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
( ) Unable to enjoy activities
( ) Sleep patterns disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Excessive Fatigue

( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decreased need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells

( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____
( ) _____

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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) _____**