Mental Health Intake Form

Holistic Approach Mental Health
7452 Baltimore-Annapolis Blvd.
Glen Burnie, MD 20161

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by the federal law.

Name: ___________________________________ Date: _______________________________
Home Address: ____
City: _____________________ State: ________________ Zip Code: ______________________
Home Phone: ____________________________ Cell Phone: ______________________________

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

Why are you scheduling appointment?
____
____

Current 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
Increased risky behavior
Decrease need for sleep
Excessive energy
Increased irritability
Crying spells
Excessive worry
Anxiety attacks
Avoidance
Hallucinations
Suspiciousness

Other: ____

Relationship History and Current Family:

Marital Status: Single Married Separated Divorced Remarried Engaged Widowed Cohabiting
If married, how long? _______________________
Partner's Name: ____________________________ Age: __________ Occupation: _____________
Describe your relationship with your spouse: ____
Have you had previous marriages? No Yes If so, how many? ________________________
If not married, are you currently in a relationship? No Yes; how long: _________________
Are you sexually active: Yes No
Sexual Orientation: Homosexual Heterosexual Bisexual I choose to not answer

If applicable, please complete the following:

If you have children, please list their name and ages:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

Who currently lives in your residence (Adult and Children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

Educational History

Highest grade completed: ________________________

Did you attend college: Yes No

Degree Obtained: ________________________________

Occupational History

Are you currently working: Working Student Unemployed Disabled Retired

How long in this present position? ____

What is/was your occupation: _________________________ Where? _________________________

Have you served in military: Yes No

How long were you enlisted? ____

What type of discharge did you receive? ____

Childhood History

Were you adopted? Yes No

Where did you grow up? ____

How many siblings do you have and their ages? ____

Did your parents' divorce? No Yes; how old were you? _________________

What was your home environment like? Stable Not Stable

Legal History

Have you ever been arrested? Yes No

If yes, please describe: ____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for: Please specify who, if yes.

Bipolar Disorder: _____________

Depression: _________________

Anxiety: ____________________

Anger: ______________________

Suicide: _____________________

Schizophrenia: _________________

Post-traumatic stress: ____________

Alcohol abuse: _________________

Other substance abuse: ___________

Violence: _______________________

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?

____

____

____

____

Trauma History

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

Please describe when, where, and by whom:

____

____

Have you ever been abused?

Verbally Physically

Emotionally Sexually

Please describe:

____

____

Have you ever had suicidal thoughts? Yes No

If yes, please fill out the suicidal risk assessment.

Past Psychiatric History

Outpatient history Yes No

If yes, please describe why, when, and where you were treated:

____

____

Psychiatric Hospitalizations Yes No

If yes, please describe why, when, and where you were treated:

Hospital	**Dates**	**Reason**

Past Medications and Treatments

If you have ever taken any **PSYCHIATRICS medications**, please indicate the name, dates, dosage, and how helpful they were:

Medication	**Dosage**	**First/Last time you took it**	**Effect of Medication**

Are you currently taking **NON-PSYCHIATRIC** medications? Yes No

Medication	**Dosage**	**How long have you been taking it?**

Do you currently see a therapist of counselor? Yes No

If yes, who: ________________________ Phone #: ________________________

Medical History

Are you **CURERNTLY** under treatment for any medical condition? No Yes

If yes, please describe:

____

____

List any prior illnesses, operations, and accidents

____

____

Date and place of last physical exam: ____

Substance Abuse History

Alcohol

Do you drink alcohol? Yes No

If yes, age of first use: _________________________

How much do you drink? _____________________________

How often do you drink? _____________________________

Have you ever passed out from drinking? No Yes; how often? ____________

Have you ever blacked out from drinking? No Yes; how often? ____________

Have you ever had the "shakes"? No Yes; how often? ____________

Have you ever felt you should cut down on your drinking/drug use? No Yes

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

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

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? ___

Tobacco

Do you use tobacco? No Yes; how often? _________________

Are you currently smoking cigarettes? Yes No

How many years have you been smoking? ___________________________

Have you used tobacco in the past? No Yes

How many years did you smoke? ____________________ When did you quit? _______________

Other drugs

Drug	Ever Used?	Age at 1st Use	Time Since Last Use	Appox. Use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				
Stimulants (Pills)				
LSD or Hallucinogens				
Pain Killers (Not prescribed)				
Methadone				
Tranquilizer/Sleeping Pills				

Suicide Risk Assessment

Please complete the following assessment if you have ever had suicidal thoughts.

Have you ever had feelings or thoughts that you did not want to live? Yes No

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? ______________________________________

On a scale of 1 to 10 (10 is the strongest), how strong is the desire to kill yourself currently? ___

Would anything make it better? ____

Has anything happened recently to make you feel this way?

____

____

Have you ever thought about how you would kill yourself? Yes No

Is the method you would use readily available? Yes No

Have you planned a time for this? Yes No

Is there anything that would stop you from killing yourself? ________________________________

Do you feel hopeless and/or worthless? Yes No

Have you ever tried to kill yourself before? Yes No

Do you have access to guns? No Yes

If yes, please explain: ____

PHQ-9 PATIENT DEPRESSION QUESTIONNAIRE

For initial diagnose:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 checks in the shaded second (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- If there are at least 5 checks in the shaded section (one of which corresponds to Question #1 and #2)

Consider Other Depressive Disorder

- If there are 2-4 checks in the shaded section (one of which corresponds to Question #1 and #2)

Note: Since the questionnaire relies on patient self-report, all responded should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up the checks by the column.
   For everything check: Several days = 1; More than half the days = 2; Nearly every day= 3
3. Add together column scores to get a TOTAL score.
4. Results may be included in patient files to assist you in setting up a treatment goal, determining degrees of response, as well as guiding treatment intervention.

Scoring:

Several days = 1; More than half the days = 2; Nearly every day= 3
Add up all checked boxed on PHQ-9.

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal Depression
5-9	Mild Depression
10-14	Moderate Depression
15-19	Moderately Severe Depression
20-27	Severe Depression

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ____ DATE: _______________________

Over the last TWO WEEKS, how often have you been bothered by any of these problems?

	Not at all	**Several Day**	**More than half the day**	**Nearly everyday**
Little interest of pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
TOTAL				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all: _______

Somewhat difficult: ______

Very difficult: __________

Extremely difficult: ______