

## Psychiatric Mental Health Intake Form

Please complete ALL information on this form before your first appointment. Many of the questions require only a check, and this allows your provider to spend more time discussing the relevant information. Thank you!

Name \_\_\_\_\_ Date \_\_\_\_\_  
Date of Birth \_\_\_\_\_

Current Therapist/Counselor \_\_\_\_\_ Therapist's Phone \_\_\_\_\_  
Do you give permission for contact with your therapist? \_\_\_\_\_

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What has been stressing you of late (e.g. Family, job, loss of loved one, finances)?

---

---

---

With starting (and/or continuing) treatment, what are your primary treatment goals?

---

---

### Current Symptoms Checklist:

(check once for any symptoms present, twice for major symptoms)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Depressed mood                                     | <input type="checkbox"/> Uncontrollable grunts, tics, or jerks                      | <input type="checkbox"/> Avoidance                                  |
| <input type="checkbox"/> Racing thoughts                                    | <input type="checkbox"/> Unable to enjoy activities                                 | <input type="checkbox"/> Loss of interest/motivation                |
| <input type="checkbox"/> Talking too fast                                   | <input type="checkbox"/> Tense muscles  | <input type="checkbox"/> Increased libido                           |
| <input type="checkbox"/> Worrying excessively                               | <input type="checkbox"/> Impulsivity (Spending, speeding)                           | <input type="checkbox"/> Decreased libido                           |
| <input type="checkbox"/> Feeling awkward in public                          | <input type="checkbox"/> Anxiety attacks  | <input type="checkbox"/> You need help caring for yourself          |
| <input type="checkbox"/> Thoughts that replay                               | <input type="checkbox"/> Increased risky behavior                                   | <input type="checkbox"/> Forgetting how to do tasks                 |
| <input type="checkbox"/> Repetitive or compulsive behaviors                 | <input type="checkbox"/> Traumatic events that come back in nightmares, flashbacks? | <input type="checkbox"/> Memory problems                            |
| <input type="checkbox"/> Hearing voices                                     | <input type="checkbox"/> Phobias or fears?  | <input type="checkbox"/> Strong feelings of guilt                   |
| <input type="checkbox"/> Seeing things other people don't see               | <input type="checkbox"/> Suspiciousness   | <input type="checkbox"/> Feelings of worthlessness                  |
| <input type="checkbox"/> Feeling people are trying to harm you or watch you | <input type="checkbox"/> Eating too much  | <input type="checkbox"/> Feelings of hopelessness                   |
| <input type="checkbox"/> Problems with concentration/forgetfulness          | <input type="checkbox"/> Eating too little  | <input type="checkbox"/> Periods of euphoria or unusually good mood |
| <input type="checkbox"/> Going days without needing to sleep                | <input type="checkbox"/> Changes in appetite  | <input type="checkbox"/> Increased irritability                     |
| <input type="checkbox"/> Problems going to sleep                            | <input type="checkbox"/> Has this resulted in weight change                         | <input type="checkbox"/> Fatigue/ Poor energy                       |
| <input type="checkbox"/> Sleep pattern disturbance                          | <input type="checkbox"/> Having very high energy for no reason?                     | <input type="checkbox"/> Inattentiveness at work or school          |
| <input type="checkbox"/> Problems finding words                             | <input type="checkbox"/> Concern about alcohol use                                  | <input type="checkbox"/> Getting lost easily                        |
| <input type="checkbox"/> Hyperactive or fidgety                             | <input type="checkbox"/> Concern about drug use                                     | <input type="checkbox"/> _____                                      |
| <input type="checkbox"/> Crying spells                                      |   | <input type="checkbox"/> _____                                      |

**Medical History:**

Primary Care Physician \_\_\_\_\_

Do you give permission for ongoing updates to be provided to your primary care physician, including but not limited to lab-work and medication changes? \_\_\_\_\_

Current Weight \_\_\_\_\_ Height \_\_\_\_\_

Allergies to medications (medication name and type of reaction):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List ALL current prescription medication name, dosage, and how often you take them: (if none, write none)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current over-the-counter medications or supplements:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past medical non-psychiatric hospitalization or surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had an EKG?  Yes  No If yes, when \_\_\_\_\_ .

