Alina Bouza MD, PLLC

11416 Slater Ave NE #202 C
Kirkland, WA 98033
(206) 393-7111

INTAKE FORM

Name: ____________________ Today's Date: __________

Please complete the information on this form and bring it to your first visit. I understand that filling out this form is time consuming, but answering these questions is an important first step in understanding your concerns. You may need to ask family members about family history. Many of the topics are sensitive and may be difficult to answer. All questions are optional. Your answers will be kept strictly confidential as a part of your medical record.

Thank you!

Mental Health History:

Primary reason for today's visit, including any significant symptoms of depression and/or anxiety (include as much detail as you wish):

List your goals for treatment:

List any previous mental health treatment (counselors and/or psychiatrists):

List any current psychiatric medications. Include doses and length of treatment and any side effects.

List any previous psychiatric medications. Include doses and length of treatment and any side effects.

List any psychiatric hospitalizations, including partial hospitalization:

Have you ever attempted suicide or been suicidal? ☐ Yes ☐ No

If yes, describe:

Do you have any history of childhood sexual, emotional, or physical abuse? ☐ Yes ☐ No

Do you have any recent history of sexual, emotional, or physical abuse? ☐ Yes ☐ No

Have you ever experienced any of the following symptoms?

☐ Hallucinations	☐ Obsessions	☐ Compulsions	☐ Panic attacks
☐ Anxiety	☐ Insomnia	☐ Poor concentration	☐ Disordered eating
☐ Iritability	☐ Impulsivity	☐ Memory problems	☐ Elevated mood

Psychiatric Family History:

(Include parents, children, siblings, grandparents.)

Have any blood relatives ever suffered from the following?

Symptom or Disorder	Who has/had it?	Treated for it?
Depression		
Anxiety		
Bipolar disorder (manic depression)		
Postpartum depression		
Obsessive compulsive disorder		
Schizophrenia or other psychosis		
Suicide or suicide attempt		
Drug addiction		
Alcohol abuse/dependence		
Personality Disorder		
Other: please describe		

Social and Occupational History:

If employed outside the home, describe your current job (title and main duties):

Describe any significant job stress(es) you are experiencing:

Are you in a committed relationship? ☐ Yes ☐ No

If so, how happy are you in the relationship?

Any current or past history of domestic violence? ☐ Yes ☐ No

Do you have a history of physical violence? ☐ Yes ☐ No

Reproductive History (if applicable):

Are you currently pregnant? ☐ Yes ____ weeks ☐ No ☐ Trying to conceive

Are you breastfeeding? ☐ No ☐ Yes, as sole nutrition ☐ Yes, part time ☐ Weaning

Age of first menstrual period: ____

Are your periods regular? ☐ Mostly yes ☐ Mostly no ☐ Not at all ☐ I no longer have periods

Number of pregnancies: ____ # live births: ____ #abortions: ____ # miscarriages: ____

Please identify your current method of contraception:

☐ Vasectomy ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Oral Contraceptives ☐ None ☐ Not applicable

Health Habits:

Number of caffeinated drinks per day: ____

Tobacco use: ☐ Never smoked ☐ Smoked but quit ☐ I smoke ____ Packs per day

Number of alcoholic drinks per week: ____ ☐ I abstain from alcohol

Do you use cannabis? ☐ Yes ☐ No If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

Have you used any other recreational drugs? ☐ Yes ☐ No If yes, please list:

If yes: When did you most heavily use drugs?

When was the last time you used drugs?

Have you ever received treatment for drug or alcohol abuse? ☐ Yes ☐ No If yes, please describe:

Do you exercise regularly? ☐ Yes ☐ No

If so, how may days per week? How many minutes per day of exercise?

Preferred or usual form of exercise:

Do you practice any of the following? ☐ Yoga ☐ Meditation ☐ Other relaxation practice

Do you have any guns in the house? ☐ Yes ☐ No

List your hobbies, interests, and/or sports:

Dietary habits:

Do you consider your diet to be healthy? ☐ Yes ☐ No

Are you vegetarian or vegan? ☐ Yes ☐ No

Do you have any concerns about your diet? ☐ Yes ☐ No

Personal Medical History:

Height: [ ] Weight: [ ]

Has your weight increased or decreased by more than ten pounds in the last five years? ☐ Yes ☐ No

If yes, explain the circumstances:

[ ]

Sleep:

Do you:

- ☐ Have difficulty falling asleep?
- ☐ Wake up often and have difficulty falling back asleep?
- ☐ Snore?
- ☐ Feel tired upon awaking in the morning?
- ☐ Have nightmares?
- ☐ Use sleep aids (including over the counter)?
- ☐ Sleepwalk?
- ☐ Do you wake up too early in the morning?

Medical conditions:

- ☐ Thyroid problems
- ☐ Migraine headaches
- ☐ High blood pressure
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart disease
- ☐ Cancer
- ☐ Seizure disorder
- ☐ Multiple Sclerosis
- ☐ Stomach ulcers
- ☐ Irritable bowel syndrome
- ☐ Inflammatory bowel disease
- ☐ COPD
- ☐ Kidney disease
- ☐ Liver disease
- ☐ HIV

Have you had any surgeries? ☐ Yes ☐ No If yes, please list:

[ ]

Do you have any allergies to medications? ☐ Yes ☐ No If yes, list:

Medication:	Reaction:

List any medications you take. Include non-prescription medications, vitamins, supplements, and herbs:

List any other information you would like me to know:

Thank you!