# INITIAL INTAKE AND HISTORY

The Clinic for Mental Health & Wellness
502 S 4th Street
Laramie, WY 82070
Phone: (307) 755 – 1000
Fax: (307) 742 – 9717

**NAME:** **DATE:**

**Person completing form? Patient / Parent / Grandparent / Guardian / Case worker / Other**

**WHAT BRINGS YOU IN TODAY?**

**CURRENT SYMPTOMS:**

Sadness / depression
Loss of pleasure / interest
Hopelessness
Helplessness
Loneliness
Low self-worth
Guilt / shame
Fatigue
Decreased appetite
Increased appetite
Lack of motivation
Social withdrawal
Difficulty concentrating
Over sleeping
Difficulty with sleep maintenance
Difficulty with sleep onset
Inability to sleep

Seasonal mood changes

Alcohol overuse
Other:

Anxiety / Worry
Panic attacks
Fear
Social discomfort
Phobias
Obsessive thoughts
Compulsive behavior

Flashbacks
Nightmares
Recurring, disturbing memories
Hypervigilance

Aggressive physically
Aggressive verbally

Conduct Problems
Disruptive Behavior
Irritability / anger
Fire setting

Illicit substance overuse

Racing thoughts
Excessive energy
Wide mood swings
Excessive money spending
Hypersexual behaviors

Distractibility
Hyperactivity
Impulsivity
Boredom
Poor Memory

Hallucinations
Delusions
Suspicion/paranoia

Eating problems
Laxative / diet pill / diuretic misuse / abuse
Body Image problems

Prescription drug abuse

Financial problems
Major loss
Significant life changes
Work / School problems

Gender Identity Issues
Difficulties with religion / Spirituality
Child-Parent relationship problems
Martial problems
Intimacy problems
Peer relationship problems

Chronic pain
Health concerns

Gambling problems
Computer addiction
Pornography addiction

Legal problems

In your opinion how severe is/are the problem(s)? Mild / Moderate / Severe

How long have you been experiencing symptoms? Days / Weeks / Months / 1 year / less than 5 years / more than 5 years

How often are your symptoms present throughout the day? Never / Sometimes / Frequent / Constant

To what degree are these impacting your level of functioning? Mild / Moderate / Severe

**Are you currently prescribed psychiatric medication**? YES NO

Prescriber / Name of facility:

How long have you been seeing them?

**Are you currently in counseling / therapy**? YES NO

Therapist Name:

How long have you been seeing them?

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**Are you presently having any suicidal thoughts**? YES NO

Do you have a plan? YES NO

**Do you own or have access to firearms?** YES NO

**Are you experiencing any homicidal thoughts**? YES NO

**Are you presently self-harming**? YES NO

**Have you recently been physically, emotionally, sexually hurt or threatened by someone?** YES NO

Details: ______________________________________________________________

**PAST HISTORY:**

Previous self-harm behaviors (cutting, burning, head banging): NO YES (provide details)

______________________________________________________________

Previous thoughts, made statements or attempted to hurt and/or kill yourself? NO YES (provide details)

______________________________________________________________

Previous thoughts, made statements or attempted to hurt and/or kill someone else? NO YES (provide details)

______________________________________________________________

Do you have a history of abuse or trauma related events? NO YES (provide details)

______________________________________________________________

**Previous diagnosis / treatment of any mental health problems or substance use?** NO YES (list below)

| Date (s) | Diagnosis / Where / Treatment received |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Previous Psychiatric testing performed? NO YES (provide details)

______________________________________________________________

**SOCIAL HISTORY:**

Sexual Orientation: ______________________ Gender Expression: ______________________

**RELATIONSHIP**:

Relationship status (married, single, divorced, partnered, etc):______________________

Duration & quality of relationship: ______________________

Previous marriage(s): NO YES How many: ______ Dates of marriage(s): ______________________

Children: NO YES Number of children; _______

Name & Ages (specify if biological, adopted, step, & previous or current relationship):

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

**DEVELOPMENTAL HISTORY:**

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Please note any speech, language, hearing, visual, learning disabilities, etc. Concerns or Problems:

Please explain any developmental concerns / delays:

Place of Birth:

Raised by:

Siblings and ages (please indicate full, half, step, adopted):

| | Current Members in the Household | Relationship to Patient | Age |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

**CURRENT EDUCATION:**

Are you presently attending school: YES NO

Current School & Grade:

IEP / 504: YES NO For what: ____________________________________________

Academic performance: below average average above average

Easiest subject: Most difficult subject:

School / Parents' concerns:

**EDUCATIONAL HISTORY:**

Highest level of education

Graduated High School: Year _______ GED: Year ______________

Attended college:

Trade (facility, focus, year):

Associates (college, degree, year):

