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_____

Address _____

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)

- **( ) Depressed mood**
- **( ) Unable to enjoy activities**
- **( ) Sleep pattern disturbance**
- **( ) Loss of interest**
- **( ) Concentration/forgetfulness**
- **( ) Change in appetite**
- **( ) Excessive guilt**
- **( ) Fatigue**
- **( ) Decreased libido**

Suicide Risk Assessment

( ) Racing thoughts ( ) Impulsivity ( ) Increase risky behavior ( ) Increased libido
( ) Decrease need for sleep ( ) Excessive energy ( ) Increased irritability ( ) Crying spells
( ) Excessive worry ( )Anxiety attacks ( ) Avoidance( ) Hallucinations ( ) Suspiciousness

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:

List ALL current prescription or over the counter medications and how often you take them: (if none, write none)

Name	Dosage	Estimated Start Date

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

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 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).

_____

_____

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 Depression Anxiety
Anger: yes ( ) no ( )
Schizophrenia: yes ( ) no ( )
Post-traumatic stress: yes ( ) no ( )
Alcohol abuse: yes ( ) no ( )
Other substance abuse: yes ( ) no ( ) _____

Suicide:
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 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? _____

_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? **( )** Yes **( )** No

Other forms of tobacco? ( ) 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? _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No

Where did you grow up? _____

Siblings? Please enter name, age, and sex

Father's occupation? _____

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 names, ages and gender:

Describe your relationship with your children: _____

Anyone else who currently lives with you?

Legal History:
Have you ever been arrested? ( ) Yes ( ) No? If yes, for what? _____
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?

_____

_____

_____

_____

_____

_____

Signature_____ **Date**_____

Guardian Signature (if under age 18) _____ **Date** _____

Emergency Contact _____ **Relationship** _____ **Phone #** _____