Nancy Hunter
COUNSELING † PSYCHOTHERAPY

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_____ Age_____

Date of Birth_____ Phone _____

Primary Care Physician_____

Emergency Contact _____ Phone: _____

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

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:

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

Medication Name	Total Daily Dosage	Estimated Start Date

Current medical problems: _____

Past medical problems, hospitalization, or surgeries: _____

For women only: Are you currently pregnant or do you think you might be pregnant? _____
Birth control method contain hormones? _____

How many times have you been pregnant? _____ How many live births? _____

Date and place of last physical exam: _____

Past Psychiatric History:

_____

_____

_____

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

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

_____

_____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

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, forwhich 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? _____

Have you ever felt you ought to cut down on 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 illegal drugs: ( ) (List drugs below)

_____

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

Do you smoke Marijuana? ( ) yes ( ) No If so, How often? _____

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? _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No

List your siblings and their ages: _____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No How old were you when they divorced? _____ If your parents divorced, who did you live with?_____

Describe your father and your relationship with him: _____

Describe your mother and your relationship with her: _____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect?

( ) Yes ( ) No.

As a child, was there fighting in your home? _____

Educational History:

Highest Grade Completed? _____

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? _____

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

Name _____

Is there anything else you would like me to know?

_____

_____

_____

_____

Signature_____Date_____

Address _____