Innovative Behavioral Medicine LLC

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!

First Name_____ Middle Initial____ Last Name_____

Today's Date_____ Date of Birth_____ Gender: _____

Social Security Number_____

Do you have a primary care provider (PCP)?_____ If yes, please provide name and contact information for PCP.

PCP Contact Information:

Name:_____ Phone Number:_____

Street Name_____ City_____ State_____ Zip Code_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Do you have a therapist or counselor currently? _____ If yes, please provide their name and contact information.

Current Therapist/Counselor Name:_____ Phone_____

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

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check the box for any symptoms present)

( ) Depressed mood

( ) Unable to enjoy activities

( ) Sleep pattern disturbance

- **( ) Difficulty Falling Asleep**
- **( ) Difficulty Staying Asleep**
- **( ) Both**

How many hours per night do you sleep?_____

( ) Loss of interest

( ) Concentration/forgetfulness

( ) Change in appetite

( ) Decreased appetite

( ) Increased appetite

( ) Change in weight

_____ ___ **lbs over**

_____

( ) Excessive guilt

( ) Fatigue

( ) Racing thoughts

( ) Impulsivity

( ) Increase risky behavior

If yes, please describe:_____

_____

_____

( ) Increased libido

( ) Decreased libido

( ) Decrease need for sleep

( ) Excessive energy

( ) Increased irritability

( ) Crying spells

( ) Excessive worry

( ) Anxiety attacks

( ) Avoidance

( ) Hallucinations

- **( ) Auditory**
- **( ) Visual**

( ) Suspiciousness

( ) Other: Please specify:

_____

( ) Other: Please specify:

_____

List each symptom and provide onset (when it first started); duration/how long you have been experiencing the symptom; and anything that worsens or helps improve symptom:_____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? _____

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? _____

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? _____ If yes, please describe event:_____

_____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better?_____ If yes, please state:_____.

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? _____ If yes, please state:_____

_____.

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:

Current Age____ Weight_____Height: Feet___Inches____

Do you have any medication allergies?_____ If so, please list medications and describe reaction.

Medication_____ Reaction_____

Medication_____ Reaction_____

Medication_____ Reaction_____

Do you currently take any prescription medications?_____ If yes, please list below.

List ALL current prescription medications and how often you take them:

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

Do you currently take any over-the-counter medications or supplements? _____If yes, please list:_____

_____

Do you currently have any medical problems? _____If yes, please list:_____

_____

Do you have any past medical problems, nonpsychiatric hospitalizations, or surgeries? _____If yes, please list:

_____

Have you ever had an EKG?_____If yes, when_____ and was it ( ) normal ( ) abnormal or ( ) unknown**?**

For women only:

Date of last menstrual period: _____

Are you currently pregnant or do you think you might be pregnant? _____

Are you planning to get pregnant in the near future? _____ If not, what is your current method of birth control:_____

How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health? _____ If yes, please explain:_____

Date of last physical exam:09-12-2021 Provider:_____

_____

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease ----------	( )	( )	
Anemia----------	( )	( )	
Liver Disease ----------	( )	( )	
Chronic Fatigue ----------	( )	( )	
Kidney Disease ----------	( )	( )	
Diabetes ----------	( )	( )	
Asthma/respiratory problems ------	( )	( )	
Stomach or intestinal problems ---	( )	( )	
Cancer (type) ----------	( )	( )	
Fibromyalgia ----------	( )	( )	
Heart Disease ----------	( )	( )	
Epilepsy or seizures ----------	( )	( )	
Chronic Pain ----------	( )	( )	
High Cholesterol ----------	( )	( )	
High blood pressure----------	( )	( )	
Head trauma ----------	( )	( )	
Liver problems ----------	( )	( )	
Other ----------	( )	( )	

Is there any additional personal or family medical history? _____ If yes, please explain below:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?_____

Past Psychiatric History:

Outpatient treatment? _____ If yes, Please describe when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

Psychiatric Hospitalization _____ If yes, describe for what reason, when and where.

Reason	**Date of Hospitalization**	**Reason**
-		
-		
-		

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).

