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	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) 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?

____

Signature ____________________________________ Date ____________________

Guardian Signature (if under age 18) ____________________ Date ____________________

Emergency Contact ____________________________ Telephone # ________________

For Office Use Only:

Reviewed by ____________________________________ Date ____________________

Reviewed by ____________________________________ Date ____________________