MindHealthPsychiatry-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: ___________________

Current Primary Care Physician______________________ Primary Care Physician Phone: ________________
Do you give permission for ongoing regular updates to be provided to your primary care physician? ☐ Yes ☐ No

Current Therapist/Counselor__________________________ Therapist's Phone________________________
Do you give permission for ongoing regular updates to be provided to your Therapist/Counselor? ☐ Yes ☐ No
What are the primary problem(s) for which you are seeking help?
1.____
2.____
3.____

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

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

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. ______________________________

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?
____
____

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

____

____

____

____

Current Pharmacy Name, Address, Telephone: ____

____

Current Over-the-Counter Medications / Supplements: ____

____

Current Medical Problems: ____

____

Past Medical Problems, Non-Psychiatric Hospitalization, or Surgeries: ____

____

Have you ever had an EKG? ☐ Yes ☐ No If yes, when __________

Was the EKG ☐ Normal ☐ Abnormal or ☐ Unknown?

Have you ever had an EEG? ☐ Yes ☐ No If yes, when __________

Was the EEG Normal ☐ Abnormal or ☐ Unknown?

Have you ever had a Sleep Study? ☐ Yes ☐ No If yes, when__________

Was the Sleep Study ☐ 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/Contraceptive 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 Disease	☐	☐	____________________
Stomach or Intestinal Problems	☐	☐	____________________
Cancer (type) -----------------------	☐	☐	____________________
Fibromyalgia -------------------------	☐	☐	____________________
Heart Disease ------------------------	☐	☐	____________________
Epilepsy or Seizures ------------------	☐	☐	____________________
Chronic Pain -------------------------	☐	☐	____________________
High Cholesterol --------------------	☐	☐	____________________
High blood pressure------------------	☐	☐	____________________
Head trauma -------------------------	☐	☐	____________________
Liver problems ----------------------	☐	☐	____________________

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:

Antidepressants

( ) Yes ( ) No Prozac (fluoxetine)
( ) Yes ( ) No Zoloft (sertraline)
( ) Yes ( ) No Luvox (fluvoxamine)
( ) Yes ( ) No Paxil (paroxetine)
( ) Yes ( ) No Celexa (citalopram)
( ) Yes ( ) No Lexapro (escitalopram)
( ) Yes ( ) No Effexor (venlafaxine)
( ) Yes ( ) No Cymbalta (duloxetine)
( ) Yes ( ) No Wellbutrin (bupropion)
( ) Yes ( ) No Remeron (mirtazapine)
( ) Yes ( ) No Serzone (nefazodone)
( ) Yes ( ) No Anafranil (clomipramine)
( ) Yes ( ) No Pamelor (nortrptyline)
( ) Yes ( ) No Tofranil (imipramine)
( ) Yes ( ) No Elavil (amitriptyline)
Other______________________________

Mood Stabilizers

( ) Yes ( ) No Tegretol (carbamazepine)
( ) Yes ( ) No Lithium
( ) Yes ( ) No Depakote (valproate)
( ) Yes ( ) No Lamictal (lamotrigine)
( ) Yes ( ) No Tegretol (carbamazepine)
( ) Yes ( ) No Topamax (topiramate)
Other______________________________

ADHD Medications

( ) Yes ( ) No Adderall (amphetamine)
( ) Yes ( ) No Concerta (methylphenidate)
( ) Yes ( ) No Ritalin (methylphenidate)
( ) Yes ( ) No Strattera (atomoxetine)
Other______________________________

Antipsychotics/Mood Stabilizers

( ) Yes ( ) No Seroquel (quetiapine)
( ) Yes ( ) No Zyprexa (olanzepine)
( ) Yes ( ) No Geodon (ziprasidone)
( ) Yes ( ) No Abilify (aripiprazole)
( ) Yes ( ) No Clozaril (clozapine)
( ) Yes ( ) No Haldol (haloperidol)
( ) Yes ( ) No Prolixin (fluphenazine)
( ) Yes ( ) No Risperdal (risperidone)
Other______________________________

Sedative/Hypnotics

( ) Yes ( ) No Ambien (zolpidem)
( ) Yes ( ) No Sonata (zaleplon)
( ) Yes ( ) No Rozerem (ramelteon)
( ) Yes ( ) No Restoril (temazepam)
( ) Yes ( ) No Desyrel (trazodone)
Other______________________________

Antianxiety Medications

( ) Yes ( ) No Xanax (alprazolam)
( ) Yes ( ) No Ativan (lorazepam)
( ) Yes ( ) No Klonopin (clonazepam)
( ) Yes ( ) No Valium (diazepam)
( ) Yes ( ) No Tranxene (clorazepate)
( ) Yes ( ) No 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? ______________________________

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

____
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____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, forwhich 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 /used drugs first thing in 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)	( )	( )	______
Prescription Medications (abuse/misuse)	( )	( )	______
Methadone/Suboxone	( )	( )	______
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? _________________

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

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: ___

___

___

___

___

Preferred Pharmacy: ___

Preferred Lab: ___

Emergency Contact with Full PHI Access Name: ___

Emergency Contact with Full PHI Number: ___

Print Name___Date___

Signature___Date___

Guardian Signature (if under age 18)___Date___

Emergency Contact___Telephone # ___

For Office Use Only:

Reviewed by___Date___

Reviewed by___Date ___