MENTAL HEALTH INTAKE FORM

To help us better serve you, please provide us with the following information prior to your initial visit. While the packet appears to be long, please be aware that it is mostly check boxes and tables. All information is confidential and will be part of your clinical record. Feel free to use additional paper if you need more space. You may need to ask family members about family history. Please let us know if you have any questions about any of the information requested.

If you are currently feeling suicidal, please call the Careline Crises line at 1-877-266-4357, the Anchorage Community Mental Health hotline at (907) 563-3200, or go to the nearest emergency room.

Thank you- The Wisdom Team

Full Name: _____ Date: _____

What do you prefer to be called? _____

What brings you in for counseling today?

Please check the following life experiences that occur more often than you would like them to:

☐ Anger	☐ Eating disorder	☐ Loneliness	☐ Suicidal thoughts
☐ Suspiciousness	☐ Concentration difficulties	☐ Sick often	☐ Loss of interest
☐ Excessive worry	☐ Fatigue	☐ Avoidance	☐ Excessive guilt
☐ Distractibility	☐ Impulsivity	☐ Increased libido	☐ Crying spells
☐ Disorientation	☐ Hopelessness	☐ Decreased libido	☐ Increase in risky behavior

☐ Depression	☐ High blood pressure	☐ Sexual addiction	☐ Speech problems
☐ Significant relationship difficulties	☐ Heart palpitations	☐ Recurring thoughts	☐ Unable to enjoy activities
☐ Chest pain	☐ Hallucinations	☐ Phobias/fears	☐ Worrying
☐ Avoiding people	☐ Gambling	☐ Feelings of panic	☐ Trouble adjusting to life events
☐ Anxiety	☐ Fatigue	☐ Mood shifts	☐ Trembling
☐ Isolation	☐ Elevated mood	☐ Memory impairment	☐ Thoughts disorganized
☐ Alcohol use	☐ Drug use	☐ Judgement errors	☐ Increased sleep
☐ Aggression	☐ Dizziness	☐ Irritability	☐ Decreased sleep

☐ Other _____

How do these experiences affect your daily life?

What would be different if we are successful in counseling?

BIO/MEDICAL HISTORY

Please list current prescription 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:

_____

_____

_____

_____

Have you ever experienced any head injuries or trauma? ☐ Yes ☐ No If yes, when? _____

Loss of consciousness? ☐ Yes ☐ No Hospitalized for it? ☐ Yes ☐ No

Other past medical problems, non-mental health hospitalization, or surgeries:

_____

_____

_____

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? _____

MENTAL HEALTH HISTORY

Have you participated in past outpatient treatment? If yes, please describe when, by whom, and nature of treatment. If no, leave blank.

Reason	Estimated Dates	Treated by Whom

Mental Health Hospitalization History: Have you ever been hospitalized for a mental health or substance use disorder? If yes, please describe when, where and nature of treatment. If no, leave blank.

Reason	Estimated Dates/Length	Where/By Whom

Current/Past Mental Health 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) _____

Other _____

Mood Stabilizers

Tegretol (carbamazepine)_____

Lithium_____
Depakote (valproate)_____

Lamictal (lamotrigine) _____
Tegretol (carbamazepine)_____

Topamax (topiramate) _____
Other _____

Antipsychotics/Mood Stabilizers

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)_____
Other _____

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 _____

How is your Current Appetite? ☐ Good ☐ Fair ☐ Poor

Do you currently, or have you ever:

Past Appetite Change? ☐ Yes ☐ No
Sudden Weight Gain or Loss ☐ Yes ☐ No
Binge eat ☐ Yes ☐ No
Laxatives for weight loss ☐ Yes ☐ No
Self-induced vomiting ☐ Yes ☐ No
Diet Pills ☐ Yes ☐ No
Fasting for weight loss ☐ Yes ☐ No
Prior Diagnosis ☐ Yes ☐ No
Current signs/symptoms of eating disorder ☐ Yes ☐ No

FAMILY HISTORY

Family Information/Significant Relationships (siblings, step-relatives, etc.)

