**Mental Health Adult Intake Form**

**Please complete all information, front and back of these forms and bring to the first visit**. It may seem long, but most of the questions require only a check, so it will go quickly. This form is required for your initial intake appointment, so if it is not completed, you will be asked to fill it out in the lobby before seeing your provider. Thank you 

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | Click or tap here to enter text. | | | **Date**: | Click or tap here to enter text. | | |
| **Date of Birth:** | | Click or tap here to enter text. | **Primary Care Dr:** | | | Click or tap here to enter text. | |
| **Do you give permission for regular on-going updated to your Primary Care Provider?** | | | | | | | Y  N |

**What are your main concern(s) for which you are seeking assistance?**

|  |  |
| --- | --- |
| **1.** | Click or tap here to enter text. |
| **2.** | Click or tap here to enter text. |
| **3.** | Click or tap here to enter text. |

**Current Symptoms Checklist: (check once for any symptoms present):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Racing thoughts |  | Decreased need for sleep |  | Avoidance |
|  | Impulsivity |  | Excessive energy |  | Crying spells |
|  | Increased risky behavior |  | Excessive worry |  | Excessive guilt |
|  | Increased libido |  | Anxiety attacks |  | Suspiciousness |
|  | Decreased libido |  | Increased irritability |  | Hallucinations |

**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 below. If NO, please skip to the next section. (Depression Scale)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Do you currently feel that you don't want to live?** |  | | Yes |  | No | |
| **How often do you have these thoughts?** | | | | | | |
| Click or tap here to enter text. | | | | | | |
| **When was the last time you had thoughts of dying?** | | | | | | |
| Click or tap here to enter text. | | | | | | |
| **Has anything happened recently to make you feel this way?** | | | | | | |
| Click or tap here to enter text. | | | | | | |
| **Have you had recent thoughts of suicide?** |  | | Yes |  | No | |
| **If Yes, do you have a plan? (please explain)** |  | | Yes |  | No | |
| Click or tap here to enter text. | | | | | | |
| **Is there anything that would stop you from killing yourself? (please explain)** |  | | Yes |  | No | |
| Click or tap here to enter text. | | | | | | |
| **Do you feel hopeless and/or worthless?** |  | Yes | |  | | No |
| **Have you ever tried to kill or harm yourself before?** |  | | Yes |  | No | |

**DEPRESSION SCREEN:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the past TWO weeks, how often have you been bothered by the follow concerns?** | **Not at all** | **Several Days** | **Half the days** | **Nearly Everyday** |
| 1. Little interest or pleasure in doing things |  |  |  |  |
| 2. Feeling down, depressed, or hopeless |  |  |  |  |
| 3. Trouble falling or staying asleep, or sleeping  too much |  |  |  |  |
| 4. Feeling tired or having little energy |  |  |  |  |
| 5. Poor appetite or overeating |  |  |  |  |
| 6. Feeling bad about yourself---or that you are a  failure or have let yourself or your family down |  |  |  |  |
| 1. Trouble concentrating on things such as reading |  |  |  |  |
| 1. 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 |  |  |  |  |
| 1. Thoughts that you would be better off dead or   of hurting yourself in some way |  |  |  |  |

**How *difficult* have these concerns impacted your work, home life or relationships? (*please*  *one)***

Not difficult at all  Somewhat difficult  Very difficult  Extremely difficult

**Anxiety Screen**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the past TWO weeks, how often have you been bothered by the following concerns?** | **Not at all** | **Several Days** | **Half the days** | **Nearly Everyday** |
| 1. Feeling nervous, anxious or on edge |  |  |  |  |
| 2. Not being able to stop or control worrying |  |  |  |  |
| 3. Worrying too much about different things |  |  |  |  |
| 4. Troubling relaxing |  |  |  |  |
| 5. Being so restless that it is hard to sit still |  |  |  |  |
| 6. Becoming easily annoyed or |  |  |  |  |
| 7. Feeling afraid as if something awful might happen |  |  |  |  |

**Trauma Screening:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Have you been threatened with death, serious injury or sexual violence? |  | | Yes | |  | | No | |
| Do you have intense memories of a previous traumatic events? |  | | Yes | |  | | No | |
| Do you avoid people, places or things associated with a traumatic event? |  | | Yes | |  | | No | |
| Have your thoughts/moods been negatively impacted by a traumatic event? |  | | Yes | |  | | No | |
| Do you feel numb, detached or isolated from other? |  | | Yes | |  | | No | |
| Do you have intense mood swings (Sudden change in your mood) |  | | Yes | |  | | No | |
| Have you been abused emotionally, sexually, physically or by neglect? When, Where and by whom? | |  | | Yes | |  | | No |
| Click or tap here to enter text. | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **List ALL your current medications, how often you take them, and how long you’ve been taking them (if none, write none)** | | |
| **Medication name:** | **Dosage? (*Example: One Pill twice a day – 30mg per pill*)** | **How long on medication?** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

|  |  |
| --- | --- |
| **List ALL over the counter medications that you take and how often:** | |
| **Name of Medication** | **How often** |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

