TRIBECA
PSYCHIATRY

New Patient Intake Packet

Our approach is thoughtful, individualized, and grounded in evidence-based psychiatry. This intake helps us understand your history, goals, and context so care can be thoughtfully tailored to you.

Please complete this packet as thoroughly as possible prior to your first appointment so we can make the most of our time together. All patient information and documentation are maintained in accordance with applicable federal and state confidentiality laws, including the Health Insurance Portability and Accountability Act (HIPAA). Exceptions to confidentiality may apply and will be outlined in the Notice of Privacy Practices.

For questions, please contact the practice directly:

+1 (917) 246-7293 · **hello@tribeca-psychiatry.com**

PATIENT DEMOGRAPHICS

Last Name: First Name:

Middle Name: Preferred Name:

Date of Birth: Age:

Sex assigned at birth: Gender identity:

Pronouns: Sexual orientation:

Address:

City: State: Zip:

Cell Phone: OK to leave voicemail?

Email: OK to email about appointments?

Marital status: Occupation:

Employer: Highest level of education:

Primary language: Race/Ethnicity:

Emergency Contact

Name: Relationship:

Phone:

May we share information with this person in an emergency?

Primary Care Physician

Coordination with your primary care physician helps ensure safe, comprehensive care, particularly when managing medications, medical conditions, or overlapping symptoms.

Name: Practice:

Phone: Fax:

OK to coordinate care?

How did you hear about Tribeca Psychiatry?

REASON FOR CONSULTATION

Please describe what brings you in today and what you are hoping to get out of treatment.

When did these concerns begin?

What makes them better or worse?

How are these concerns currently affecting your life?
(Work, school, relationships, sleep, daily functioning, etc.)

What has helped — or not helped — with these concerns in the past?
(e.g., therapy, medications, lifestyle changes, other supports)

PSYCHIATRIC HISTORY

Have you ever been diagnosed with a psychiatric condition? Yes No

If yes, please check all that apply:

- Major Depression
- Persistent Depression
- Bipolar I
- Bipolar II
- Generalized Anxiety
- Panic Disorder
- Social Anxiety
- OCD
- PTSD
- Acute Stress
- ADHD
- Autism Spectrum
- Eating Disorder
- Substance Use
- Personality Disorder
- Sleep Disorder
- Schizophrenia
- Adjustment Disorder
- PMDD
- Postpartum Depression

Other (please specify):

Prior Outpatient Treatment

Have you ever seen a mental health provider in the past (therapist, psychiatrist, NP, PA)?

Provider Name	Type (MD/Therapist/NP)	Dates	Reason / Modality

Psychiatric Hospitalizations

Please list any inpatient or partial hospitalization psychiatric admissions.

Date(s)	Hospital / Facility	Reason	Vol/Invol	Level of Care	Length	Discharge Meds

Level of Care: Inpatient / PHP (partial) / IOP (intensive outpatient) / Residential / Detox

Suicidal Thoughts and Self-Harm

Have you ever had thoughts of suicide? Yes ___ No ___

Explain:

Have you ever attempted suicide? Yes ___ No ___

Explain:

Have you ever engaged in self-harm (e.g., cutting, burning)? Yes ___ No ___

Explain:

Are you currently having thoughts of harming yourself or others? Yes ___ No ___

Explain:

PSYCHIATRIC MEDICATION HISTORY

Please list ALL psychiatric medications you have ever tried, organized by class. Include current and past medications.

Antidepressants (SSRIs, SNRIs, atypicals — e.g., Lexapro, Zoloft, Wellbutrin, Effexor)

Medication	Dose	Dates	Prescriber	Response (1–10)	Side Effects / Reason Stopped

Anxiolytics / Benzodiazepines (e.g., Xanax, Klonopin, Ativan, BuSpar, hydroxyzine)

Medication	Dose	Dates	Prescriber	Response (1–10)	Side Effects / Reason Stopped

Mood Stabilizers (e.g., Lithium, Lamictal, Depakote)

Medication	Dose	Dates	Prescriber	Response (1–10)	Side Effects / Reason Stopped

Antipsychotics (e.g., Abilify, Seroquel, Risperdal, Latuda, Vraylar)

Medication	Dose	Dates	Prescriber	Response (1–10)	Side Effects / Reason Stopped

ADHD / Stimulants (e.g., Adderall, Vyvanse, Ritalin, Concerta, Strattera, Qelbree)

Medication	Dose	Dates	Prescriber	Response (1–10)	Side Effects / Reason Stopped

Sleep Medications (e.g., trazodone, Ambien, Belsomra, melatonin, Remeron)

Medication	Dose	Dates	Prescriber	Response (1–10)	Side Effects / Reason Stopped

Other Psychiatric Medications (ketamine, naltrexone, Antabuse, beta-blockers, etc.)