Relationship	Name	Age	Living? (y/n)	Living with you? (y/n)
Mother				
Father				
Spouse				
Children				

Are there any mental health or general health problems in your immediate family? ☐ No ☐ Yes

(Describe)_____

_____

_____

_____

_____

_____

Marital Status:

☐ Single	☐ Divorce in Progress	☐ Unmarried, living together
	Length of time: _____	Length of time: _____
☐ Legally Married	☐ Separated	☐ Divorced
Length of time: _____	Length of time: _____	Length of time: _____
☐ Widowed	☐ Annulment	Total number of marriages: _____
Length of time: _____	Length of time: _____	

If not married, are you currently in a relationship? _____ If yes, how long? _____

Are you sexually active? _____

How would you identify your sexual orientation? _____

What is your spouse or significant other's occupation? _____

Describe your current relationship:

_____

_____

_____

_____

_____

Tell us about your parents:

☐ Parents legally married ☐ Mother remarried: Number of times_____

☐ Parents have ever been separated ☐ Father remarried: Number of times_____

☐ Parents ever divorced

Special circumstances (E.g. raised by a person other than parents, information about spouse/children not living with you, etc.)

_____

_____

_____

Were you adopted? ☐ Yes ☐ No

Where did you grow up? _____

What was your mother's occupation? _____

What was your father's occupation? _____

Describe your mother and your relationship with her _____

_____

_____

_____

Describe your father and your relationship with him _____

_____

_____

_____

How old were you when you left home? _____

TRAUMA AND DEVELOPMENT

Were there any complications or situations that impacted your mother's pregnancy or your development? _____

_____

_____

_____

_____

Have you ever experienced the following:

	Before age 18	After age 18	Currently
Emotional Abuse			
Physical Abuse			
Sexual Abuse			
Emotional Neglect			
Physical Neglect			
Domestic Abuse			
Parent treated violently			
Substance use in household			
Mental illness in household			
Parental separation/divorce			
Incarcerated household member			

Please elaborate as you feel comfortable: _____

_____

_____

_____

_____

_____

SUBSTANCE USE

What (if any) is your experience with substances?

	Method and Amount	Frequency	Age of 1st use	Age of last use	Used in the last 48 hours? (y/n)	Used in the last 30 days? (y/n)
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSD						
Inhalants						
Caffeine						
Nicotine						
Over the counter						
Prescription drugs						
Other						

Are there any recent changes in your use patterns? _____

_____

How has your use affected your family and friends (please include their perceptions, if known)

_____

_____

_____

How do you believe substances are affecting your life? _____

_____

Does anyone in your family have a diagnosed or suspected substance use disorder? _____

_____

_____

Have you ever had withdrawal symptoms when you stopped using? ☐ No ☐ Yes (Describe) ___

_____

_____

_____

LEGAL

Are you involved in any active cases (including traffic, civil, criminal)? ☐ No ☐ Yes (Describe)

_____

_____

_____

Are you currently on probation or parole? ☐ No ☐ Yes (Describe)_____

_____

In the past, have you been involved in any of the following:

Traffic Violations ☐ Yes ☐ No

DWI/DUI/OUI, Etc. ☐ Yes ☐ No

Criminal Involvement ☐ Yes ☐ No

Civil Involvement ☐ Yes ☐No

If you responded yes to any of the above, please fill in the following:

Charges	Date	Where (City)	Results

CULTURAL/SPIRITUAL

What cultures do you identify with? _____

_____

Do you engage in any cultural activities? _____

_____

_____

Do you engage in any spiritual activities?_____

_____

_____

Are you affiliated with a spiritual or religious group? ☐ No ☐ Yes (Describe)_____

_____

Were you raised in a spiritual or religious group? ☐ No ☐Yes (Describe)_____

_____

Would you like your spiritual/religious beliefs incorporated into the counseling? ☐No ☐ Yes

(Describe)_____

_____

EDUCATION AND EMPLOYMENT

Are you currently in school? ☐ No ☐ Yes (Describe)_____

What is your highest level of education? _____ _____

Other trainings (ex. trade school, union apprentices, etc.) _____

_____

Special circumstances (learning disabilities, gifted, etc.) _____

_____

Are you currently employed? ☐ No ☐ Yes (Describe)_____

Do you currently experience any difficulties at work (missing work, etc.) _____

_____

_____

_____

Describe your work history (do you change jobs often, any significant periods of

unemployment, etc) _____

_____

_____

_____

_____

Do you have any military experience? ☐ Yes ☐ No Combat experience? ☐ Yes ☐ No

Branch_____ Discharge Date_____

Date Drafted_____ Type of Discharge_____

Date Enlisted_____ Rank at Discharge_____

RECREATION AND LEISURE

Describe any areas of interest, hobbies, or recreational activities you typically enjoy (e.g. art, books, sports, church activities, hunting, traveling, bowling, etc.).

Activity	How often now?	How often in the past?

What do you do for movement or exercise? How often? Please describe.

How many hours of screen time do you engage in per day?

TV _____ Phone_____ Computer _____ Other_____

OTHER

What would you describe as your strengths?

Is there anything else you would like us to know about you?