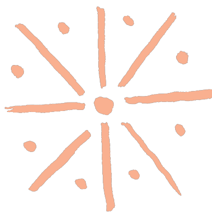

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Mental Health Intake Form

This form will help ensure we have a good understanding of your history, so we can help you to the best of our ability.

Date filling out this form____________________

Name____ **Date of Birth**____________________

Phone________________________ **Email**____

Address____

Primary Care Physician (PCP)__________________________________ **Phone(___)**_____________
Most recent appointment_________________

Psychiatrist or other Specialist_______________________________ **Phone(___)**_____________
Most recent appointment_________________

Current Therapist/Counselor__________________________________ **Phone(___)**_____________
Most recent appointment_________________

(Please sign attached for Consent to Release with Therapist and PCP for ongoing regular updates)

In case of emergency who are we to contact?

Name: __________________________________ Relationship to Client _______________________

Phone: (____)__________________

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

1)____

2)____

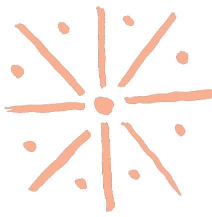
3)____

What are your personal treatment goals?

____

____

____



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Current Symptom Checklist: **check once for any symptom present and twice for any major symptoms**

( )Depressed mood	( )Racing thoughts	( )Excessive worry
( )Unable to enjoy activities	( )Impulsivity	( )Anxiety attacks
( )Sleep pattern disturbance	( )Increase risky behavior	( )Avoidance
( )Loss of interest	( )Increase libido	( )Hallucinations
( )Concentration/forgetfulness	( )Decrease need for sleep	( )Suspiciousness
( )Change in appetite	( )Excessive energy	( )Decreased libido
( )Excessive guilt	( )Increased irritability	( )_______________
( )Fatigue	( )Crying spells	( )_______________

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? Yes or No

If YES, please answer the following question. If NO, please skip to the next section.

Do you currently feel that you do not want to live? Yes or No

Past Medical History:

Current Weight_____________ Height _____________ Allergies ____________________________________

List ALL current prescriptions and how often you take them (in none, write none)

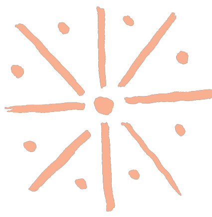
Medication name	Total daily dosage	Estimate state date
________________________________	________________________	__________________________
________________________________	________________________	__________________________
________________________________	________________________	__________________________
________________________________	________________________	__________________________
________________________________	________________________	__________________________

Current over-the-counter medications or supplements____

____

Past medical problems, non-psychiatric hospitalization, or surgeries________________________________

____



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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--------------------------------------	( )	( )	______________________________

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

Bipolar	( )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

Is there any additional personal or family medical history? Yes or No. If Yes, please explain below:

____

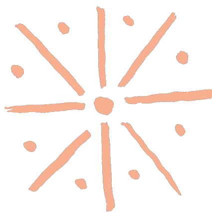
____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?
Yes or No
If yes, please explain the circumstances:

____

____

Family Background and Childhood History:



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Were you adopted? Yes or No Where did you grow up?________________________________

List your siblings and their ages: ____

Did your parents divorce? Yes or No If Yes, how old were you when they divorced? ______________

Describe your father and your relationship with him:____

____

Describe your mother and your relationship with her:____

____

Past Psychiatric History:
Outpatient Treatment: Yes or No
If yes, please describe when, by whom and nature of the treatment.

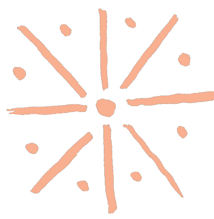
Reason	Date treated	By whom

Psychiatric Hospitalization: Yes or No
If yes, please describe for what reason, when and where.

Reason	Date treated	By whom

Past Psychiatric medications:
If you have ever taken any of the following medications, please include the dates, dosage, and how helpful they were. If you cannot remember all the details, just write in what you do remember.

