

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)

- | | | |
|--|--|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Anxiety attacks |
| <input type="checkbox"/> Sleep pattern disturbance | <input type="checkbox"/> Increase risky behavior | <input type="checkbox"/> Avoidance |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Concentration/forgetfulness | <input type="checkbox"/> Decrease need for sleep | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Increased irritability | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Crying spells | |
| <input type="checkbox"/> Decreased libido | | |

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

| Medication Name | Total Daily Dosage | Estimated Start Date |
|-----------------|--------------------|----------------------|
| | | |
| | | |
| | | |
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| | | |
| | | |

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:

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 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: _____

