Patient - Mental Health Intake Form

Confidential Information

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 ______________________________

Current Therapist/Counselor ____________________ Therapist's Phone ______________

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
( ) 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
( ) ______________
( ) ______________

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 **PAST MEDICAL HISTORY**

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? ( ) Yes ( ) No

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? ( ) Yes ( ) No

If yes, please explain. ______________________________

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 over-the-counter medications or supplements: ____

Current medical problems: ____
____

Past medical problems, non-psychiatric hospitalization, or surgeries: ______________________________________
____
____

Have you ever had an EKG? ( ) Yes, if yes when ______________________ ( ) No
Was the EKG findings ( ) Normal ( ) Abnormal or ( ) Unknown?

FOR FEMALE ONLY:

Date of last menstrual period__________________________ Currently pregnant or think you may 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? _________

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	( )	( )	
Stomach/Intestinal	( )	( )	
Cancer (Specify)	( )	( )	
Fibromyalgia	( )	( )	
Heart Disease	( )	( )	
Epilepsy or Seizures	( )	( )	
Chronic Pain	( )	( )	
High Blood Pressure	( )	( )	
High Cholesterol	( )	( )	
Head Trauma	( )	( )	
Liver Disease	( )	( )	
Other (Specify)	( )	( )	

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***, specify reason(s), when, and where:

Reason	Date(s) Treated	By Whom

Psychiatric Hospitalization: ( ) Yes ( ) No If ***YES***, specify reason(s), when, and where:

Reason	Date(s) Treated	Where

Past Psychiatric Medications:

List any psychiatric medication you have been prescribed. Please indicate the dates, dosage, and how helpful they were (if you cannot recall the details, list to the best of your abilities).

Medication(s)	Date(s)	Dosage(s)	Response/Side-Effects

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	( ) 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 psychiatric medication(s)? ( ) Yes ( ) No If **"YES"** , who was treated, what medication(s) prescribed, and how effective was treatment? ______________________________

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Substance Use:

Check if you have ever tried the following: If **"YES",** how long and last use?

Substance		If "YES", how long and last use?
Methamphetamine	( )Yes ( )No	
Cocaine	( )Yes ( )No	
Stimulants (Pills)	( )Yes ( )No	
Heroin	( )Yes ( )No	
LSD or Hallucinogens	( )Yes ( )No	
Marijuana	( )Yes ( )No	
Pain Killers (not as prescribed)	( )Yes ( )No	
Methadone	( )Yes ( )No	
Tranquilizer/Sleeping Pills	( )Yes ( )No	
Alcohol	( )Yes ( )No	
Ecstasy	( )Yes ( )No	
Other(s)	( )Yes ( )No	

How many caffeinated beverage(s) do you drink a day? Coffee _________ Sodas ________ Tea __________

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No If **"YES"**, please continue.

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 dayon average? __________ How many years? __________

Social History:

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: ____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed How long? ____________

Do you have children? ( ) Yes ( ) No If **"YES"**, list age(s) and gender(s): ________________________

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Legal History:

Have you ever been arrested? ? ( ) Yes ( ) No Do you have any pending legal problems? ( ) Yes ( ) No

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Patient's Signature: ____________________________________ **Date:** ______________________

Guardian's Signature: (if underage 18) _____________________ **Date:** ______________________

Emergency Contact: ____________________________________ **Telephone #:** __________________

For Office Use Only:

Reviewed by____Date__________________________