**Legal Info:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever been arrested? |  | Yes |  | No |
| Do you have any pending Legal issues? |  | Yes |  | No |
| Is this Visit referred by the courts, probation office, or any other legal entities? |  | Yes |  | No |

**Past Psychiatric History:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Have you received Outpatient counseling services at any other facilities?** | | | | | |  | Yes |  | No |
| Where: | Click or tap here to enter text. | Reason: | | | Click or tap here to enter text. | | | | |
| When: | Click or tap here to enter text. | Provider: | | | Click or tap here to enter text. | | | | |
| Where: | Click or tap here to enter text. | Reason: | | | Click or tap here to enter text. | | | | |
| When: | Click or tap here to enter text. | Provider: | | | Click or tap here to enter text. | | | | |
| **Have you ever been admitted for Mental Health issues before? List the latest** | | | | | |  | Yes |  | No |
| Where: | Click or tap here to enter text. | | Reason: | Click or tap here to enter text. | | | | | |
| When: | Click or tap here to enter text. | | Provider: | Click or tap here to enter text. | | | | | |
| Where: | Click or tap here to enter text. | | Reason: | Click or tap here to enter text. | | | | | |
| When: | Click or tap here to enter text. | | Provider: | Click or tap here to enter text. | | | | | |

**Past Psychiatric Medications: (*please*  all that apply*)***

Antidepressants:

Prozac (fluoxetine)

Zoloft (sertraline)

Luvox (fluvoxamine)

Paxil (paroxetine)

Celexa (citalopram)

Lexapro (escitalopram)

Effexor (venlafaxine)

Cymbalta (duloxetine)

Wellbutrin (bupropion)

Remeron (mirtazapine)

Mood Stabilizers:

Tegretol (carbamazepine)

Lithium

Depakote (valproate)

Lamictal (lamotrigine)

Topamax (topiramate)

Antipsychotics/Mood Stabilizers:

Abilify (aripiprazole)

Risperdal (risperidone)

Seroquel (quetiapine)

Zyprexa (olanzepine)

Geodon (ziprasidone)

Clozaril (clozapine)

Haldol (haloperidol)

Prolixin (fluphenazine)

Sleep Medications:

Ambien (zolpidem)

Sonata (zaleplon)

Rozerem (ramelteon)

Restoril (temazepam)

Desyrel (trazodone)

ADHD medications

Adderall (amphetamine)

Concerta (methylphenidate)

Ritalin (methylphenidate)

Strattera (atomoxetine)

Antianxiety medications:

Xanax (alprazolam)

Ativan (lorazepam)

Klonopin (clonazepam)

Valium (diazepam)

Tranxene (clorazepate)

Buspar (buspirone)

**Family Psychiatric History**:

|  |  |  |  |
| --- | --- | --- | --- |
| **Has anyone in your family been diagnosed with or treated for any of the following:** | | | |
|  | Bipolar disorder | Who: | Click or tap here to enter text. |
|  | Schizophrenia |  | Click or tap here to enter text. |
|  | Depression |  | Click or tap here to enter text. |
|  | Post-traumatic stress |  | Click or tap here to enter text. |
|  | Anxiety |  | Click or tap here to enter text. |
|  | Alcohol abuse |  | Click or tap here to enter text. |
|  | Anger |  | Click or tap here to enter text. |
|  | Violence |  | Click or tap here to enter text. |
|  | Other substance abuse |  | Click or tap here to enter text. |
|  | Suicide |  | Click or tap here to enter text. |

**Substance Use:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Do you think you may have a problem with alcohol or drug use? | | | | |  | Yes |  | No |
| Have you ever been treated for alcohol or drug use or abuse? | | | | |  | Yes |  | No |
| Where: | Click or tap here to enter text. | | When: | Click or tap here to enter text. | | | | |
| What substance: | | Click or tap here to enter text. | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Check if you have ever tried the following:** | | | | | **If yes, how long and when did you last use?** |
| Marijuana |  | Yes |  | No | Click or tap here to enter text. |
| Alcohol |  | Yes |  | No | Click or tap here to enter text. |
| Methamphetamine |  | Yes |  | No | Click or tap here to enter text. |
| Pain killers (not as prescribed) |  | Yes |  | No | Click or tap here to enter text. |
| Stimulants (pills) |  | Yes |  | No | Click or tap here to enter text. |
| Cocaine |  | Yes |  | No | Click or tap here to enter text. |
| Heroin |  | Yes |  | No | Click or tap here to enter text. |
| Methadone |  | Yes |  | No | Click or tap here to enter text. |
| Sleeping pills |  | Yes |  | No | Click or tap here to enter text. |
| Ecstasy |  | Yes |  | No | Click or tap here to enter text. |
| Other |  | Yes |  | No | Click or tap here to enter text. |

