THE CLINIC
FOR MENTAL HEALTH & WELLNESS

INITIAL INTAKE

NAME:_____DOB:_____

Individual completing this form: Patient / Guardian / Grandparent / 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
- ☐ Anxiety / Worry
- ☐ Panic attacks
- ☐ 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
- ☐ Legal problem(s)
- ☐ 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
- ☐ Gender Identity
- ☐ Financial problems
- ☐ Major loss
- ☐ Significant life changes
- ☐ Work / School problems
- ☐ Difficulties with religion / Spirituality
- ☐ Child-Parent relationship problems
- ☐ Peer relationship problems
- ☐ Marital problems
- ☐ Intimacy problems
- ☐ Chronic pain
- ☐ Health concerns
- ☐ Gambling addiction
- ☐ Computer addiction
- ☐ Pornography addiction
- ☐ Illicit substance use
- ☐ Prescription drug abuse
- ☐ Alcohol overuse

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?

INITIAL INTAKE

Are you presently having any suicidal thoughts? NO YES

Do you have a plan? NO YES (details)_____

Do you own or have access to firearms? NO YES (are they locked up) yes no

Are you experiencing any homicidal thoughts? NO YES

Are you presently self-harming? NO YES

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

PAST HISTORY:

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

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

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

History of abuse or trauma related events? NO YES (details)

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

Date	Where treated	Diagnosis	Treatment

Previous Psychiatric testing performed? NO YES (Date(s), diagnosis)

SOCIAL HISTORY:

Sexual Orientation: _____ Gender Expression:_____

Relationship status: married / single / divorced / widowed / partnered / other:_____

Duration & quality of relationship:_____

Previous marriage(s): NO YES Number: _____ Dates of marriage(s): _____

Children: NO YES Number of children: _____

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

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EMPLOYMENT:

Current Employer:_____ Length of employment:_____

Current Position:_____ Do you like your job:_____

Previous Employment(s): _____

On Disability: NO YES (for what) _____

LIVING SITUATION: House Apartment Other: _____

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

DEVELOPMENTAL HISTORY:

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 EDUCATION:

Are you presently attending school: NO (skip this section) YES (please fill out the following)

Current School & Grade:_____

IEP / 504: NO YES For what:_____

Academic performance below average average above average

Easiest subject: _____ Most difficult subject: _____

School / Parents' concerns: _____

EDUCATIONAL HISTORY:

Graduated High School: NO YES Year _____ GED: Year _____

Attended:

Trade (facility, focus, year): _____

Associates (college, degree, year):_____

Bachelors (college, degree, year):_____

Masters (college, degree, year):_____

PhD (college, degree, year):_____

Highest level of education: _____

INITIAL INTAKE

MILITARY:

Have you ever served in the military? NO YES

If YES, what branch and when? _____

LEGAL:

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

_____

Previous legal proceedings (arrest, charges, trial, probation, jail or prison sentences): NO YES (provide details)

_____

ADDITIONAL INFORMATION:

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

_____

Personal strengths and abilities?_____

Interests and Hobbies?_____

Needs and preferences during treatment?_____

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

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

PATIENT'S FAMILY HISTORY:

Please list which blood relatives 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			

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MEDICAL INFORMATION:

Primary Care Provider:_____ Last Seen:_____

Are your immunizations up to date? YES NO Do you have an advanced directive? YES NO

CURRENT Medical Problems / Health Concerns / Needs / Co-occurring Disabilities:_____

PAST Medical / Surgical History with dates:_____

History of Seizures: NO YES (details)_____

History of Head Injuries? NO Yes (how many, when, severity)_____

FEMALES:

Are you currently pregnant? NO YES – are you receiving prenatal care YES NO

Have you been pregnant before? NO YES – Health issues related to pregnancy? _____

Number of live births: _____ Miscarriages: _____ Abortions: _____

Do you use birth control? NO YES (what type) _____

MEDICATION:

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

Medication	Dose	Frequency	Provider	Reason it's taken

Allergies to medications: NKDA YES (what & reaction)_____

Allergies to food: NKA YES (what & reaction)_____

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

Additional Information you'd like your practitioner to know:_____

INITIAL INTAKE

SUBSTANCE USE:

CURRENT	YES	NO	HOW MUCH daily / weekly, often / amount
Caffeine			
Cigarettes			
Electronic cigarettes / Vape			
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 probleem? YES NO

PAST	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			

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