Antidepressants	**Dates**	**Dosage**	**Response/Side effects**
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (flubozamine)			



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Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (excitalopram)			

Past Psychiatric Medications: (Continued)

	Dates	Dosage	Response/Side effects
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mitazapine)			
Serzone (nefazodone)			
Anafrainil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Pristiq (Desvenlafaxine)			
Fetzima (levomilnacipran)			
Savella (milnacipran)			
Brintellix (votioxetine)			
Viibryd (vilazodone)			
Other			

Mood Stabilizers

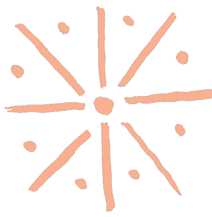
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Topamax (topiramate)			
Neurontin (gabapeatin)			
Lyrica (pregabalin)			
Other			

Antipsychotics/Mood Stabilizers

Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolizin (fluphenazine)			
Ripserdal (risperidone)			
Vraylar (cariprazine)			

Sedative/Hypnotics

Ambien (zolpidem)			
Sonata (zaleplon)			



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Rozerem (ramelteon)	________	________	________
Restoril (temazepam)	________	________	________
Desyrel (trazodone)	________	________	________
Lunesta	________	________	________

Past Psychiatric Medications: (Continued)

	Dates	**Dosage**	**Response/Side effects**
Belsomra	________	________	________
Triazolam	________	________	________
Other	________	________	________
ADHD medications			
Adderall (amphetamine)	________	________	________
Concerta (methylphenidate)	________	________	________
Ritalin (methylphenidate)	________	________	________
Strattera (atomoxetine)	________	________	________
Provigil (mondafinil)	________	________	________
Nuvigil (armodafinil)	________	________	________
Vyvanse (lisdexamfetamine)	________	________	________
Dexedrine (dextoamphetamine)	________	________	________
Other	________	________	________
Antianxiety medications			
Xanax (alprazolam)	________	________	________
Ativan (lorazepam)	________	________	________
Klonopin (clonazepam)	________	________	________
Valium (diazepam)	________	________	________
Tranxene (clorazepate)	________	________	________
Buspar (buspirone)	________	________	________
Vistaril (hydroxyzine)	________	________	________
Other	________	________	________

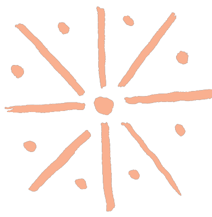
Your Exercise Level:
Do you exercise regularly? Yes or No
How many days a week do you exercise? ____________________
How many times each day do you exercise? ____________________
What kind of exercise do you do? ______________________________

Substance use:
Have you ever been treated for alcohol or drug use or abuse? Yes or No

If Yes, for which substances? ____

If Yes, where were you treated and when? ____

____



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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 or No

Have people annoyed you by criticizing your drinking or drug use? Yes or No

Have you ever felt bad or guilty about your drinking or drug use? Yes or No

Do you think you may have a problem with alcohol or drug use? Yes or No

Have you used any street drugs in the past 3 months? Yes or No
If Yes, which ones? ____

Have you ever abused prescription medication? Yes or No
If Yes, which ones and for how long? ____

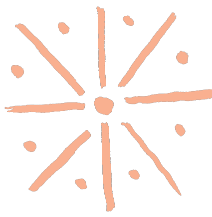
Check if you have ever tried any of the following:

	Yes	No	If Yes, for 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 _______ Soda ______ Tea _______

Tobacco History:
Have you ever smoked or vaped cigarettes? Yes or No Currently? Yes or No

How many packs per day on average? ____________ How many years? ____________



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Education History:
Highest Grade Completed ______________ Where? ____

Did you attend college? _____________ Where? _______________________ Major ___________________

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 or No Other type of 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 or No If Yes, how long? ___________________

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 or No If Yes, how many?______________________________

Do you have children? Yes or No If Yes, list ages and gender __________________________________

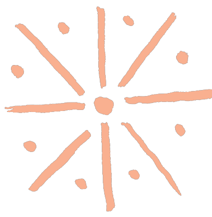
Describe your relationship with your children: ____

____

List everyone who currently lives with you:

Name	Age	Relationship to Client

Legal History:



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Have you ever been arrested? Yes or No

Do you have any pending legal problems? ____

Spiritual Life:
Do you belong to a religion or spiritual group? Yes or No

If Yes, what is the level of your involvement? ___________________________

List your strengths and hobbies:

____

____

____

Is there anything else that you would like us to know? ____________________________________

____

____

____

____

Signature ____ Date _________________________