TENSAS & VIDALIA
COMMUNITY HEALTH CENTERS

MENTAL HEALTH INTAKE FORM

Please complete all information on this form and bring it to the first visit. Date:_____

Name_____Date of Birth_____

Who referred you?_____Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your PCP? ☐ Yes ☐ No

Current Therapist/Counselor_____ Therapist's Phone_____

PRESENTING PROBLEM

Chief Complaint (What brings you here today?) _____

_____

What are the main stressors in your life right now?_____

_____

Please circle all that apply to you Choose severity that applies: (1) Mild, (2) Moderate, or (3) Severe

Depression	☐ 1 ☐ 2 ☐ 3	**Confusion**	☐ 1 ☐ 2 ☐ 3	**Panic Attacks**	☐ 1 ☐ 2 ☐ 3
Anxiety	☐ 1 ☐ 2 ☐ 3	**Memory Problems**	☐ 1 ☐ 2 ☐ 3	**Obsessive Thoughts**	☐ 1 ☐ 2 ☐ 3
Mood Swings	☐ 1 ☐ 2 ☐ 3	**Loss of Interest**	☐ 1 ☐ 2 ☐ 3	**Ritualistic Behaviors**	☐ 1 ☐ 2 ☐ 3
Appetite Change	☐ 1 ☐ 2 ☐ 3	**Irritability**	☐ 1 ☐ 2 ☐ 3	**-Checking**	☐ 1 ☐ 2 ☐ 3
Sleep Changes	☐ 1 ☐ 2 ☐ 3	**Excessive Worrying**	☐ 1 ☐ 2 ☐ 3	**-Counting**	☐ 1 ☐ 2 ☐ 3
Hallucinations	☐ 1 ☐ 2 ☐ 3	**Suicidal Thoughts**	☐ 1 ☐ 2 ☐ 3	**Change in Sexual Interest**	☐ 1 ☐ 2 ☐ 3
Work Problems	☐ 1 ☐ 2 ☐ 3	**Marital Stress**	☐ 1 ☐ 2 ☐ 3	**Poor Concentration**	☐ 1 ☐ 2 ☐ 3
Racing Thoughts	☐ 1 ☐ 2 ☐ 3	**Low Energy**	☐ 1 ☐ 2 ☐ 3	**Hyperactivity**	☐ 1 ☐ 2 ☐ 3

Describe a brief history of your present symptoms:_____

_____

How long have you had these symptoms_____

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)***

Do you **currently** feel that you don't want to live? ☐ Yes ☐ No

Have you ever tried to kill or harm yourself before?☐ Yes ☐ No If yes, When?_____How?_____

Do you have access to guns? ☐ Yes ☐ No If yes, please explain_____

PAST MEDICAL HISTORY:

Allergies_____ Current Weight _____ Height _____

List **ALL** current prescription medications (if none, write none) ** **BRING BOTTLES WITH YOU TO EVERY VISIT**

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

Have you ever had an EKG? ☐ Yes ☐ No If yes, When?_____EKG Results ☐ normal ☐ abnormal ☐ unknown

Do you have any concerns about your physical health that you would like to discuss with us? ☐ Yes ☐ No

Date and place of last physical exam: _____

When your mother was pregnant with you, were there any complications during the pregnancy or birth? ☐ Yes ☐ No

If yes, explain_____

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?_____

PAST PSYCHIATRIC HISTORY:

Outpatient treatment ☐ Yes ☐ No If yes, Please describe when, by whom, and nature of treatment.

_____

_____

Inpatient treatment ☐ Yes ☐ No If yes, describe for what reason, when and where.

_____

_____

PAST PSYCHIATRIC MEDICATIONS *Please check if you have ever taken any of the following medications.*

Antidepressants

- ☐ 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)

Mood Stabilizers

- ☐ Tegretol (carbamazepine)
- ☐ Lithium
- ☐ Depakote (valproate)
- ☐ Lamictal (lamotrigine)
- ☐ Tegretol (carbamazepine)
- ☐ Topamax (topiramate)

Antipsychotics / Mood Stabilizers

- ☐ Seroquel (quetiapine)
- ☐ Zyprexa (olanzepine)
- ☐ Geodon (ziprasidone)
- ☐ Abilify (aripiprazole)
- ☐ Clozaril (clozapine)
- ☐ Haldol (haloperidol)
- ☐ Prolixin (fluphenazine)
- ☐ Risperdal (risperidone)

Sedative/Hypnotics

- ☐ 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)

Other _____

_____

Please indicate the dates, dosage, side-effects and how helpful the above checked medicines were.

_____

_____

_____

_____

SUBSTANCE USE:

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No If yes, for which substances? _____

_____

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/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? _____

_____

SUBSTANCE USE CONTINUED:

Have ever tried the following?

☐ Methamphetamine ☐ Cocaine ☐ Stimulants (pills) ☐ Heroin

☐ LSD or Hallucinogens ☐ Marijuana ☐ Ecstasy ☐ Pain killers (not as prescribed)

☐ Methadone ☐ Mojo ☐ Tranquilizer/sleeping pills ☐ Other_____

If yes, how long and when did you last use?_____

_____

Tobacco History:

How you ever smoked cigarettes? ☐ Yes ☐ No Currently? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

How many packs per day on average? _____How many years?_____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? _____

Do you Vape? ☐ Yes ☐ No

How many caffeinated beverages do you drink a day? ☐ Coffee ☐ Sodas ☐ Tea ☐ Engergy Drinks / Loaded Teas

FAMILY PSYCHIATRIC HISTORY:

Has anyone in your family been diagnosed with or treated for:

☐ Bipolar disorder ☐ Schizophrenia ☐ Depression ☐ No Post-traumatic stress

☐ Anxiety ☐ Alcohol abuse ☐ Anger ☐ Other substance abuse

☐ Suicide ☐ Violence

If yes, explain?_____

_____

FAMILY BACKGROUND AND CHILDHOOD HISTORY:

Were you adopted? ☐ Yes ☐ No Where did you grow up?_____

List your siblings and their ages: _____

_____

Did your parents' divorce? ☐ Yes ☐ No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with?_____

Describe your relationship with father:_____

Describe your relationship with mother:_____

How old were you when you left home? _____

Has anyone in your immediate family died? ☐ Yes ☐ No Who and when? _____

TRAUMA HISTORY:

Do you have a history of being abused emotionally, verbally, sexually, physically or by neglect? ☐ Yes ☐ No

Please describe when, where and by whom: _____

EDUCATION AND OCCUPATIONAL HISTORY:

What is your highest educational level or degree attained? _____

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? ☐ Yes ☐ No

If so, what branch and when? _____ Honorable discharge ☐ Yes ☐ No Other type discharge _____

Have you ever been arrested?_____Do you have any pending legal problems? _____

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 Do you use birth control? ☐ Yes ☐ No Explain_____

What is your spouse or significant other's occupation?_____

Describe your relationship with your spouse or significant other: ☐ Good ☐ Bad ☐ Fair

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: ☐ Good ☐ Bad ☐ Fair

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 time, 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_____**Date**_____

Emergency Contact _____**Phone #**_____