Mental Health Intake Form

Please complete all information on this form. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank You!

Name_____Date_____

Address_____

Phone_____Email_____

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 () Racing Thoughts () Excessive worry

() Unable to enjoy activities () Impulsivity () Panic Attacks

() Sleep Patters Disturbance () Increase Risky Behavior () Avoidance

() Loss of Interest () Increased Libido () Hallucinations

() Lack of concentration () Decrease need for sleep () Suspiciousness

() Change in appetite () Excessive energy

() Fatigue () Increased Irritability

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 do not 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 from 1 to 10, (ten being the 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 from killing yourself?
Do you feel hopeless and/or worthless?
Have you tried to harm yourself before?
Do you have access to guns?

Medical History

Please list all current prescription medications and how often you take them:
If none, write none

_____
_____
_____

Current medical problems:_____

_____
_____

Past medical problems: _____

_____
_____

Past Psychiatric History:

Outpatient Treatment ( ) Yes ( ) No

If yes, please describe when and the nature of treatment:

_____

Psychiatric Hospitalization: ( ) Yes ( ) No
If Yes, please describe when and nature of treatment

_____

Have you ever taken any psychiatric medication such as Antidepressants, Mood Stabilizers, Antipsychotic/Mood Stabilizers, Sedatives, ADHD medications, Antianxiety medications?

If so, please indicate the dates, the dosage and how helpful they were

_____

_____

_____

Substance abuse

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, which substance? _____

If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____

Have you ever felt you ought to cut down on 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 get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Occupational History

Are you currently: ( ) Working, ( ) Student, ( ) Unemployed, ( ) Disabled, ( ) Retired

How long in present position? _____

Relationship History

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed
How long? _____

If not married, are you currently in a relationship? _____

Describe your relationship with your spouse or significant other:

_____

_____

Have you had any prior marriages? ( ) Yes ( ) No

Do you have children? ( ) Yes ( ) No

Describe your relationship with your children:

_____

_____

Is there anything else you would like me to know?

Signature_____ Date_____