Mental Health Intake Form

Date: _____

Please complete all information on this form and bring it to the first visit.

Name: _____ DOB: _____

Primary Care Physician: _____

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

Current Therapist/Counselor: _____ Phone: _____

Describe problem(s) for which you are seeking help?

_____

_____

_____

_____

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

( ) Depressed Mood	( ) Racing Thoughts	( ) Excessive Worry
( ) Mood Swings	( ) Impulsivity	( ) Anxiety Attacks
( ) Sleep Pattern Disturbance	( ) Increase Risky Behavior	( ) Avoidance of People
( ) Loss of Interest	( ) Increased Libido	( ) Hallucinations
( ) Concentration/Forgetfulness	( ) Decreased Need for Sleep	( ) Paranoia
( ) Change in Appetite	( ) Excessive Energy	( ) _____
( ) Self Harm	( ) Increased Irritability	( ) _____
( ) Fatigue	( ) Crying Spells	( ) _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you do not want to live? ( ) YES ( ) NO

If YES, please answer the following. If NO, please skip to the next section.

Do you <u>currently</u> feel that you do not 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? _____

_____

_____

Past Medical History:

Medication Allergies: _____

_____

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

Medication Name	Dosage	Number of Tablets Per Day	Estimated Start Date

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

_____

Preferred pharmacy and location: _____

Past medical problems, non-psychiatric hospitalizations, or surgeries: _____

_____

_____

Have you ever had an EKG? ( ) YES ( ) NO If YES, when? _____

Was the EKG ( ) NORMAL ( ) ABNORMAL OR ( ) UNKNOWN?

Date and place of last physical exam: _____

For Women ONLY:

Date of last menstrual cycle: _____ Birth Control Method: _____

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

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

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease	( )	( )	
Anemia	( )	( )	
Liver Disease	( )	( )	
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	( )	( )	
Liver Problems	( )	( )	
Other:	( )	( )	
Other:	( )	( )	

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

Did your mother use any drugs, alcohol or tobacco while pregnant with you? _____

Past Psychiatric History:

Outpatient Treatment/Counseling: ( ) YES ( ) NO *If YES,* describe for what reason, when and where.

Reason	Date Treated	Where

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, dosages, and how helpful they were (if you cannot remember all the details, just write what you remember).

Antidepressants	Date	Dosage	Response/Side Effects
Prozac (Fluoxetine)			
Zoloft (Sertraline)			
Luvox (Fluvoxamine)			
Paxil (Paroxetine)			
Celexa (Citalopram)			
Lexapro (Escitalopram)			
Effexor (Venlafaxine)			
Cymbalta (Duloxetine)			
Wellbutrin (Bupropion)			
Remeron (Mirtazapine)			
Pristiq (Desvenlafaxine)			
Viibryd			
Trintellix			
Doxepin			
Trazodone			
Other:			

Mood Stabilizers	Date	Dosage	Response/Side Effects
Tegretol (Carbamazepine)			
Lithium			
Depakote (Valproate)			
Lamictal (Lamotrigine)			
Topamax (Topiramate)			
Trileptal (Oxcarbazepine)			
Other:			

Antipsychotics/ Mood Stabilizers	Date	Dosage	Response/Side Effects
Seroquel (Quetiapine)			
Zyprexa (Olanzapine)			
Geodon (Ziprasidone)			
Abilify (Aripiprazole)			
Clozaril (Clozapine)			
Haldol (Haloperidol)			
Prolixin (Fluphenazine)			
Risperdal (Risperidone)			
Saphris (Asenapine)			
Fanapt (Iloperidone)			
Latuda (Lurasidone)			
Rexulti (Brexpiprazole)			
Invega (Paliperidone)			
Other:			

Past psychiatric medications (continued)

Sedative/Hypnotics	Date	Dosage	Response/Side Effects
Ambien (Zolpidem)			
Sonata (Zaleplon)			
Lunesta (Eszopiclone)			
Restoril (Temazepam)			
Belsomra (suvorexant)			
Other:			

ADD/ADHD	Date	Dosage	Response/Side Effects
Adderall (Amphetamine)			
Concerta (Methylphenidate)			
Ritalin (Methylphenidate)			
Strattera (Atomoxetine)			
Focalin (Dexmethylphenidate)			
Evekeo (Amphetamine)			
Zenzedi (Dextroamphetamine)			
Intuniv (Guanfacine)			
Dexedrine (Dextroamphetamine)			
Clonidine			
Vyvanse (Lisdexamfetamine)			
Mydayis			
Quillavant (Methylphidate)			
Daytrana			
Metadate			
Other:			

Antianxiety	Date	Dosage	Response/Side Effects
Xanax (Alprazolam)			
Ativan (Lorazepam)			
Klonopin (Clonazepam)			
Valium (Diazepam)			
Tranxene (Clorazepate)			
Buspar (Buspirone)			
Restoril (Temaepam)			

Exercise Level:

Do you exercise regularly? ( ) YES ( ) NO

What kind of exercise do you do? _____

How many days per week? _____

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	Borderline Personality Disorder	( ) 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 substance(s)? _____

_____

IF YES, where were you treated and when? _____

_____

How many days per week do you drink alcohol? _____

How many drinks of alcohol do you consume per day? _____

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

Do you think you may have a problem with alcohol and 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 medications? ( ) 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 prescribed)	( )	( )	
Methadone	( )	( )	
Tranquilizers/Sleeping Pills	( )	( )	
Alcohol	( )	( )	
Ecstasy	( )	( )	
Other:	( )	( )	

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

Tobacco History:

Have 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 How many years? _____

Family Background and Childhood History:

Were you adopted? ( ) YES ( ) NO Where did you grow up? _____

Did your parents' divorce? ( ) YES ( ) NO 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? _____

Trauma History:

Do you have history of being abused emotionally, sexually, physically or by neglect?
( ) YES ( ) NO

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

_____

Do you have any history of head injuries, concussions or seizures? _____

Education History:

Highest Grade Completed? _____ Where? _____

Did you attend college or trade school? ( ) YES ( ) NO

If YES, where and what was your major or trade? _____

What is your highest educational level or degree attained? _____

Occupational History:

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

How long in your present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? ( ) YES ( ) NO Which branch and when? _____

Honorable discharge? ( ) YES ( ) NO Other type of 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/significant other's occupation? _____

Describe your relationship with your spouse/significant other: _____

_____

Have you had any prior marriages? ( ) YES ( ) NO

If YES, how many? _____ How long? _____

Do you have children? ( ) YES ( ) NO If YES, List names and DOB: _____

_____

Describe your relationship with your children: _____

_____

List everyone who lives with you: _____

_____

Legal History:

Have you ever been arrested? ( ) YES ( ) NO

Do you have any pending legal problems? ( ) YES ( ) NO

If YES, please describe: _____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Emergency Contact: _____ Date: _____

For Office Use Only:

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____