressants:

☐ Fluoxetine/Prozac	☐ Sertraline/Zoloft	☐ Paroxetine/Paxil
☐ Fluvoxamine/Luvox	☐ Citalopram/Celexa	☐ Escitalopram/Lexapro
☐ Venlafaxine/Effexor	☐ Bupropion/Wellbutrin	☐ Mirtazapine/Remeron
☐ Duloxetine/Cymbalta	☐ Trazodone	☐ Vortioxetine/Trintellix
☐ Desvenlafaxine/Pristiq	☐ Other	

Antipsychotics:

☐ Paliperidone/Invega	☐ Risperidone/Risperdal	☐ Clozapine/Clozaril
☐ Cariprazine/Vraylar	☐ Olanzapine/Zyprexa	☐ Quetiapine/Seroquel
☐ Ziprasidone/Geodon	☐ Aripiprazole/Abilify	☐ Brexpiprazole/Rexulti
☐ Lurasidone/Latuda	☐ Lumateperone/Caplyta	☐ Other

Mood stabilizers:

☐ Lithium	☐ Valproic Acid/Depakote	☐ Lamotrigine/Lamictal
☐ Carbamazepine/Tegretol	☐ Oxcarbazepine/Trileptal	☐ Gabapentin/Neurontin
☐ Pregabalin/Lyrica	☐ Topiramate/Topamax	☐ Other

Sleep/anxiety:

☐ Diazepam/Valium	☐ Lorazepam/Ativan	☐ Alprazolam/Xanax
☐ Clonazepam/Klonopin	☐ Buspirone/Buspar	☐ Temazepam/Restoril
☐ Zolpidem/Ambien	☐ Eszopiclone/Lunesta	☐ Ramelteon/Rozerem
☐ Suvorexant/Belsomra	☐ Hydroxyzine/Vistaril/Atarax	☐ Other

Eating, Caffeine & Tobacco

Eating habits:

Daily items:

☐ Caffeinated soda

☐ Energy drinks

☐ Pills/other

Confidential Patient Information

Tobacco use:

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ADDITIONAL HISTORY & CONTACTS

Other Substance Use

Have you ever used any of the following? Select all that apply.

☐ Marijuana/Cannabis	☐ MDMA/Ecstasy	☐ LSD
☐ Mescaline/Peyote	☐ Psilocybin/Mushrooms	☐ DMT/STP
☐ Inhalants	☐ Pain medicines/opioids	☐ Heroin
☐ Quaaludes	☐ Barbiturates	☐ Bath salts
☐ Cocaine/Crack	☐ GHB/Rohypnol	☐ Ketamine
☐ Kratom	☐ Methamphetamine	☐ PCP
☐ Stimulants/Adderall	☐ Synthetic marijuana	☐ Other

Military & Legal

Military service:

Current legal problems:

Details, if applicable:

Psychotherapy / Healing Practices

Please list past psychotherapy (CBT, EMDR, IFS, psychoanalysis, etc.) or other healing practices.

Providers & Pharmacy

Provider name:

Specialty:

Provider contact:

Pharmacy name:

Location:

Phone:

Emergency Contact

Name:

Phone:

Email:

Additional Comments

Please provide any additional information that would be helpful to your care.