Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date_____

Date of Birth _____ Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor_____ Therapist's Phone_____

What are the problem(s) for which you are seeking help?

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood ( ) Racing thoughts ( ) Excessive worry ( ) Unable to enjoy activities ( ) Impulsivity ( ) Anxiety attacks

( ) Sleep pattern disturbance ( ) Increase risky behavior ( ) Avoidance ( ) Loss of interest ( ) Increased libido ( ) Hallucinations

( ) Concentration/forgetfulness ( ) Decrease need for sleep ( ) Suspiciousness ( ) Change in appetite ( ) Excessive energy

( ) Excessive guilt ( ) Increased irritability ( ) Fatigue ( ) Crying spells ( ) Decreased libido

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No. If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

Past Medical History:

Allergies_____ Current Weight _____ Height _____

List ALL current prescription and over the counter medications and how often you take them: (if none, write none)

Medication Name	Dosage	Estimated Start Date

Current medical problems: _____
_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____
_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____

Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Birth control method _____

How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No

Date and place of last physical exam: _____

Personal and Family Medical History:

	Yes	No	Family Member (specify)	Comments
Thyroid Disease				
Chronic Fatigue				
Asthma/Respiratory Problems				
Fibromyalgia				
Chronic Pain				
Head Trauma				
Anemia				
Kidney Disease				
Stomach/Intestinal Issues				
Heart Disease				
High Cholesterol				
Liver Problems				
Liver Disease				
Diabetes				
Cancer (type?)				
Epilepsy				
High Blood Pressure				
Other (explain)				

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No

If yes, describe when, by whom, and nature of treatment. **Reason/Dates Treated/By Whom**

_____
_____
_____

Psychiatric Hospitalization ( ) Yes ( ) No

If yes, describe for what reason, when and where. **Reason/Date Hospitalized/Where**

_____
_____
_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember). Dosage/Dates/ Response/Side-Effects

Antidepressants	**Dosage:**	**Dates Taken:**	**Response/Side Effects**
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other:			
Mood Stabilizers	**Dosage:**	**Dates Taken:**	**Response/Side Effects**
Tegretol (carbamazepine)			
Lithium Carbonate			
Depakote (valproate)			
Lamictal (lamotrigine)			
Topamax (topiramate)			
Seroquel (quetiapine)			
Zyprexa (olanzapine)			

Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other:			
Sedatives/Hypnotics	**Dosage:**	**Dates Taken:**	**Response/Side Effects**
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			
ADHD Medications	**Dosage:**	**Dates Taken:**	**Response/Side Effects**
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Other			
Antianxiety Medications	**Dosage:**	**Dates Taken:**	**Response/Side Effects**
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Other			

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

	Yes	No	If yes, please explain
Bipolar Disorder			
Schizophrenia			
Depression			
Post-traumatic stress			
Anxiety			
Alcohol Abuse			
Anger			
Other Substance Abuse			
Suicide			
Violence			

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No

If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

Substance Use: Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of

a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____
_____

Please check Yes or No. If yes, please provide last date taken and frequency that you take the substance:

Substance:	Yes	No	If yes, last date taken/Frequency
Methamphetamine			
Cocaine			
Stimulants (pills)			
Heroin			
LSD or Hallucinogens			
Marijuana			
Pain Killers (not prescribed)			
Tranquilizer/sleeping pills			
Alcohol			
Ecstacy			

Caffeine Intake:

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History: How you ever smoked cigarettes? ( ) Yes ( ) No Currently? ( ) Yes ( ) No

How many packs per day on average? _____ How many years? _____

In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No

What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History: Were you adopted? ( ) Yes ( ) No

Where did you grow up? _____

List your siblings and their ages: _____
_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with?_____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History: Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.

If yes, please describe when, where and by whom: _____

_____

Educational History: Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____Major? _____

What is your highest educational level or degree attained? _____

Occupational History: Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Honorable discharge ( ) Yes ( ) No Other type discharge _____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

What is your gender? ( ) Male ( ) Female ( ) Transgender M to F ( ) Transgender F to M ( ) Gender Non-Binary/Gender Queer

How would you identify your sexual orientation? ( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) trisexual

( ) unsure/questioning ( ) asexual ( ) other_____ ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____

How long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____
_____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____
_____

Legal History: Have you ever been arrested? _____ Do you have any pending legal problems? _____

Spiritual Life: Do you belong to any particular religion or spiritual group? ( ) Yes ( ) No

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) more difficult/more stressful

Is there anything else that you would like us to know?

_____

_____

_____

_____

_____

_____

_____

_____

Signature_____Date_____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

Emergency Contact Relationship to Patient_____

For Office Use Only:

Reviewed by _____Date _____

Reviewed by _____Date _____