	Date Stopped	**Medication Trial Duration**	**Side-Effects (check box)**	**Reason Stopped**
Antidepressants				
Prozac (fluoxetine)				
Zoloft (sertraline)				
Luvox (fluvoxamine)				
Paxil (paroxetine)				
Celexa (citalopram)				
Lexapro (escitalopram)				
Effexor (venlafaxine)				
Cymbalta (duloxetine)				
Wellbutrin (bupropion)				
Remeron (mirtazapine)				
Serzone (nefazodone)				
Anafranil (clomipramine)				

Pamelor (nortrptyline) _____

Tofranil (imipramine) _____

Elavil (amitriptyline) _____

Other_____

Mood Stabilizers

	Date Stopped	Medication Trial Duration	Side-Effects (check box)	Reason Stopped

Tegretol (carbamazepine)_____

Lithium_____

Depakote (valproate) _____ _____

Lamictal (lamotrigine) _____

Topamax (topiramate)

Other : _____

_____

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers

	Date Stopped	Medication Trial Duration	Side-Effects (check box)	Reason Stopped
Seroquel (quetiapine)				
Zyprexa (olanzepine)				
Geodon (ziprasidone)				
Abilify (aripiprazole)				
Clozaril (clozapine)				
Haldol (haloperidol)				
Prolixin (fluphenazine)				
Risperdal (risperidone)				
Other				

Sedative/Hypnotics

	Date Stopped	Medication Trial Duration	Side-Effects (check box)	Reason Stopped
Ambien (zolpidem)				
Sonata (zaleplon)				
Rozerem (ramelteon)				
Restoril (temazepam)				
Desyrel (trazodone)				
Other				

ADHD Medications

	Date Stopped	Medication Trial Duration	Side-Effects (check box)	Reason Stopped
Adderall (amphetamine)				
Concerta (methylphenidate)				
Ritalin (methylphenidate)				
Strattera (atomoxetine)				
Other				

Anti-anxiety Medications

	Date Stopped	Medication Trial Duration	Side-Effects (check box)	Reason Stopped

Xanax (alprazolam) _____

Ativan (lorazepam)_____

Klonopin (clonazepam): _____

Valium (diazepam) _____

Tranxene (clorazepate) _____

Buspar (buspirone) _____

Other _____

Your Exercise Level:

Do you exercise regularly? _____ If so, please quantify frequency, duration, and type of exercise below:

How many days a week do you exercise? _____

What is the duration of time spent exercising? Hours: _____ Minutes: _____

What kind of exercise do you do? _____

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, list each family member and corresponding problem? _____

_____

Has any family member been treated with a psychiatric medication? _____

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? _____

If yes, for which substances, 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 highest number of drinks you will drink in a day? _____

In the past three months, what is the highest number of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? _____

Have people annoyed you by criticizing your drinking or drug use? _____

Have you ever felt bad or guilty about your drinking or drug use? _____

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? _____

Do you think you may have a problem with alcohol or drug use? _____

Have you used any street drugs in the past 3 months? _____

If yes, please list:

_____

Have you ever abused prescription medication? _____

If yes, please list medications and duration of abuse:

_____

Check if you have ever tried the following:

	Yes	No	If yes:	quantify duration	Date of last use
Methamphetamine					
Cocaine					
Stimulants (pills)					
Heroin					
LSD or Hallucinogens					
Marijuana					
Pain killers (not prescribed)					
Methadone					
Tranquilizer/sleeping pills					

Alcohol

Ecstasy

Other

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

Tobacco History:

How you ever smoked cigarettes? _____

Currently? _____ If so, many packs per day on average? _____ How many years? _____

Did you smoke in the past? _____ How many years did you smoke? _____When did you quit? _____

Pipe, cigars, or chewing tobacco?_____ Currently?_____ In the past? _____

If so, what kind? _____How often per day on average? _____ How many years past/current?_____

Family Background and Childhood History:

Were you adopted? _____ 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? _____ 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? _____

If so, who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? _____

If yes, please describe when, where and by whom: _____

_____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ If so, 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/status? _____

What is/was your occupation? _____

Name of current employer/past employer? _____

Have you ever served in the uniformed services? _____ If so, what branch and when? _____

Honorable Discharge? _____ 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? _____ If yes, how long? _____

Are you sexually active? _____

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? _____ If so, how many? ___

If applicable, specify duration all prior marriages? _____

Do you have children? _____ 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? _____ If so, what was the charge and when did it occur?_____

Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? _____

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_____ Telephone # _____

For Office Use Only: