MENTAL HEALTH INTAKE FORM

Date_____

Name_____ DOB: _____

What issue(s) bring(s) you to the Psychiatry Clinic?

_____

_____

_____

_____

What has been stressing you of late (e.g. Family, job, recent loss of loved ones, financial issues)?

_____

_____

_____

_____

SAFETY

Do currently have thoughts of hurting yourself? Yes/no Please explain.

_____

Have you tried to hurt yourself in the past? If so, please explain.

_____

_____

_____

Do you currently have thoughts of hurting anyone else? Yes/no Please explain.

_____

Do you own any guns or knives? _____

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 Date 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). Dates Dosage Response/Side-Effects

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) _____
Other _____

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers Dates Dosage Response/Side-Effects

Seroquel (quetiapine) _____
Zyprexa (olanzepine) _____
Geodon (ziprasidone)_____
Abilify (aripiprazole)_____
Clozaril (clozapine)_____
Haldol (haloperidol_____
Prolixin (fluphenazine)_____
Risperdal (risperidone)_____

Other _____

Sedative/Hypnotics

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

ADHD medications

Adderall (amphetamine)_____
Concerta (methylphenidate)_____
Ritalin (methylphenidate)_____
Strattera (atomoxetine)_____
Other _____

Antianxiety medications

Xanax (alprazolam)_____
Ativan (lorazepam)_____
Klonopin (clonazepam)_____
Valium (diazepam)_____
Tranxene (clorazepate)_____
Buspar (buspirone)_____
Other _____

Past Medical History:

Allergies_____ Current Weight _____ Height _____

LIST ALL CURRENT MEDICATIONS and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____
_____
_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements:

_____
_____

Current medical problems:

_____

Past medical problems, non-psychiatric hospitalization, or surgeries:

_____
_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ .
Was the EKG ( ) normal ( ) abnormal or ( ) unknown**?**

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? _____
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: _____

Is there any 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?
_____

Signature➡_____Date_____
Guardian Signature (if under age 18) _____ Date _____
Emergency Contact _____ Telephone # _____
For Office Use Only:
Reviewed by _____Date