

## 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 |
|-----------------|--------------------|----------------------|
|                 |                    |                      |
|                 |                    |                      |
|                 |                    |                      |
|                 |                    |                      |
|                 |                    |                      |
|                 |                    |                      |
|                 |                    |                      |
|                 |                    |                      |
|                 |                    |                      |

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:

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

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**Past Psychiatric History:**

**Outpatient treatment** ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason

Dates Treated

By Whom

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**Psychiatric Hospitalization** ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason

Date Hospitalized

Where

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**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 (nortriptyline) \_\_\_\_\_

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?

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature (if under age 18) \_\_\_\_\_ Date \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone # \_\_\_\_\_

**For Office Use Only:**

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_