ALL DAY
Family Care Clinic
Primary Care | Behavioral Health

MENTAL HEALTH INTAKE FORM

Please complete all information on this form and bring to your first visit. 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** _____
Date of Birth _____ **Age** _____
Do you give permission for ongoing regular updates to be provided to your primary care physician _____
Name of PCP _____ **PCP Phone** _____
Current/Prior Therapist/Counselor _____ **Therapist's Phone** _____
Current/Prior Psychiatrist _____ **Psychiatrist's Phone** _____
Any special considerations for scheduling (day/eve/weekends)? _____
What is/are the problem(s) for which you are seeking therapy at this time?

_____
_____
_____

What are your treatment goals?

_____
_____
_____

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

( ) Depressed Mood	( ) Racing thoughts	( ) Excessive worry
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety attacks
( ) Sleep patterns disturbance	( ) Increase risky behavior	( ) Avoidance
( ) Loss of interest	( ) Increased libido	( ) Hallucinations
( ) Concentration/forgetfulness	( ) Decreased need for sleep	( ) Suspiciousness
( ) Change in appetite	( ) Excessive energy	( ) _____
( ) Excessive guilt	( ) Increased irritability	( ) _____
( ) Excessive Fatigue	( ) Crying spells	( ) _____

<u>Suicide Risk Assessment</u>

Have you ever had feelings or thoughts that you did not want to live? ( ) Yes ( ) No
If YES, please answer the following. If NO, please skip to 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 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 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. _____

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Do you have any significant medical conditions (i.e. chronic pain, hypertension, Fibromyalgia, chronic fatigue syndrome, chronic infections, ect.)

_____

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 or developments?

_____

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, where

Reason **Date Hospitalized** **Where**

_____

_____

Current/Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember)

Antidepressants	Dates	Dosage	Response/Side Effects	Current
Prozac (fluoxetine)				
Zoloft (sertraline)				
Luvox (fluvoxamine)				
Paxil (paroxetine)				
Celexa (citalopram)				
Lexapro (escitalopram)				
Effexor (venlafaxine)				
Cymbalta (duloxetine)				
Wellbutrin (bupropion)				
Remeron (mirtazapine)				
Serzone (nefazodone)				
Anafranil (clomipramine)				
Pamelor (nortrptyline)				
Tofranil (imipramine)				
Elavil (amitriptyline)				
Other				
Mood Stabilizers				
Tegretol (carbamazepine)				

Lithium				
Depakote (valproate)				
Lamictal (lamotrigine)				
Tegretol (carbamazepine)				
Topamax (topiramate)				
Other				

Other general medications currently taking:

_____

_____

Substance Use

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

If yes, for which substance_____

If yes, where were you treated and when? _____

_____

How many days per week do you drink 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 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:

		If Yes, how long when did you last use and frequency of use?
Methamphetamine	( ) Yes ( ) No	_____
Cocaine	( ) Yes ( ) No	_____
Stimulants (pills)	( ) Yes ( ) No	_____
Heroin	( ) Yes ( ) No	_____
LSD or Hallucinogens	( ) Yes ( ) No	_____
Marijuana	( ) Yes ( ) No	_____
Pain killers (not as prescribed)	( ) Yes ( ) No	_____
Methadone	( ) Yes ( ) No	_____
Tranquilizer/sleeping pills	( ) Yes ( ) No	_____
Alcohol	( ) Yes ( ) No	_____
Ecstasy	( ) Yes ( ) No	_____
Other		_____

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How many caffeinated beverages do you drink a day? Coffee __ Sodas __ Tea __

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No

Currently ( ) Yes ( ) No How many packs per day average? ( ) Yes ( ) No 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 average? _____ How many years? _____

Any other addictions or concerns about overuse/abuse (i.e. gambling, overspending, ect)

_____

Legal History:

Have you ever been arrested? ( ) Yes ( ) No

Do you have any pending legal problems? ( ) Yes ( ) No

Spiritual Life:

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No

If Yes, what is the level if 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 _____

Guardian Signature (if under 18) _____Date _____

Emergency Contact _____Phone _____

PLEASE DON'T WRITE BELOW THIS LINE

Clinicians Notes:

_____

_____

Other Notes:

_____

_____

Brief Impressions:

_____

_____

Recommendations for Treatment: Type/Frequency (IT, FT, GT) _____