Mental Health Intake Form

Hawaii Clinical Psychology
Cynthia J'Anthony, PhD

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.

Name_____Date_____

Phone #: _____ Social Security # _____

Address: _____

Email Address: _____

Date of Birth _____ Annual Income_____

Emergency Contact _____ Relationship _____

Phone # _____

What are the problem(s) for which you are seeking help?

_____
_____
_____

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 problems	❑ Increased risky behavior	❑ Avoidance
❑ Loss of interest	❑ Increased libido	❑ Nightmares
❑ Concentration/forgetfulness	❑ Decreased need for sleep	❑ Self-harm/high risk behaviors
❑ Change in appetite	❑ Excessive energy	❑ On guard/alert
❑ Excessive guilt	❑ Increased irritability	❑ Extreme startle response
❑ Fatigue	❑ Hallucinations	❑ Cut-off/distant from others
❑ Decreased libido	❑ Suspiciousness	❑ Anger outbursts

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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
- Do you feel hopeless and/or worthless? ❑ Yes ❑ No
- Have you ever tried to kill or harm yourself before? ❑ Yes ❑ No
- Do you have access to guns? ❑ Yes ❑ No
    - If yes, please explain. _____

Medical History

Current Weight _____ Height _____

Please list *ALL* current prescription medications and how often you take them:

_____
_____
_____
_____
_____
_____

Current medical problems:

_____
_____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____
_____

Date and place of last physical exam:

_____

Your Personal Medical History (check all that apply to you):

❑ Thyroid Disease
❑ Liver problems
❑ Chronic Fatigue
❑ Diabetes
❑ Asthma/respiratory problems
❑ Cancer (type)
❑ High blood pressure
❑ Other: _____
❑ Stomach or intestinal problems
❑ Fibromyalgia
❑ Heart Disease
❑ Epilepsy or seizures
❑ Chronic Pain
❑ Head trauma
❑ Migraines

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Is there any additional personal or family medical history? ❑ Yes ❑ No

If yes, please explain:

_____

Psychiatric History

Have you ever received outpatient psychotherapy or psychiatrist treatment?
❑ Yes ❑ No
If yes, Please describe when, by whom, and nature of treatment.

Reason - Dates Treated - By Whom

_____
_____
_____
_____

Have you ever been hospitalized for a psychiatric disorder/issue? ❑ Yes ❑ No
If yes, describe for what reason, when and where.

Reason - Date Hospitalized - Where

_____
_____
_____
_____

Family Psychiatric History

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

Disorder:			Who had the problem?
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	_____
Substance (drug) abuse	❑ Yes	❑ No	_____
Suicide	❑ Yes	❑ No	_____
Violence	❑ Yes	❑ No	_____

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Substance Use

Have you ever been treated for alcohol or drug use or abuse? ❑ Yes ❑ No
If yes, for which 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? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you should cut down on your drinking/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?

_____

_____

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

Tobacco History:
Have you ever smoked cigarettes or used other forms of tobacco? ❑ Yes ❑ No
Do you current use any form of tobacco? ❑ Yes ❑ No
How many packs per day on average? _____
How many years? _____

Your Exercise Level:
Do you exercise regularly? ❑ Yes ❑ No
How many days a week do you get exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do?

_____

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Trauma History

Have you ever been abused (emotionally, sexually, physically, neglect)? ❑ Yes ❑ No

Have you ever experienced, or witnessed a traumatic event? ❑ Yes ❑ No

Educational History

Highest Grade Completed? _____ Where?_____
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? ❑ Yes ❑ No
If so, what branch and when? _____
Rank and MOS: _____
Were you deployed to combat? ❑ Yes ❑ No
If so, how many deployments, where 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

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:
_____
_____

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How would you identify your sexual orientation?

❑ straight/heterosexual	❑ lesbian/gay/homosexual
❑ bisexual	❑ transsexual
❑ unsure/questioning	❑ asexual
❑ other	❑ prefer not to answer

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

If yes, what is the level of 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 me to know?

_____
_____
_____
_____
_____
_____

Primary Care Physician_____ PCP's Phone_____

- Do you give permission for ongoing regular updates to be provided to your Primary Care Physician? _____

Current Psychiatrist_____ Psychiatrist's Phone_____

- Do you give permission for ongoing regular updates to be provided to your Psychiatrist? _____

Signature _____ Date_____

Legal Guardian Signature (if appropriate) _____

Date _____