Was the EKG  normal  abnormal or  unknown?

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

\_\_\_\_\_

Date and place of last physical exam: \_\_\_\_\_

**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? \_\_\_\_\_

Miscarriages?  Yes  No

Elective abortions?  Yes  No



**Past Psychiatric Medications:**

If you have ever taken any of the following medications, please indicate the dates, dosage, and whether they were helpful or had side effects (just write what you do remember).

**Antidepressants/Anxiolytics**

- Prozac (fluoxetine) \_\_\_\_\_
- Zoloft (sertraline) \_\_\_\_\_
- Luvox (fluvoxamine) \_\_\_\_\_
- Paxil (paroxetine) \_\_\_\_\_
- Celexa (citalopram) \_\_\_\_\_
- Lexapro (escitalopram) \_\_\_\_\_
- Effexor (venlafaxine) \_\_\_\_\_
- Pristiq (desvenlafaxine) \_\_\_\_\_
- Cymbalta (duloxetine) \_\_\_\_\_
- Wellbutrin (bupropion) \_\_\_\_\_
- Serzone (nefazodone) \_\_\_\_\_
- Anafranil (clomipramine) \_\_\_\_\_
- Pamelor (nortrptyline) \_\_\_\_\_
- Tofranil (imipramine) \_\_\_\_\_
- Elavil (amitriptyline) \_\_\_\_\_
- Buspar (buspirone) \_\_\_\_\_
- Viibryd \_\_\_\_\_
- Trintellix \_\_\_\_\_
- Other \_\_\_\_\_

**Mood Stabilizers**

- Tegretol (carbamazepine) \_\_\_\_\_
- Lithium \_\_\_\_\_
- Depakote (valproate) \_\_\_\_\_
- Lamictal (lamotrigine) \_\_\_\_\_
- Trileptal (Oxcarbazepine) \_\_\_\_\_
- Topamax (topiramate) \_\_\_\_\_
- Neurontin (gabapentin) \_\_\_\_\_
- Other \_\_\_\_\_

**Antipsychotics/Mood Stabilizers**

- Seroquel (quetiapine) \_\_\_\_\_
- Zyprexa (olanzepine) \_\_\_\_\_
- Geodon (ziprasidone) \_\_\_\_\_
- Abilify (aripiprazole) \_\_\_\_\_
- Clozaril (clozapine) \_\_\_\_\_
- Haldol (haloperidol) \_\_\_\_\_
- Prolixin (fluphenazine) \_\_\_\_\_
- Risperdal (risperidone) \_\_\_\_\_
- Vraylar \_\_\_\_\_
- Rexulti \_\_\_\_\_
- Latuda \_\_\_\_\_
- Other \_\_\_\_\_

**Past Psychiatric Medications (continued):**

**Sedative/Hypnotics**

Ambien (zolpidem) \_\_\_\_\_  
Sonata (zaleplon) \_\_\_\_\_  
Lunesta ( ) \_\_\_\_\_  
Restoril (temazepam) \_\_\_\_\_  
Desyrel (trazodone) \_\_\_\_\_  
Remeron (mirtazapine) \_\_\_\_\_  
Other \_\_\_\_\_

**ADHD medications**

Adderall (amphetamine-dextroamphetamine) \_\_\_\_\_  
Concerta/Ritalin (methylphenidate) \_\_\_\_\_  
Vyvanse (lisdexamphetamine) \_\_\_\_\_  
Strattera (atomoxetine) \_\_\_\_\_  
Other \_\_\_\_\_

**As needed medications**

Xanax (alprazolam) \_\_\_\_\_  
Ativan (lorazepam) \_\_\_\_\_  
Klonopin (clonazepam) \_\_\_\_\_  
Valium (diazepam) \_\_\_\_\_  
Other \_\_\_\_\_

**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
- Anxiety ( ) Yes ( ) No
- Obsessive Compulsive Disorder ( ) Yes ( ) No
- Anger ( ) Yes ( ) No
- Other substance abuse ( ) Yes ( ) No
- Suicide ( ) Yes ( ) No
- Violence ( ) Yes ( ) No
- Other ( ) Yes ( ) No

If yes, who had each problem?

\_\_\_\_\_

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No

If yes, what medications did they take, and how effective was the treatment?

