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)

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

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

Personal and Family Medical History:

	You	Family
Chronic Fatigue ---------	( )	( )
Chronic Pain ----------	( )	( )
Fibromyalgia ----------	( )	( )
Epilepsy/seizures --------	( )	( )
Head trauma/concussion	( )	( )
Migraines/headaches----	( )	( )
Glaucoma----------	( )	( )
Heart Disease ----------	( )	( )
High Cholesterol --------	( )	( )
High blood pressure-----	( )	( )
Asthma/breathing issues	( )	( )
Sleep apnea----------	( )	( )
Stomach/GI issues----- -	( )	( )
IBS/constipation/diarrhe	( )	( )
Anemia----------	( )	( )
Liver Disease/ problems	( )	( )
Kidney Disease ----------	( )	( )
Diabetes ----------	( )	( )
Thyroid Disease ---------	( )	( )
Muscle/joint problems--	( )	( )
Cancer (type) ----------	( )	( )

Legal History:

Have you ever been arrested? _____

Do you have any history of DUI/DWI? _____

Do you have any pending legal problems? _____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No

If yes, Reason Year Treated Facility/Provider

_____

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No

If yes, Reason Date Hospitalized Where

_____

_____

_____

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

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

Date completed: _____

Emergency Contact _____
Telephone # _____

For Office Use Only:
Reviewed by _____Date _____