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:

Allergies______________________________ Current Weight ____________ Height ____________

List ALL current prescription 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).

Dates   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 Stabilizers

Tegretol (carbamazepine)____

Lithium____

Depakote (valproate) _________________________ _____________________________

Lamictal (lamotrigine) ____

Tegretol (carbamazepine) ____

Topamax (topiramate) ____

Other ____

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (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
Depression	( ) Yes	( ) No
Anxiety	( ) Yes	( ) No
Anger	( ) Yes	( ) No
Suicide	( ) Yes	( ) No
Schizophrenia	( ) Yes	( ) No
Post-traumatic stress	( ) Yes	( ) No
Alcohol abuse	( ) Yes	( ) No
Other substance abuse	( ) Yes	( ) No
Violence	( ) Yes	( ) No

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	( )	( )	____________________
Other			____________________

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?
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Signature____Date______________________________

Guardian Signature (if under age 18) ___________________________ Date ______________________________

Emergency Contact ____ Telephone # _______________________

For Office Use Only:

Reviewed by ____Date _____________________________

Reviewed by ____Date _____________________________