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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: ___/____/_______

Address:____

Date of Birth: ___/____/_______ Age:__________ Phone Number: ( ) ______-_________

Primary Care Physician: ___________________________________ Phone Number: ( ) ______-_________

Do you give permission for ongoing regular updates to be provided to your primary care physician? *Yes* or *No*

Therapist/Counselor You Are Seeing: ____

Emergency Contact: ____________________________ Phone Number: ( ) ______-_________

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

1. ____

2. ____

3. ____

Current Symptoms Checklist:
☐ Depressed mood ☐ Racing thoughts ☐ Excessive worry ☐ Excessive guilt ☐ Increased irritability

☐ Unable to enjoy activities ☐ Impulsivity ☐ Anxiety Attacks ☐ Crying spells ☐ Increased libido ☐ Decreased libido

☐ Sleep pattern disturbance ☐ Increase risky behavior ☐ Avoidance ☐ Hallucinations ☐ Excessive energy

☐ Change in appetite ☐ Fatigue ☐ Decrease need for sleep ☐ Loss of interest ☐ Concentration/forgetfulness

Suicide Risk Assessment
Have you ever had feelings or thoughts that you didn't want to live? *Yes* or *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* or *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 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. ______________________________

Identification:

Ethnicity:________________(optional)

Do you belong to a particular religion or spiritual group? *Yes* or *No*

Do you find your religious affiliation helpful during this time, or does the involvement make things more difficult or stressful for you? ☐ More helpful ☐ Stressful

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* or *No*

How would you identify your sexual orientation?
☐ straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual ☐ transsexual ☐ unsure ☐ other ☐ prefer not to answer

Do you have children? *Yes* or *No* If yes, list ages and gender: __________________

History of Present Problem:

How long have you had the above checked symptoms? ____________________

How often do these symptoms present? ____________________________

Past Psychiatric History:
Outpatient treatment: *Yes* or *No* If yes, Please describe when, by whom, and nature of treatment.
Reason/ Dates / Treated By Whom: ____

____

Psychiatric Hospitalization: *Yes* or *No* If yes, describe for what reason, when and where.
Reason/ Date / Hospitalized Where: ____

____

Past Psychiatric Medications: Please indicate if you are currently taking or have taken any of the following medication.

Antidepressants:

☐Prozac (fluoxetine) (*Past/Present*)
☐Zoloft (sertraline) (*Past/Present*)
☐Luvox (fluvoxamine) (*Past/Present*)
☐Paxil (paroxetine) (*Past/Present*)
☐Celexa (citalopram) (*Past/Present*)
☐Lexapro (escitalopram) (*Past/Present*)
☐Effexor (venlafaxine) (*Past/Present*)
☐Cymbalta (duloxetine) (*Past/Present*)
☐Wellbutrin (bupropion) (*Past/Present*)
☐Remeron (mirtazapine) (*Past/Present*)
☐Serzone (nefazodone) (*Past/Present*)
☐Anafranil (clomipramine) (*Past/Present*)
☐Pamelor (nortrptyline) (*Past/Present*)
☐Tofranil (imipramine) (*Past/Present*)
☐Elavil (amitriptyline) (*Past/Present*)
☐Other ______________________________

Mood Stabilizers:

☐Tegretol (carbamazepine) (*Past/Present*)
☐Lithium (*Past/Present*)
☐Depakote (valproate) (*Past/Present*)
☐Lamictal (lamotrigine) (*Past/Present*)
☐Tegretol (carbamazepine) (*Past/Present*)
☐Topamax (topiramate) (*Past/Present*)
☐Other ______________________________

Antipsychotics/Mood Stabilizers:

☐Seroquel (quetiapine) (*Past/Present*)
☐Zyprexa (olanzepine) (*Past/Present*)
☐Geodon (ziprasidone) (*Past/Present*)
☐Abilify (aripiprazole) (*Past/Present*)
☐Clozaril (clozapine) (*Past/Present*)
☐Haldol (haloperidol) (*Past/Present*)
☐Prolixin (fluphenazine) (*Past/Present*)
☐Risperdal (risperidone) (*Past/Present*)
☐Other ______________________________

Sedative/Hypnotics:

☐Ambien (zolpidem) (*Past/Present*)
☐Sonata (zaleplon) (*Past/Present*)
☐Rozerem (ramelteon) (*Past/Present*)
☐Restoril (temazepam) (*Past/Present*)
☐Desyrel (trazodone) (*Past/Present*)
☐Other ______________________________
☐Other ______________________________