\_\_\_\_\_

\_\_\_\_\_

**Substance Use History:**

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? \_\_\_\_\_

**Alcohol**

In the past two months:

How many days per week do you drink any alcohol? \_\_\_\_\_

What is the least number of drinks you drink in a day? \_\_\_\_\_

What is the most number of drinks you drink in a day? \_\_\_\_\_

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? \_\_\_\_\_

**Drug Use**

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 experimented with the following:

*(If yes, note how long and when you last tried it)*

- Methamphetamine ( ) \_\_\_\_\_
- Cocaine ( ) \_\_\_\_\_
- Stimulants (pills) ( ) \_\_\_\_\_
- Heroin ( ) \_\_\_\_\_
- LSD or Hallucinogens ( ) \_\_\_\_\_
- Marijuana ( ) \_\_\_\_\_
- Pain killers (not as prescribed) ( ) \_\_\_\_\_
- Methadone ( ) \_\_\_\_\_
- Tranquilizer/sleeping pills ( ) \_\_\_\_\_
- Ecstasy ( ) \_\_\_\_\_
- Other ( ) \_\_\_\_\_

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

**Caffeine**

How many caffeinated beverages do you drink a day?

Coffee \_\_\_\_\_ Sodas \_\_\_\_\_ Tea \_\_\_\_\_

Do you have any adverse effects to caffeine or sensitivity? \_\_\_\_\_

**Tobacco History:**

How you ever smoked cigarettes, pipes, cigars or chewed tobacco? ( ) Yes ( ) No  
Currently? ( ) Yes ( ) No If not currently, when did you quit? \_\_\_\_\_  
How many years did you use nicotine/tobacco? \_\_\_\_\_  
Have you ever tried to quit? ( ) Yes ( ) No If yes, how long did it last: \_\_\_\_\_  
How many packs per day (for pipes/chewing tobacco - how often per day)? \_\_\_\_\_

**Social History:**

**Childhood and Family:**

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? \_\_\_\_\_  
Did your parents' divorce? ( ) No ( ) Yes, If yes, how old were you? \_\_\_\_\_  
If your parents divorced, who did you live with? \_\_\_\_\_  
How old were you when you left home? \_\_\_\_\_  
Has anyone in your immediate family died? \_\_\_\_\_  
If so, who and when? \_\_\_\_\_  
\_\_\_\_\_

**Educational History:**

Highest Grade Completed? \_\_\_\_\_ Where? \_\_\_\_\_  
Any struggles at school (bullying, dyslexia, etc)? \_\_\_\_\_  
Did you attend college? \_\_\_\_\_ Where? \_\_\_\_\_  
Major? \_\_\_\_\_  
What is your highest educational level or degree attained? \_\_\_\_\_  
List any certifications or additional training: \_\_\_\_\_

**Occupational History:**

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired  
How long in the present position? \_\_\_\_\_  
What is/was your occupation? \_\_\_\_\_  
Where do you work? \_\_\_\_\_  
Have you ever served in the military? \_\_\_\_\_  
If so, what branch and when? \_\_\_\_\_  
Were you ever stationed somewhere with live combat? \_\_\_\_\_  
If so, where and when? \_\_\_\_\_  
Honorable discharge ( ) Yes ( ) No, If no, \_\_\_\_\_

**Relationship History and Current Family:**

Are you currently:  Married  Partnered  Divorced  Single  Widowed  
Since what year? \_\_\_\_\_

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 did each last? \_\_\_\_\_

Do you have any children?  Yes  No  
If yes, list name, year born, and gender: \_\_\_\_\_  
\_\_\_\_\_

Describe your relationship with your children:  
\_\_\_\_\_

List everyone who currently lives with you, and their relationship to you:  
\_\_\_\_\_  
\_\_\_\_\_

**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? \_\_\_\_\_

**Spiritual Life:**

Do you belong to a particular religion or spiritual group?  Yes  No  
If no, do you have any religious or spiritual belief, or consider yourself agnostic, atheist,  
or undecided? \_\_\_\_\_  
If yes, what is the level of your involvement? \_\_\_\_\_  
Do you find your involvement helpful at this time, or does the involvement make things  
more difficult or stressful for you?  more helpful  stressful