**Tobacco Use:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you currently smoke cigarettes, cigars, pipe or use chewing tobacco? | |  | Yes |  | No |
| If no, have you used in the past? | |  | Yes |  | No |
| How many cigarettes or packs do/did you use a day? | Click or tap here to enter text. | | | | |
| How many times do/did you use cigars, pipe or chewing tobacco a day? | Click or tap here to enter text. | | | | |
| How long have/did you use tobacco products? | Click or tap here to enter text. | | | | |
| When did you stop using tobacco products? | Click or tap here to enter text. | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **How many caffeinated beverages do you drink a day?** | | | | | |
|  | 0-1 | 1-2 | 3-4 | 5-6 | None |
| Coffee |  |  |  |  |  |
| Soda |  |  |  |  |  |
| Tea |  |  |  |  |  |
| Energy Drink |  |  |  |  |  |

**Family Background and Childhood:**

|  |  |  |
| --- | --- | --- |
| Where did you grow up? | Click or tap here to enter text. | |
| List your siblings and their ages: | | Click or tap here to enter text. |
| Click or tap here to enter text. | | |
| Has anyone in your immediate family died? | | |
| Click or tap here to enter text. | | |

**Past Medical History:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Any Allergies? |  | | Yes |  | | No | If Yes please list below: | | | | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | |
| Current Weight: | | Click or tap here to enter text. | | | | | | Height: | Click or tap here to enter text. | | | | | | | | | | |
| Current Medical problem? Please list below if Yes: | | | | | | | | | |  | | | Yes | | |  | | | No |
| Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | |
| Any past medical problems, surgeries, or prolonged hospital stays? | | | | | | | | | | |  | | | Yes | | |  | | No |
| Please list, when and why: | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | |
| Do you exercise regularly? | | | | | | | | | | | |  | | | Yes | | |  | No |

**For women only:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date of your last menstrual period? | Click or tap here to enter text. | | | | | |
| Are you expecting or think you might be expecting? | | |  | Yes |  | No |
| Are you planning on becoming pregnant soon? | | |  | Yes |  | No |
| What type of birth control are you currently using if any? | | Click or tap here to enter text. | | | | |
| How many pregnancies have you had? | | Click or tap here to enter text. | | | | |

**Personal and Family Medical History**:

|  |  |  |
| --- | --- | --- |
| **Have you or your family had any of the following? Check below** | | |
| **Medical Condition** | **Yourself** | **Family** |
| Thyroid Disease |  |  |
| Anemia |  |  |
| Liver Disease |  |  |
| Chronic Fatigue |  |  |
| Kidney Disease |  |  |
| Diabetes |  |  |
| Asthma/respiratory problems |  |  |
| Stomach or intestinal problems |  |  |
| Cancer |  |  |
| Fibromyalgia |  |  |
| Heart Disease |  |  |
| Epilepsy or seizures |  |  |
| Chronic Pain |  |  |
| High Cholesterol |  |  |
| High blood pressure |  |  |
| Liver problems |  |  |

**Occupational History:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Are you currently working? | | | | | | | | | | | | | |
|  | Working |  | Student |  | Unemployed |  | Disabled | | |  | | Retired | |
| How long have you been working in your current position? | | | | | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | | | | | |
| What is/ was your current position? | | | | | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | | | | | |
| Have you served in the military? | | | | | | | |  | Yes | |  | | No |

**Relationship History and Current Family:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Are you currently any of the following below and for how long? | | | | | | | | | Click or tap here to enter text. | | | | | | |
|  | Married |  | | Partnered |  | | Divorced |  | | Single | |  | | Widowed | |
| Are you currently in a relationship and for how long? | | | | | | | | | | | |  | Yes |  | No |
| Click or tap here to enter text. | | | | | | | | | | | | | | | |
| Are you sexually active? | | | | | | | | | | | |  | Yes |  | No |
| How do you identify your sexual orientation? | | | | | | | Click or tap here to enter text. | | | | | | | | |
| Straight/Heterosexual | | | Bisexual | | | Unsure | | | | | Other | | | | |
| Gay/Lesbian | | | Trans | | | Asexual | | | | | Prefer not to answer | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have any children? List genders and ages below: |  | Yes |  | No |
| Click or tap here to enter text. | | | | |
| Who all currently lives with you? | | | | |
| Click or tap here to enter text.  Click or tap here to enter text. | | | | |

**Spiritual Life:**

|  |  |
| --- | --- |
| Do you belong to a particular religion or spiritual group? | Yes No |
| Are you heavily involved in your religion or spirituality? | Yes No |
| Do you find your involvement during hard times? | More helpful More Stressful |

**Other comments or concerns:**

|  |
| --- |
| Click or tap here to enter text. |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_