Mental Health Intake Form

Please complete all information on this form and bring it to the first visit.

Name:_____ Date:_____

Date of Birth: _____ Age:_____ Race:_____ Gender:_____

Contact Number:_____ May we leave a message () Yes No()
Address: _____
_____
Email: _____* *Please note; Email correspondence is not considered to be a confidential medium of communication*
Insurance Information (Type & Member Number): _____
_____

What are the problem(s) for which you are seeking help?
1._____
2._____
3._____

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 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. _____

Trauma History:

Do you have a history of being abused verbally, emotionally, sexually, physically or by neglect? ( ) Yes ( ) No

Please describe when and what type of abuse: _____
_____

Family Background and Childhood History:
Where were your born? _____ Where did you grow up? _____

Who were you raised by? _____

Do you have any siblings, if yes, how many and what birth order are you (e.g. oldest; middle; youngest)?_____
_____
_____

If your parents were married, are they still married?( ) Yes ( ) No If not, how old were you when they divorced? _____ If your parents divorced, who did you live with_____

Describe your relationship with your family of origin: _____
_____
Has anyone in your immediate family died? _____
Who and when? _____

Educational History:
What is your highest educational level or degree attained? _____
What kind of student were you? _____
Were you ever held back a grade?_____

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

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 those who currently lives with you: _____

Medical History: ***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: _____
_____

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, and 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 psychotropic medications or mood stabilizers, if so 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).
_____
_____
_____

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
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? _____
_____

Check if you 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, vaping, or chewing tobacco: Currently? **( )** Yes **( )** No In the past? **( )** Yes **( )** No
What kind? _____ How often per day on average? _____ How many years? _____

Family Psychiatric History:
Has anyone in your family been diagnosed with or treated for a mental condition? ( ) Yes ( ) No

If yes, who, and for what ? _____
_____
_____
_____

Legal History:
Have you ever been arrested? _____ If so, for what? _____

Have you ever been convicted?_____ If so, for what? _____

Have you ever been incarcerated?_____ If so, for what and how long? _____

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 _____ Telephone # _____

For Office Use Only:

Reviewed by _____Date _____

Reviewed by _____Date _____