Psychiatric Mental Health Intake Form

Please complete ALL information on this form before your first appointment. Many of the questions require only a check, and this allows your provider to spend more time discussing the relevant information. Thank you!

Name_____Date_____
Date of Birth _____ Gender Assigned at Birth: _____
Preferred Name: _____
Gender Identity: _____ Preferred Pronouns: _____

Current Therapist/Counselor_____ Therapist's Phone_____
Do you give permission for contact with your therapist? _____

What are the main problem(s) for which you are seeking help?
1._____
2._____
3._____

What has been stressing you of late (e.g. Family, job, loss of loved one, finances)?
_____
_____
_____

With starting (and/or continuing) treatment, what are your primary treatment goals?
_____
_____

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

□ Depressed mood
□ Racing thoughts
□ Talking too fast
□ Worrying excessively
□ Feeling awkward in public
□ Thoughts that replay
□ Repetitive or compulsive behaviors

□ Hearing voices
□ Seeing things other people don't see
□ Feeling people are trying to harm you or watch you
□ Problems with concentration/forgetfulness
□ Going days without needing to sleep
□ Problems going to sleep
□ Sleep pattern disturbance
□ Problems finding words
□ Hyperactive or fidgety
□ Crying spells

□ Uncontrollable grunts, tics, or jerks
□ Unable to enjoy activities
□ Tense muscles
□ Impulsivity (Spending, speeding)
□ Anxiety attacks
□ Increased risky behavior
□ Avoidance
□ Traumatic events that come back in nightmares, flashbacks?
□ Phobias or fears?
□ Suspiciousness
□ Eating too much
□ Eating too little
□ Changes in appetite
□ Has this resulted in weight change
□ Having very high energy for no reason?
□ Concern about alcohol use
□ Concern about drug use

□ Loss of interest/motivation
□ Increased libido
□ Decreased libido
□ You need help caring for yourself
□ Forgetting how to do tasks
□ Memory problems

□ Strong feelings of guilt
□ Feelings of worthlessness
□ Feelings of hopelessness
□ Periods of euphoria or unusually good mood
□ Increased irritability
□ Fatigue/ Poor energy
□ Inattentiveness at work or school
□ Getting lost easily
□ _____
□ _____

Medical History:

Primary Care Physician_____
Do you give permission for ongoing updates to be provided to your primary care physician, including but not limited to lab-work and medication changes? _____
Current Weight _____ Height _____

Allergies to medications (medication name and type of reaction):
_____
_____
_____

List ALL current prescription medication name, dosage, and how often you take them: (if none, write none)
_____
_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements:
_____
_____
_____

Past medical non-psychiatric hospitalization or surgeries:
_____
_____
_____
_____

Have you ever had an EKG? □ Yes □ No If yes, when _____ .
Was the EKG □ normal □ abnormal or □ unknown?

When your mother was pregnant with you, were there any complications during the pregnancy or birth?
_____
Date and place of last physical exam: _____

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? _____
Miscarriages? □ Yes □ No
Elective abortions? □ Yes □ No

Personal and Family Medical History:

	You	Family
Chronic Fatigue ---------	□	□
Chronic Pain ----------	□	□
Fibromyalgia ----------	□	□
Epilepsy/seizures --------	□	□
Head trauma/concussion	□	□
Migraines/headaches----	□	□
Glaucoma----------	□	□
Heart Disease ----------	□	□
High Cholesterol --------	□	□
High blood pressure-----	□	□
Asthma/breathing issues	□	□
Sleep apnea----------	□	□
Stomach/GI issues----- -	□	□
IBS/constipation/diarrhe	□	□
Anemia----------	□	□
Liver Disease/ problems	□	□
Kidney Disease ----------	□	□
Diabetes ----------	□	□
Thyroid Disease ---------	□	□
Muscle/joint problems--	□	□
Cancer (type) ----------	□	□

Legal History:

Have you ever been arrested? _____

Do you have any history of DUI/DWI? _____

Do you have any pending legal problems? _____

Past Psychiatric History:

Outpatient treatment □ Yes □ No

If yes, Reason Year Treated Facility/Provider

_____

_____

_____

Psychiatric Hospitalization □ Yes □ No

If yes, Reason Date Hospitalized Where

_____

_____

_____

Past Psychiatric Medications:

If you have ever taken any of the following medications, please indicate the dates, dosage, and whether they were helpful or had side effects (just write what you do remember).

