The Rajan Center for Family Wellness LLC

Adult Mental Health Intake Questionnaire

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly.

Name_____Date_____

Date of Birth _____ Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor_____ Therapist's Phone_____

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

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major 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
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

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 Medical History:

Allergies_____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none) Medication Name Total Daily Dosage Estimated Start Date

_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements: _____
_____

Current medical problems: _____
_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____
_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ .
Was the EKG ( ) normal ( ) abnormal or ( ) unknown**?**

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? _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No

Date and place of last physical exam: _____

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 ----------	( )	( )	_____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:
_____
_____

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

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment. Reason Dates Treated By Whom
_____
_____
_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.
Reason Date Hospitalized Where
_____
_____
_____

Past Psychiatric Medications: If you have ever taken any medications for anxiety, sleep, mood, addiction or psychotic symptoms, 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).

MEDICATION NAME	DATES USED	DOSAGE PRESCRIBED	RESPONSE/SIDE-EFFECTS

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No
How often do you get 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?

_____

Substance Use:

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? _____
_____
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 ( )
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:

	Yes	No	If yes, 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 _____ Sodas _____ Tea _____

Tobacco History:

How 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? _____

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? _____ 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? _____ If so, what branch and when?

_____

Honorable discharge ( ) Yes ( ) No Other type 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 so, how many? _____

How long? _____

Do you have 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? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a 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? ( ) more helpful ( ) stressful

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

Signature_____Date_____

Emergency Contact _____ Telephone # _____