Bachelors (college, degree, year):

Masters (college, degree, year):

PhD (college, degree, year):

**EMPLOYMENT**:

Current Employer:_____________________________________Current Position: _______________________________

Length of employment: ________________________________ Do you like your job: ____________________________

Previous Employment: _____________________________________________

On Disability: NO YES (for what) ________________________________

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**MILITARY:**

Have you ever served in the military? NO YES

If yes, what branch and when? ____________________

**ADDITIONAL INFORMATION:**

Current legal proceedings (arrests, charges, trial, probation)? NO YES (provide details)

____________________

Previous legal proceedings (arrests, charges, trial, probation)? NO YES (provide details)

____________________

Current support system (family, friends, community members, etc.): ____________________

Do you have a need for additional social supports? NO YES ____________________

What are your abilities and personal strengths? ____________________

What are your interests and things you like to do to relax? ____________________

What individual needs and preferences do you have during treatment? ____________________

What role does spirituality or religion currently play in your life? ____________________

What is your personal culture? ____________________

Do you have a need for assistive technology or accommodations with receiving services? ____________________

**SUBSTANCE USE:**

| CURRENT | YES | NO | HOW MUCH daily / weekly, often / amount |
|---|---|---|---|
| Caffeine | | | |
| Cigarettes | | | |
| Electronic cigarettes | | | |
| Chew | | | |
| Alcohol | | | |
| Marijuana (any form) | | | |
| Cocaine | | | |
| Methamphetamines | | | |
| Opioids / narcotics | | | |
| Mushrooms | | | |
| Ecstasy | | | |
| LSD | | | |
| PCP | | | |
| Inhalants | | | |
| Prescription pills | | | |
| (over use of own prescription) | | | |
| (not prescribed to you) | | | |
| OTHER | | | |

Do you believe your substance use is a problem? YES NO

Do others believe your substance use is a problem? YES NO

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| PAST Substance Use | YES | NO | AGE STARTED, FREQUENCY, DURATION & QUIT |
|---|---|---|---|
| Caffeine | | | |
| Cigarettes | | | |
| Electronic cigarettes | | | |
| Chew | | | |
| Alcohol | | | |
| Marijuana (any form) | | | |
| Cocaine | | | |
| Methamphetamines | | | |
| Opioids / narcotics | | | |
| Mushrooms | | | |
| Ecstasy | | | |
| LSD | | | |
| PCP | | | |
| Inhalants | | | |
| Prescription pills | | | |
| (over use of own prescription) | | | |
| (not prescribed to you) | | | |
| OTHER | | | |

In the past has your substance use been a problem? YES NO

**PATIENT'S FAMILY HISTORY:**
**Please list blood relatives who have been diagnosed with the following conditions:**

| | | | |
|---|---|---|---|
| ADHD / ADD | | Seizures | |
| Alcohol abuse | | Diabetes | |
| Anger | | High blood pressure | |
| Anxiety | | Thyroid | |
| Bipolar disorder | | Cancer | |
| Depression | | Osteoporosis | |
| Post Trauma Stress Disorder | | Heart disease/arrhythmias | |
| Personality disorder | | Strokes | |
| Schizophrenia | | | |
| Substance abuse | | Other: | |
| Suicides | | | |

**MEDICAL INFORMATION:**

Primary Care Provider:

Last Seen:

Do you have an advanced directive? NO YES (what it states) ____________________

Are your immunizations up to date? NO YES

Current Medical Problems / Health Concerns / Needs / Co-occurring Disabilities:

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PAST Medical / Surgical History with dates: ____________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

History of Seizures? NO YES (details)______________________________
History of Head Injuries? NO YES (details)______________________________

FEMALES: Are you currently pregnant? NO YES – are you receiving prenatal care YES NO
Health issues related to pregnancy? ______________________________________
Have you been pregnant before? NO YES
number of live births ______ Miscarriages ______ Abortions____
Do you use birth control? NO YES (what type) ______________________

**MEDICATION:**
Allergies to medications: NKDA YES (what & reaction)

________________________________________________________________

________________________________________________________________

Allergies to food: NKA YES (what & reaction)

________________________________________________________________

________________________________________________________________

Are you using any complementary health approaches (alternative medicine, use of natural products, mind and body practices, homeopathy, naturopathy)? ____________________________________________

________________________________________________________________

**ALL Current Medications: (prescription, supplement, over the counter)** Current Pharmacy: _______________

| Medication | Dose | Frequency | Prescribing Provider | Reason you're taking it |
|---|---|---|---|---|
| | | | | |
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Additional Information you'd like your practitioner to know:

________________________________________________________________

________________________________________________________________

________________________________________________________________

PLEASE INITIAL HERE ON EACH PAGE _____________