Antidepressants/Anxiolytics

Prozac (fluoxetine) _____
Zoloft (sertraline) _____
Luvox (fluvoxamine) _____
Paxil (paroxetine) _____
Celexa (citalopram) _____
Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Pristiq (desvenlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Serzone (nefazodone) _____
Anafranil (clomipramine) _____
Pamelor (nortrptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Buspar (buspirone) _____
Viibryd _____
Trintellix _____
Other _____

Mood Stabilizers

Tegretol (carbamazepine) _____
Lithium _____
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Trileptal (Oxcarbazepine) _____
Topamax (topiramate) _____
Neurontin (gabapentin) _____
Other _____

Antipsychotics/Mood Stabilizers

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

Past Psychiatric Medications (continued):

Sedative/Hypnotics

Ambien (zolpidem) _____
Sonata (zaleplon) _____
Lunesta () _____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Remeron (mirtazapine) _____
Other _____

ADHD medications

Adderall (amphetamine-dextroamphetamine) _____
Concerta/Ritalin (methylphenidate) _____
Vyvanse (lisdexamphetamine) _____
Strattera (atomoxetine) _____
Other _____

As needed medications

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Other _____

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
Obsessive Compulsive Disorder □ Yes □ No
Anger □ Yes □ No
Other substance abuse □ Yes □ No
Suicide □ Yes □ No
Violence □ Yes □ No
Other □ Yes □ No

If yes, who had each problem?

_____
_____

Has any family member been treated with a psychiatric medication? □ Yes □ No
If yes, what medications did they take, and how effective was the treatment?

_____
_____

Substance Use History:

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? _____
_____

Alcohol

In the past two months:
How many days per week do you drink any alcohol? _____
What is the least number of drinks you drink in a day? _____
What is the most number of drinks you drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Drug Use

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 experimented with the following:
(If yes, note how long and when you last tried it)

Methamphetamine	□_____
Cocaine	□_____
Stimulants (pills)	□_____
Heroin	□_____
LSD or Hallucinogens	□_____
Marijuana	□_____
Pain killers (not as prescribed)	□_____
Methadone	□_____
Tranquilizer/sleeping pills	□_____
Ecstasy	□_____
Other	□_____

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

Caffeine

How many caffeinated beverages do you drink a day?
Coffee _____ Sodas _____ Tea _____
Do you have any adverse effects to caffeine or sensitivity?_____

Tobacco History:
How you ever smoked cigarettes, pipes, cigars or chewed tobacco? □ Yes □ No
Currently? □ Yes □ No If not currently, when did you quit? _____
How many years did you use nicotine/tobacco? _____
Have you ever tried to quit? □ Yes □ No If yes, how long did it last: _____
How many packs per day (for pipes/chewing tobacco - how often per day)? _____

Social History:

Childhood and Family:
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? □ No □ Yes, If yes, how old were you? _____
If your parents divorced, who did you live with?_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
If so, who and when? _____
_____

Educational History:
Highest Grade Completed? _____ Where?_____
Any struggles at school (bullying, dyslexia, etc)? _____
Did you attend college? _____ Where?_____
Major? _____
What is your highest educational level or degree attained? _____
List any certifications or additional training:_____

Occupational History:
Are you currently: □ Working □ Student □ Unemployed □ Disabled □ Retired
How long in the present position? _____
What is/was your occupation? _____
Where do you work? _____

Have you ever served in the military? _____
If so, what branch and when? _____
Were you ever stationed somewhere with live combat? _____
If so, where and when? _____
Honorable discharge □ Yes □ No, If no, _____

Relationship History and Current Family:
Are you currently: □ Married □ Partnered □ Divorced □ Single □Widowed
Since what year? _____

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 did each last? _____

Do you have any children? □ Yes □ No
If yes, list name, year born, and gender: _____
_____
_____
Describe your relationship with your children:
_____
List everyone who currently lives with you, and their relationship to you:
_____
_____

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? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? □ Yes □ No
If no, do you have any religious or spiritual belief, or consider yourself agnostic, atheist, or undecided?_____
If yes, what is the level of your involvement? _____
Do you find your involvement helpful at this time, 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?

Date completed: _____

Emergency Contact _____
Telephone # _____

For Office Use Only:
Reviewed by _____Date _____