Medication	Dose	Dates	Prescriber	Response (1–10)	Side Effects / Reason Stopped

CURRENT SYMPTOMS

Please check any symptoms you have experienced in the past two weeks:

Mood

- ☐ Depressed mood
- ☐ Loss of interest / pleasure
- ☐ Hopelessness
- ☐ Worthlessness / guilt
- ☐ Tearfulness
- ☐ Irritability
- ☐ Mood swings
- ☐ Elevated mood / euphoria
- ☐ Decreased need for sleep
- ☐ Racing thoughts
- ☐ Pressured speech
- ☐ Increased goal-directed activity
- ☐ Risky behavior
- ☐ Grandiosity

Anxiety

- ☐ Excessive worry
- ☐ Restlessness
- ☐ Muscle tension
- ☐ Difficulty concentrating
- ☐ Panic attacks
- ☐ Heart racing / palpitations
- ☐ Shortness of breath
- ☐ Fear of losing control
- ☐ Avoidance
- ☐ Social anxiety
- ☐ Obsessive thoughts
- ☐ Compulsive behaviors

Trauma-related

- ☐ Flashbacks
- ☐ Nightmares
- ☐ Intrusive memories
- ☐ Avoidance of reminders
- ☐ Hypervigilance
- ☐ Easily startled
- ☐ Emotional numbing
- ☐ Dissociation

Sleep, Appetite, Energy

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Waking too early
- ☐ Sleeping too much
- ☐ Fatigue / low energy
- ☐ Decreased appetite
- ☐ Increased appetite
- ☐ Significant weight loss
- ☐ Significant weight gain

Cognition / Attention

- ☐ Difficulty focusing
- ☐ Forgetfulness
- ☐ Difficulty completing tasks
- ☐ Procrastination
- ☐ Disorganization
- ☐ Slowed thinking

Psychotic / Other

- ☐ Hearing voices
- ☐ Seeing things others don't
- ☐ Paranoid thoughts
- ☐ Feeling unreal / detached
- ☐ Body image concerns
- ☐ Disordered eating

MEDICAL HISTORY

Active Medical Conditions

(e.g., diabetes, hypertension, thyroid disease, migraines, asthma, autoimmune)

Surgical History

Year	Procedure	Hospital / Facility

Allergies

Drug allergies:

Food/environmental allergies:

Reaction(s):

Current Non-Psychiatric Medications & Supplements

Medication / Supplement	Dose	Frequency	Prescriber

Reproductive / OB-GYN History (if applicable)

Last menstrual period: Menstrual regularity:

Pregnancies: Live births:

Currently pregnant or trying to conceive? ☐ Yes ☐ No

Currently breastfeeding? Yes No

Form of contraception (if any):

History of postpartum depression or anxiety? Yes No

Explain:

Significant PMS / PMDD symptoms? Yes No

Perimenopause or menopause symptoms? Yes No

LIFESTYLE FACTORS

Sleep

Typical bedtime: Typical wake time:

Hours of sleep per night: Quality (1–10):

Do you nap during the day? Yes No

Snoring, gasping, or witnessed apneas? Yes No

Sleep aids used (Rx, OTC, or supplements):

Nutrition

Describe a typical day's eating (breakfast, lunch, dinner, snacks):

Special diet (vegetarian, vegan, GF, kosher, etc.):

Do you binge eat, restrict, or purge? Yes No

Explain:

Exercise & Movement

Type of exercise:

Days per week: Minutes per session:

Caffeine

Coffee/tea/energy drinks per day: Time of last serving:

Alcohol

Do you currently drink alcohol? Yes No

Drinks per week: Type(s):

Have you ever had concerns about your drinking? Yes No

Explain:

Has anyone in your life ever raised concerns about your drinking? Yes No

History of withdrawal symptoms (tremor, seizures, DTs)? Yes No

Tobacco / Nicotine

Do you currently use tobacco or nicotine (cigarettes, vape, pouches)? Yes No

Type & amount per day: Years of use:

Cannabis

Do you currently use cannabis? Yes No

Form (flower, edibles, vape, concentrate): Frequency:

Other Substances

Have you ever used any of the following? Please indicate frequency and most recent use.

