Nancy Hunter
COUNSELING † PSYCHOTHERAPY

MENTAL HEALTH INTAKE FORM

Please complete all information on this form and submit it prior 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	**( ) Racing thoughts**	**( ) Excessive worry**
( ) Unable to enjoy activities	**( ) Impulsivity**	**( ) Anxiety attacks**
( ) Sleep pattern disturbance	**( ) Increase risky behavior**	**( ) Avoidance**
( ) Loss of interest	**( ) Increased libido**	**( ) Hallucinations**
( ) Concentration/forgetfulness	**( ) Decrease need for sleep**	**( ) Suspiciousness**
( ) Change in appetite	**( ) Excessive energy**	**( ) _____**
( ) Excessive guilt	**( ) Increased irritability**	**( ) _____**
( ) 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:

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 _____