ADHD medications:

☐Adderall (amphetamine) (*Past/Present*)
☐Concerta (*Past/Present*)
☐Ritalin (methylphenidate) (*Past/Present*)
☐Strattera (atomoxetine) (*Past/Present*)

Antianxiety medications:

☐Xanax (alprazolam) (*Past/Present*)
☐Ativan (lorazepam) (*Past/Present*)
☐Klonopin (clonazepam) (*Past/Present*)
☐Valium (diazepam) (*Past/Present*)
☐Buspar (buspirone) (*Past/Present*)
☐Other ______________________________

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? *Yes* or *No*

Please describe when, where and by whom: ____

Family Psychiatric History:
Has anyone in your family been diagnosed with or treated for:
Bipolar disorder ☐Schizophrenia ☐ Depression ☐ PTSD ☐ Suicide ☐ Anxiety ☐ Anger ☐ Violence ☐ Substance Abuse

If yes, who had each problem? ___________________________

Past Medical History:
Allergies: ____

Current Weight: ______ Height: _______

List ALL current prescription medications and how often you take them: (if none, check this box ☐)
Medication Name: ____

Current over-the-counter medications or supplements: ______________________________________

Current medical problems: ______________________________________

Past medical problems, nonpsychiatric hospitalization, or surgeries: ______________________________________

Personal and Family Medical History:
If No Medical Problems, Please check here: ☐

You	Family History	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	☐	___________________________

Other Medical Problems: ____

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

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? *Yes* or *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 1 day? Click here to enter text.

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

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

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

Have you ever had a drink/drugs first thing in the morning to steady your nerves or to get rid of a hangover? *Yes* or *No*

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

Have you used any street drugs in the past 3 months? *Yes* or *No*

If yes, which ones? ______________________________

Have you ever abused prescription medication? *Yes* or *No*

If yes, which ones and for how long? ______________________________

Check if you have ever tried the following:

☐Methamphetamine
☐Cocaine
☐Stimulants (pills)
☐Heroin
☐LSD or Hallucinogens
☐Marijuana
☐Pain killers (not prescribed) ________________________
☐Methadone
☐Tranquilizer/sleeping pills
☐Alcohol
☐Ecstasy
☐Other ______________________________

How many caffeinated beverages do you drink a day?

Coffee ________________________ Sodas ________________________ Tea ________________________

Tobacco History:

Have you ever smoked cigarettes? *Yes* or *No*

Currently? *Yes* or *No* Packs/Day on average? ____________________ How many years? ____________________

In the past? *Yes* or *No* How many years did you smoke? ______________________________

When did you quit? ______________________________ Why? ______________________________

Family Background and Childhood History:

Were you adopted? *Yes* or *No*

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

List your siblings and their ages: ____

Did your parents' divorce? *Yes* or *No* If so, how old were you when they divorced? ___________________

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

Do you get along well with your family? ____________________________________

Who do you go to for support? ____

Describe your relationship with your spouse or significant other: ____________________________

Have you had any prior marriages? *Yes* or *No*

If so, how many? ____________________________

Developmental History:
Any Developmental/Cognitive Delays? ____________________________________

Have you ever needed special education or any special accommodations? ____
____

Your Exercise Level:
Do you exercise regularly? *Yes* or *No*
If yes, What kind of exercise do you do? ____

How many days a week do you get exercise? __________

Educational History:
Highest Grade Completed? ____________________________

Did you attend college? *Yes* or *No*

What is your highest educational level or degree attained? ____

Occupational History:
Are you currently: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

What is/was your occupation? ________________________________

Where do you work? _______________________________________

Legal History:
Have you ever been arrested? *Yes* or *No*
Do you have any pending legal problems? *Yes* or *No* If yes, please describe: ____________________________

For women only:
Date of last menstrual period ___/____/_______

Are you currently pregnant or do you think you might be pregnant? *Yes* or *No*

Are you planning to get pregnant in the near future? *Yes* or *No*

Birth control method (if any): ____________________________

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

Date and place of last physical exam: ____

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

Signature ____ Date: ___/____/_______

Guardian Signature (if under age 18) ____ Date: ___/____/_______

For Office Use Only:

Reviewed by ____Date _____________________________

Reviewed by ____Date _____________________________