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_____Date_____
Date of Birth_____Primary Care Physician_____
Do you give permission for regular on-going updates to your primary care physician? _____

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

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms):

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

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?

_____
Have you had recent thoughts of suicide?_____
If Yes, do you have a plan? (please explain)

_____
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?

_____

PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 **+** _____ **+** _____ **+** _____

=Total Score: _____

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**
⑤	⑤	⑤	⑤

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

List ALL current prescription medications and how often you take them, (if none, write none)

Medication: Dose: When Started:

Current over-the-counter medications/supplements/vitamins:

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:

Have you been exposed to Domestic Violence?

Legal History:

Have you ever been arrested?

Do you have any pending legal problems?

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No; If yes, please describe below:

Reason: Dates: Provider:

Psychiatric Hospitalization: ( ) Yes ( ) No; If yes, describe below:

Reason: Date/Length of stay: Hospital:

Past Psychiatric Medications: If you have ever taken any of the following medications, please state if they were helpful, and any side affects you remember (it is ok if you do not remember all aspects, please fill in what you can).

	WHEN:	**DOSE:**	**RESPONSE/SIDE EFFECTS:**
Antidepressants:			
Prozac (fluoxetine)			
Zoloft(sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			

Lexapro (escitalopram)_____
Effexor (venlafaxine)_____
Cymbalta (duloxetine)_____
Wellbutrin (bupropion)_____
Remeron (mirtazapine)_____
Other_____

Mood Stabilizers:
Tegretol (carbamazepine)_____
Lithium_____
Depakote (valproate)_____
Lamictal (lamotrigine)_____
Topamax (topiramate)_____
Other _____

Antipsychotics/Mood Stabilizers:
Abilify (aripiprazole) _____
Risperdal (risperidone)_
_____
Seroquel (quetiapine) _____
Zyprexa (olanzepine) _____
_____
Geodon (ziprasidone) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine)_____
Other _____

Sleep Medications:
Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon) _____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other _____

ADHD medications
Adderall (amphetamine) _____
Concerta (methylphenidate)_____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Other _____

	WHEN:	**DOSE:**	**RESPONSE/SIDE EFFECTS:**
Antianxiety medications:			
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			

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
Anger ( ) Yes ( ) No
Violence ( ) Yes ( ) No
Other substance abuse ( ) Yes ( ) No
Suicide ( ) Yes ( ) No
If yes, who had each problem?

_____

_____

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
If yes, for which substances?

_____
If yes, where were you treated and when?

_____

_____

Check if you have ever tried the following:

	Yes / No;	If yes, how long and when did you last use?
Cocaine	( )	( ); _____
Stimulants (pills)	( )	( ); _____
Heroin	( )	( ); _____
Methamphetamine	( )	( ); _____
Marijuana	( )	( ); _____
Pain killers (not as prescribed)	( )	( ); _____
Methadone	( )	( ); _____
Sleeping pills	( )	( ); _____
Alcohol	( )	( ); _____
Ecstasy	( )	( ); _____

Other _____

***How many caffeinated beverages do you drink a day?** Coffee____Sodas____Tea____
Energy Drinks? _____

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? _____

Family Background and Childhood History:
Where did you grow up? _____
List your siblings and their ages:

_____
_____

Has anyone in your immediate family died?

_____

Past Medical History:
Allergies_____Current Weight_____Height _____

Current medical problems:

_____
_____

Past medical problems, including surgeries and prolonged hospital stays:

_____
_____

Your Exercise Level: Do you exercise regularly? ( ) Yes ( ) No

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? _____

Personal and Family Medical History:

	Yourself:	Family:
Thyroid Disease	( )	( )
Anemia	( )	( )
Liver Disease	( )	( )
Chronic Fatigue	( )	( )
Kidney Disease	( )	( )
Diabetes	( )	( )

	Yourself:	Family:
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	( )	( )

Educational History: Highest Grade Completed? _____
Did you attend college?_____Where?_____Major? _____

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? _____

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

Do you have children? ( ) Yes ( ) No; If yes, list ages and gender:

_____
List everyone who currently lives with you:
_____
_____

Spiritual Life: Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____

Other comments or concerns:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature_____Date_____

Emergency Contact_____Telephone # _____