

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	
Primary Care Physician	Date of Birth	
Do you give permission for ongoing regular updates to be provided to your primary care physician?		Yes/No
Current Therapist/Counselor		
Therapist's Phone Number		
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)		
<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Racing thoughts	<input type="checkbox"/> Excessive worry
<input type="checkbox"/> Unable to enjoy activities	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Anxiety attacks
<input type="checkbox"/> Sleep pattern disturbance	<input type="checkbox"/> Increase risky behavior	<input type="checkbox"/> Avoidance
<input type="checkbox"/> Loss of interest	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Concentration / Forgetfulness	<input type="checkbox"/> Decrease need for sleep	<input type="checkbox"/> Suspiciousness
<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Excessive energy	<input type="checkbox"/> Decreased libido
<input type="checkbox"/> Excessive guilt	<input type="checkbox"/> Increased irritability	<input type="checkbox"/>
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Crying spells	<input type="checkbox"/>
Suicide Risk Assessment		
Have you ever had feelings or thoughts that you didn't want to live? Yes / No		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?	Yes / No
Is the method you would use readily available?	Yes / No
Have you planned a time for this?	Yes / No
Is there anything that would stop you from killing yourself?	
Do you feel hopeless and/or worthless?	Yes / No
Have you ever tried to kill or harm yourself before?	Yes / No
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, nonpsychiatric hospitalization, or surgeries

Have you ever had an EKG?

Yes / No

If yes, when

Was the EKG () normal () abnormal or () unknown?

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?				
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 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?				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, please describe when, by whom, and nature of treatment			
Reason	Dates Treated	By Whom	
Psychiatric Hospitalization			Yes / No
If yes, please describe for what reason, when and where			
Reason	Date Hospitalized	Where	
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).			
Antidepressants	Dates	Dosage	Response/Side-Effects
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	Dates	Dosage	Response/Side-Effects
Tegretol (carbamazepine)			

Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			
Antipsychotics /Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other			
Sedative/Hypnotics	Dates	Dosage	Response/Side-Effects
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			
ADHD medications	Dates	Dosage	Response/Side-Effects
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Other			
Antianxiety medications	Dates	Dosage	Response/Side-Effects
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			

Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Other			
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 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 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

Have you used any street drugs in the past 3 months?			Yes / No
Have you ever abused prescription medication?			Yes / No
If yes, which ones and for how long?			
Have ever tried the following:	Yes	No	If yes, how long and when did you last use?
Methamphetamine			
Cocaine			
Stimulants (pills)			
Heroin			
LSD or Hallucinogens			
Marijuana			
Pain killers (not as prescribed)			
Methadone			
Tranquilizer/sleeping pills			
Alcohol			
Ecstasy			
Other			
How many caffeinated beverages do you drink a day?			
Coffee	Sodas	Tea	
Tobacco History			
How you ever smoked cigarettes?			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?			
Pipe, cigars, or chewing tobacco:			
Currently?			Yes / No
In the past?			Yes / No
What kind?			
How often per day on average?			
How many years?			

Family Background and Childhood History

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?	
Were you adopted?	Yes / No
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?	Yes / No
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 university?	Yes / No
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?

Yes / No

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 ages and gender:

Describe your relationship with your children:

List everyone who currently lives with you:

Legal History

Have you ever been arrested?

Yes / No

Do you have any pending legal problems?

Yes / No

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 _____ Telephone _____