

**Geriatric Psychiatry Intake Database**  
**Dr. William Orr**

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

Name of person filling out form if different from patient \_\_\_\_\_

Who referred you to Dr. Orr/The Orr Memory Clinic? \_\_\_\_\_

What is the reason for the referral?

Describe previous treatments for mental health issues (e.g., depression, anxiety, substance misuse, cognitive problems). List previous mental health providers, psychiatric hospitalizations, rehab treatments, and medications. Include dosages of medications, how long they were taken, if they were beneficial, and any adverse reactions:

**Patient and Family Background History**

Have any biologically related family members or relatives ever been:

Diagnosed or treated for a mental health and/or substance abuse issues:

Diagnosed or treated for dementia, Alzheimer's, and/or Parkinson's:

Where were you born and raised?

Who raised you?

How many siblings did you have?

Education background:

If retired, when did you retire and why?

Are you: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

How many times married? \_\_\_\_\_ How many years each marriage? \_\_\_\_\_

Number of children \_\_\_\_\_ Ages of children \_\_\_\_\_

Where did you live most of your adult life?

What is your current living situation and how many years have you lived there?

House \_\_\_\_\_ Apartment \_\_\_\_\_ Condo/Townhome \_\_\_\_\_

Senior Apartment \_\_\_\_\_ Assisted Living \_\_\_\_\_ Nursing Home \_\_\_\_\_

Other \_\_\_\_\_

Who lives with you?

What family members live near you?

**Medical History**

Primary care provider name, address, and phone number:

List other providers (doctors, therapists, specialists):

List Medical Problems (i.e., diabetes, macular degeneration, cardiac disease).

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

List Current Medications (provide dosages and how long you have taken them):

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

List any allergies (including to medications):

Have you ever had a stroke, "TIA" or seizure?

Have you ever had a CT or MRI of your head/brain?

Do you smoke? \_\_\_\_\_ If so, how much? \_\_\_\_\_ If quit, how long ago? \_\_\_\_\_

Do you drink alcohol \_\_\_\_\_ If yes, how much? \_\_\_\_\_

If quit, how many years ago, and why? \_\_\_\_\_

**Daily Activities**

Do you need assistance with any of the following activities:

	None	Some	Totally Dependent
Grocery shopping	_____	_____	_____
Balancing checkbook	_____	_____	_____
Paying bills	_____	_____	_____
Cleaning home	_____	_____	_____
Preparing meals	_____	_____	_____
Personal hygiene	_____	_____	_____
Walking	_____	_____	_____

Do you still drive? \_\_\_\_\_ Do you limit your driving in any ways?

Have you had any problems with driving?

Describe any trouble with walking/falls:

Describe any trouble with incontinence:

Describe any hearing or visual problems:

Describe any problems with chronic pain:

Describe any memory problems:

Describe any sleep problems:

If retired or not working, what do you do most days?