

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 of Birth _____ Date _____

Allergies _____ Current Weight _____ Height _____

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

What are your treatment goals? _____

Current or Previous Therapist/Counselor: _____ Phone Number: _____
May we contact this provider? ____ Yes ____ No

Previous Mental Health Provider: _____ Phone Number: _____
May we contact this provider? ____ Yes ____ No

Primary Care Physician: _____ Phone Number: _____
May we contact this provider? ____ Yes ____ No

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

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

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. _____

Exercise:

Do you exercise regularly? () Yes () No

How many days a week do you get exercise? _____ Amount of time? _____ Type? _____

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

List ALL current medications and how often you take them: (if none, write none)
 (Include all prescription, over-the-counter medications and supplements. Continue on back if needed)

Name	Total Daily Dosage	Estimated Start Date

Personal and Family Medical History

	You	Family	Who		You	Family	Who
Thyroid Disease -----	()	()	_____	Epilepsy or seizures -----	()	()	_____
Anemia-----	()	()	_____	Chronic Pain -----	()	()	_____
Liver Disease -----	()	()	_____	High Blood Pressure _____	()	()	_____
Kidney Disease -----	()	()	_____	Head trauma -----	()	()	_____
Diabetes -----	()	()	_____	Asthma/respiratory problems -	()	()	_____
Cancer (type) -----	()	()	_____	Stomach/intestinal problems -	()	()	_____
Fibromyalgia -----	()	()	_____	Other -----	()	()	_____
Heart Disease -----	()	()	_____				

Past Surgeries: _____

Is there any additional personal or family medical history? _____

Have you ever had an EKG? () Yes () No If yes, when _____ Results: () normal () abnormal or () unknown

Past Psychiatric History:

Outpatient treatment () Yes () No

Reason	Dates Treated	By Whom

Psychiatric Hospitalization () Yes () No

Reason	Date Hospitalized	Where

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for: If yes, please indicate who.

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	_____

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? _____

Family Background and Childhood History:

Who did you live with growing up? _____ Where did you grow up? _____

Did your parents' divorce? () Yes () No. How old were you? _____ Who did you live with? _____

Trauma History:

Have you ever been abused emotionally, sexually, physically or by neglect? () Yes () No By whom: _____

Do you have a history of PTSD, hx of traumatic event? () Yes () No, explain: _____

Educational History:

Did you graduate High School? _____ Did you attend college? _____ Did you graduate College? _____

What is your highest educational level or degree attained? _____

Occupational History:

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

What is/was your occupation? _____ How long? _____

Have you ever served in the military? _____ Branch and when? _____ Discharged? () Yes () No () Honorable

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? _____ () 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. Do you find your involvement () more helpful () stressful

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? _____ the most? _____

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 in the morning to steady your nerves or 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 _____			_____

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)	_____	_____	_____
Anafranil (clomipramine)	_____	_____	_____
Pamelor (nortrptyline)	_____	_____	_____
Tofranil (imipramine)	_____	_____	_____
Elavil (amitriptyline)	_____	_____	_____

Mood Stabilizers

Tegretol (carbamazepine)	_____
Lithium	_____
Depakote (valproate)	_____
Lamictal (lamotrigine)	_____
Topamax (topiramate)	_____

Antipsychotics/Mood Stabilizers

Seroquel (quetiapine) _____
Rexulti (brexpiprazole) _____
Zyprexa (olanzepine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperidone) _____

Sedative/Hypnotics

Ambien (zolpidem) _____
Lunesta (eszopiclone) _____
Sonata (zaleplon) _____
Rozerem (ramelteon) _____
Restoril (temazepam) _____
Desyrel (trazodone) _____

ADHD medications

Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____

Antianxiety medications

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____
Other _____

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

Patient Signature or Guardian Signature _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Recommendations: _____

Follow-up in: _____ Weeks

Medications: _____

Reviewed by _____ Date _____

Reviewed by _____ Date _____