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
( ) Unable to enjoy activities
( ) Sleep pattern **disturbance**
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) **Excessive guilt**
( ) Fatigue
( ) Decreased libido
( ) **Racing** thoughts
( ) **Impulsivity**
( ) Increase **risky** behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased **irritability**
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

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:

Allcrgics _____ Current Weight _____Height _____

List ALL current prescri$_p$tion medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

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:

	You	**Family**	**Which Family Member?**
Thyroid Disease ----------	☐	☐	_____
Anemia----------	☐	☐	_____
Liver Disease ----------	☐	☐	_____
Chronic Fatigue ----------	☐	☐	_____
Kidney Disease ----------	☐	☐	_____
Diabetes ----------	☐	☐	_____
Asthma/respiratory problems ------	☐	☐	_____
Stomach or intestinal problems ---	☐	☐	_____
Cancer (type) ----------	☐	☐	_____
Fibromyalgia ----------	☐	☐	_____
Heart Disease ----------	☐	☐	_____
Epilepsy or seizures ----------	☐	☐	_____
Chronic Pain ----------	☐	☐	_____
High Cholesterol ----------	☐	☐	_____
High blood pressure----------	☐	☐	_____
Head trauma ----------	☐	☐	_____
Liver problems ----------	☐	☐	_____
Other ----------	☐	☐	_____

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, Please 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).

Dam Dosage Response/Side-Effects

Antidepressants

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 (nortrptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Other _____

Mood Stabilisers

Tegretol (carbamazepine) _____
Lithium _____
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Tegretol (carbamazepine) _____
Topamax (topiramate) _____
Other _____

Past Psychiatric medications (continued)

Antipsychotics/Mood **Stabilizers**	Dam	Dosage	Response/Side-Effects

Seroquel (quetiapine) _____
Zyprexa (olanzepine) _____
Geodon (ziprasidone) _____
Ability (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperidone) _____
Other _____

Sedative/Hypnotics

Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon) _____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other _____

ADHD medications

Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Other _____

Antianxiety medications

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:

Bipolar disorder	Yes	No	Schizophrenia
Depression	Yes	No	Post-traumatic stress
Anxiety	Yes	No	Alcohol abuse
Anger	Yes	No	Other substance abuse
Suicide	Yes	No	Violence

If yes, who had each problem? _____

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? _____
_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants(pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
			_____

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.
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
How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) 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 a 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 ( ) stressful

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

Signature _____ Date _____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____ Date _____

Reviewed by _____ Date _____