Mental Health Intake Form

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. You may need to ask family members about the family history. Thank you!

Name: ____ Date: __________________

Date of Birth: ____/____/____

Primary Care Physician: ____

Do you give permission for ongoing regular updates to be provided to your primary care physician? ○ Yes ○ No

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
☐ Racing thoughts
☐ Impulsivity
☐ Increase risky behavior
☐ Increased libido
☐ Decrease need for sleep
☐ Excessive energy
☐ Increased irritability
☐ Excessive worry
☐ Anxiety attacks
☐ Avoidance
☐ Hallucinations
☐ Suspiciousness
☐ ________________
☐ ________________

☐ Fatigue

☐ Crying spells

☐ Decreased libido

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

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	Dates Hospitalized	Where

Past Psychiatric Medications: If you have ever taken any of the following medications, 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).

Antidepressants	Dates	Dosage	Response/Side-Effects

Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Cymbalta (duloxetine)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other:			

Mood Stabilizers	**Dates**	**Dosage**	**Response/Side-Effects**
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Haldol (haloperidol)			
Risperdal (risperidone)			
Clozaril (clozapine)			
Other:			

Sedative/Hypnotics	**Date**	**Dosage**	**Response/Side-Effects**

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

ADHD Medications	**Date**	**Dosage**	**Response/Side-Effects**
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine			
Other:			

Antianxiety & Anti-Depression Medications	**Date**	**Dosage**	**Response/Side-Effects**
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Prozac (Fluoxetine)			
Zoloft (sertraline)			
Other:			

Your Exercise Level

Do you exercise regularly? ○ Yes ○ No

How many days a week do you get exercise? ____

How much time each day do you 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:

		If yes, how long and when did you last 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		________________

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

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______________________________

Guardian Signature (if under age 18) ___________________________ Date ______________________________

Emergency Contact ____ Telephone # _______________________

For Office Use Only:

Reviewed by ____Date _____________________________

Reviewed by ____Date _____________________________

PROFFESIONAL COUNSELING ASSOCIATES

FINANCIAL AGREEMENT INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE PROFESSIONAL COUNSELING ASSOCIATES TO FURNISH INFORMATION TO INSURANCE CARRIERS CONERNING MY ILLNESS AND TREATMENT, AND HEREBY ASSIGN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE AND AFTER SIXTY (60) DAYS IF NO PAYMENT HAS BEEN RECEIVED BY THIS OFFICE, FULL PAYMENT IS DUE AND IS MY FINANCIAL RESPONSIBILITY. I AGREE THAT I WILL PAY OUT OF POCKET THE COST OF ANY SERVICES RENDERED THAT ARE NOT PAID FOR ANY REASON BY MY HEALTH INSURANCE CARRIER.

I have read, and I understand and agree to the above terms and conditions. I am aware of my financial responsibility to PROFESSIONAL COUNSELING ASSOCIATES

SIGNATURE____DATE__________________ (PATIENT OR PARENT IF MINOR)

MEDICARE PATIENTS MUST SIGN BELOW

I AM AWARE THAT PROFESSIONAL COUNSELING ASSOCIATES ARE NOT MEDICARE PROVIDERS AND CANNOT BILL MEDICARE FOR ANY SERVICES THAT I MAY RECEIVE. I UNDERSTAND THAT ANY SERVICES THAT I RECEIVE WILL BE SOLELY MY FINANCIAL RESPONSIBILITY AND I AGREE TO PAY OUT OF POCKET FOR THESE SERVICES

SIGNATURE_______________________________________ DATE_____________________