Mental Health Intake Form

Date:_____

Name:_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

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

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.	

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No | If yes, please describe when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

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 (sertaline)			
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			

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Past Psychiatric Medications (continued)

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

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Substance Use:

Have you ever been treated for alcohol or drug use?	( ) Yes ( ) No
If yes, for which substance(s)?	
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 o drinks you will drink in a day?	
In the pas 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:

		If yes, how long and when did you 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	( ) Yes ( ) No	

How many caffeinated beverages do you drink a day?	Coffee		Sodas		Tea	

Tobacco History:

Have 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?		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?	( ) Yes ( ) No	If yes, how old were you when they divorced?	
If your parents divorced, who did you live with?			
Describe your father and your relationship with him:			

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Family Background and Childhood History (continued)

Describe your mother and your relationship with her:

How old were you when you left home?

Has anyone in your immediate family died?

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 college? ( ) 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 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 ( ) 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 yes, how many? | How long?

Do you have any 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 toa 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? ( ) Yes ( ) No

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Additional Information:

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	