Substance	Ever Used	Frequency	Last Use	Notes

(Examples: cocaine, MDMA, opioids, hallucinogens, ketamine, stimulants not prescribed, benzodiazepines not prescribed, GHB, inhalants)

Behavioral Patterns

Some behaviors can become difficult to control or may impact well-being. Please indicate any that apply:

Gambling	Online shopping	Pornography
Social media / scrolling	Video games	Work / overworking
Exercise (compulsive)	Eating	Sex / hookups
Cryptocurrency / day trading	Streaming / binge-watching	Other

Screens & Technology

Hours/day on phone: Hours/day on computer (non-work):

Do screens affect your sleep, focus, or mood? Yes No

Sexual Health

Are you sexually active? Yes No

Concerns about libido, function, or satisfaction? Yes No

History of sexually transmitted infections? Yes No

Stress & Coping

What are your current major stressors?

What helps you cope (healthy and unhealthy)?

Spiritual / Religious Practice

Faith tradition (if any):

Do spiritual practices play a meaningful role in your life? Yes No

FAMILY PSYCHIATRIC HISTORY

Please indicate any biological family members with a history of the following.

Condition	Relation(s) (mother, father, sibling, grandparent, etc.)
Depression	
Bipolar disorder	
Anxiety disorder	
OCD	
PTSD	
ADHD	
Autism spectrum	
Schizophrenia / psychotic disorde	
Eating disorder	
Substance use disorder	
Alcohol use disorder	
Suicide attempt	
Suicide (completed)	
Personality disorder	
Postpartum depression / anxiety	
Other	

SOCIAL & DEVELOPMENTAL HISTORY

Childhood

Where did you grow up?

Raised by:

Describe your childhood and family environment growing up:

Significant childhood medical or developmental issues? Yes No

Explain:

Were you ever in special education or did you have an IEP? Yes No

Explain:

Education

Highest level completed: Major / field of study:

Difficulties with learning or academic performance? Yes No

Explain:

Relationships & Family

Relationship status: Length of current relationship:

Children (ages):

Describe your support system (close friends, family, community):

Work & Finances

Describe your current work situation and any work-related stressors:

Currently experiencing financial stress? Yes No

Living Situation

Currently living with:

Stable housing? Yes No

TRAUMA HISTORY

This section is sensitive but important for your care. Please share what you feel comfortable disclosing — you can also choose to discuss any of these in person.

Have you ever experienced or witnessed an event that felt life-threatening or deeply distressing? Yes No

Explain:

History of physical abuse? Yes No

History of emotional or psychological abuse? Yes No

History of sexual abuse, assault, or unwanted sexual experiences? Yes No

History of neglect (childhood or adult)? Yes No

History of significant accident, injury, or medical trauma? Yes No

History of military or combat exposure? Yes No

History of community violence, refugee experience, or displacement? Yes No

Significant losses (death of a loved one, miscarriage, divorce, etc.)? Yes No

Explain:

Anything else you would like me to know about your trauma history at this time?

LEGAL HISTORY

Have you ever been arrested? Yes No

Explain:

Have you ever been convicted of a crime? Yes No

Explain:

Are you currently involved in any legal proceedings? Yes No

Explain:

Are you on probation or parole? Yes No

Custody disputes (current or past)? Yes No

MISCELLANEOUS

Strengths & Resources

What do you consider your personal strengths? What is going well in your life?

Goals for Treatment

What would you like to accomplish through psychiatric treatment?

Anything Else

Is there anything else you would like me to know that we haven't covered?

HIPAA NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGEMENT

This notice describes how medical information about you may be used and disclosed by Tribeca Psychiatry and how you can get access to this information. Please review it carefully.

Tribeca Psychiatry is required by law to maintain the privacy of your protected health information (PHI), to provide you with this Notice of our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect.

Uses and Disclosures of PHI

We may use or disclose your PHI for the following purposes without your specific authorization: (1) Treatment — to provide, coordinate, or manage your psychiatric care, including coordination with other providers; (2) Payment — to bill and collect payment from you, your insurance, or another third-party payer; (3) Health Care Operations — for activities such as quality assessment, training, licensing, and business management.

We may also use or disclose your PHI without authorization in limited circumstances required by law, including: reporting suspected abuse or neglect of a child, elder, or dependent adult; responding to a court order or subpoena; averting a serious threat to health or safety; reporting to public health authorities; or in cases of medical emergency.

Your Rights

You have the right to: (a) inspect and copy your PHI; (b) request amendments to your record; (c) request restrictions on certain uses and disclosures; (d) request confidential communications; (e) receive an accounting of disclosures; and (f) receive a paper copy of this Notice.

Psychotherapy Notes

Psychotherapy notes (process notes) are kept separately from your medical record and require your specific written authorization to be released, except in limited circumstances permitted by law.

By signing below, I acknowledge that I have received and reviewed the Tribeca Psychiatry Notice of Privacy Practices.

Patient Name (printed): _____

Signature: _____ Date: _____

Thank you for taking the time to complete this intake. It allows us to begin our work together with a deeper understanding of your experiences and goals.