Mental Health Intake Form

This may seem long, but most of the questions require only a check, so it will go quickly.

Name_____Date_____

What are the problem(s) for which you are seeking help?
1._____
2._____
3._____
Treatment goals? ( ) Medication changes ( ) Therapy ( ) Resources
( ) Diagnostic clarification ( ) Other _____

Psychiatric History:
Have you ever been diagnosed with any of the following?

( ) Depression
( ) Post partum depression
( ) Anxiety
( ) Bipolar disorder
( ) Psychosis
( ) Schizophrenia
( ) PTSD
( ) ADHD
( ) OCD
( ) Phobias
( ) Chronic fatigue
( ) Fibromyalgia
( ) Borderline Personality Disorder
( ) Substance use disorder
If yes, what substance_____
( ) Other not listed _____

Have you ever been hospitalized for mental health issues? ( ) Yes ( ) No
Has anyone in your family ever died of suicide ( ) Yes ( ) No
Have you ever attempted Suicide? ( ) Yes ( ) No **If yes**, how many times _____
Have you ever self harmed (cutting, hitting, burning) ? ( ) Yes ( ) No

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

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep difficulty
( ) Loss of interest
( ) Concentration
( ) Forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue/ low energy
( ) Other symptoms not listed
( ) Decreased libido
( ) Increased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Isolation
( ) Hallucinations
( ) Paranoia
( ) Flashbacks

_____
_____

How is your sleep? ( ) Normal ( ) Can't get to sleep ( ) Can't stay asleep ( ) Insomnia ( ) Not restful ( ) Nightmares
Have you ever had a seizure? ( ) Yes ( ) No
Have you ever had a concussion or serious head injury? ( ) Yes ( ) No

Trauma History (check if yes)
Do you have a history of being abused ( )emotionally ( )sexually ( ) physically or ( ) by neglect?

Occupation:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed
Do you have children? ( ) No ( ) Yes, how many _____

Substance use
Have you ever had a substance use issue? ( ) Yes ( ) No
Have you ever been treated for substance use, been to detox or rehab? ( ) Yes ( ) No
Have you ever been through withdrawal from a substance? ( ) Yes ( ) No

Do you currently use:

( )Alcohol	( )Heroin	( ) Suboxone
( )Tobacco products	( )Cocaine	Other:
( )Opioid pain medication	( )Methamphetamine	_____
	( ) Hallucinogens	_____
( )Ecstasy	( ) Benzodiazepines	_____

Family psychiatric history
Has anyone in your family ever been diagnosed with any of the following?

	Mother	**Father**	**Sister**	**Brother**	**Grand-mother**	**Grand-father**	**Children**
Depression							
Anxiety							
Bipolar disorder							
Substance Addiction							
Schizophrenia							
PTSD							
ADHD							

List ALL <u>current</u> prescription medications and how often you take them: (if none, write none)

Medication Name **Estimated Start Date** **Total Daily Dosage**

_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements:

_____

Past Psychiatric Medications: If you have ever taken any of the following? **(Circle)**

Antidepressants
Celexa (*citalopram*)
Lexaro (*escitalopram*)
Luvox (*fluvoxamine*)
Paxil (*paroxetine*)
Prozac (*fluoxetine*)
Zoloft (*sertraline*)
Cymbalta (*Duloxetine*)
Effexor (*venlafaxine*)
Remeron (*Mirtazipine*)
Wellbutrin (*bupropion*)

TCA antidepressants
Anafranil (*clomipramine*)
Elavil (*amitriptyline*)
Norpramin (*desipramine*)
Pamelor (*nortriptyline*)
Aventyl Sinequan (*doxepin*)
Tofranil (*imipramine*)

Antianxiety Drugs/ Sleep
Atarax, Vistaril or Hydroxyzine
Ativan (*lorazepam*)
BuSpar (*buspirone*)
Klonopin (*clonazepam*)
Valium (*diazepam*)
Xanax (*alprazolam*)
Ambien
Lyrica *(pregabalin)*
Lunesta
Melatonin
Trazodone

Mood Stabilizers and anti- seizure medication
Depakote (*valproic acid*)
Lamictal (*lamatrogine*)
Lithium
Tegretol (*carbamazepine*)
Trileptal (*oxcarbazepine*)
Gabapentin *(neurotin)*

Anti-dopamine
Abilify (*aripiprazole*)
Clozaril (*clozapine*)
Geodon (*ziprasidone*)
Haldol (*haloperidol*)
Invega (*paliperidone*)
Latuda (*lurasidone*)
Risperdal (*risperidone*)
Seroquel (*quetiapine*)
Zyprexa (*olanzapine*)

Stimulants
Adderall
Concerta
Dexedrine
Dextrostat
Ritalin
Vyvanse

Others not listed
_____
_____
_____