Psychology & Rehabilitation Services, Ltd.
1535 Laurel Avenue
St. Paul, MN 55104
T:(651)645-0645/F:(651)645-0630

Mental Health Intake Form

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. You may need to ask family members about the family history. Thank you!

Date: _____

Name: _____ **DOB:** _____

Address: _____ **Phone:** _____

Primary Clinic: _____ **Primary Physician:** _____

Address: _____ **Phone:** _____

Current/Past Therapist: _____ **Phone:** _____

What are the problems/issues for which you are seeking help?

1. _____
2. _____
3. _____

What are your main treatment goals?

1. _____
2. _____
3. _____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbances
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Increased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increased risky behavior
( ) Increased need for sleep
( ) Decreased need for sleep
( ) Excessive energy
( ) Decreased energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness/paranoia
( ) Racing heart
( ) _____
( ) _____
( ) _____

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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, skip to the next section)

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? ( ) Yes ( ) No
If YES, please elaborate: _____
_____
On a scale from 1 to 10 (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? ( ) Yes ( ) No
Is the method you would use readily available? ( ) Yes ( ) No
Have you planned a time for this? ( ) Yes ( ) No
Is there anything that would stop you from killing yourself? _____
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: _____

Past Medical History:

Allergies: _____ Current Weight: _____ Height: _____

List ALL 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/supplements: _____
_____
_____

Current medical problems: _____
_____

Past medical problems, nonpsychiatric hospitalizations or surgeries: _____
_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when? _____
Was the EKG ( ) Normal ( ) Abnormal ( ) Unknown

For women only:

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Date of last menstrual period: _____ Currently pregnant? ( ) Yes ( ) No ( ) Unknown
Are you planning on getting pregnant in the near future? ( ) Yes ( ) No
Birth control method: _____
How many times have you been pregnant? _____ How many live births? _____

For everyone:

Do you have any physical health concerns you'd like to discuss? ( ) Yes ( ) No
If YES, please elaborate: _____
_____

Date and place of last physical exam: _____

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease	( )	( )	_____
Anemia	( )	( )	_____
Liver Disease	( )	( )	_____
Chronic Fatigue	( )	( )	_____
Kidney Disease	( )	( )	_____
Diabetes	( )	( )	_____
Asthma/respiratory problems	( )	( )	_____
Stomach/intestinal problems	( )	( )	_____
Cancer _____	( )	( )	_____
Fibromyalgia	( )	( )	_____
Heart disease	( )	( )	_____
Epilepsy/seizures	( )	( )	_____
Chronic Pain	( )	( )	_____
High Cholesterol	( )	( )	_____
High Blood Pressure	( )	( )	_____
Head Trauma	( )	( )	_____
Liver Problems	( )	( )	_____
Other	( )	( )	_____

Is there any additional 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? _____
_____

Past Psychiatric History:
Outpatient treatment ( ) Yes ( ) No (If yes, please describe when, by whom, and dates of treatment)
Reason Dates Treated By Whom
_____
_____
_____

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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 of the details, just write in what you 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 (nortriptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Other _____

Mood Stabilizers

Dates Dosage Response/Side-effects

Tegretol (carbamazepine) _____
Lithium _____
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Topomax (topiramate) _____
Other _____

Antipsychotics/Mood Stabilizers

Dates Dosage Response/Side-effects

Seroquel (quetiapine) _____
Zyprexa (olanzepine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperdone) _____
Other _____

Sedatives/Hypnotics

Dates Dosage Response/Side-effects

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

ADHD Medications

	Dates	Dosage	Response/Side-effects
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Other			

Antianxiety medication

	Dates	Dosage	Response/Side-effects
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Buspar (buspirone)			
Other			

Exercise Level

Do you exercise regularly? ( ) Yes ( ) No
How many days per week do you exercise? _____ For how long? _____
What kind of exercise do you do/enjoy? _____

Family Psychiatric History:

Has anyone in your family been diagnosed or treated for:

Bipolar disorder ( ) Yes ( ) No
Depression ( ) Yes ( ) No
Anxiety ( ) Yes ( ) No
Anger ( ) Yes ( ) No
Post-traumatic stress disorder ( ) Yes ( ) No
Schizophrenia ( ) Yes ( ) No
Alcohol abuse ( ) Yes ( ) No
Other Substance abuse ( ) Yes ( ) No

If yes, indicate which family member _____
_____

Has anyone in your family been treated or sought help for anger/violence? _____
_____

Has any family member ever been treated with psychiatric medication? ( ) Yes ( ) No
If yes, to the best of your knowledge please indicate who, which medications and efficacy of treatment: _____
_____
_____

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Substance Use:
Have you ever been treated for alcohol or drug abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____
Do you use alcohol? ( ) Yes ( ) No
If yes, how many days per week do you use alcohol? _____
How many drinks per day? _____
In the last three months, what is the largest number of alcoholic beverages have you consumed in one day? _____
Have you ever felt you should cut down on your drinking or 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 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 last three months? ( ) Yes ( ) No
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, for how long? _____

Check if you have ever tried the following:

		If yes, how long and when did you last use?
Methamphetamine	( ) Yes ( ) No	_____
Cocaine	( ) Yes ( ) No	_____
Stimulants (pills)	( ) Yes ( ) No	_____
Heroin	( ) Yes ( ) No	_____
LSD or Hallucinogens	( ) Yes ( ) No	_____
Marijuana	( ) Yes ( ) No	_____
Pain killers (not as prescribed)	( ) Yes ( ) No	_____
Methadone	( ) Yes ( ) No	_____
Tranquilizers/sleep meds	( ) Yes ( ) No	_____
Alcohol	( ) Yes ( ) No	_____
Ecstasy	( ) Yes ( ) No	_____
Other _____	( ) Yes ( ) No	_____

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

Tobacco History:
Have you ever smoked cigarettes? ( ) Yes ( ) No If YES, for how long? _____
Currently? ( ) Yes ( ) No When did you quit? _____

Pipes, Cigars or Chewing Tobacco? ( ) Yes ( ) No If YES, for how long? _____
Currently? ( ) Yes ( ) No When did you quit? _____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up? _____
Do you have siblings? ( ) Yes ( ) No If YES, what are their ages? _____
_____

What was/is your father's occupation? _____

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What is/was your mother's occupation? _____
Describe your relationship with your father: _____
_____
Describe your relationship with your mother: _____
_____
How old were you when you left home? _____
Have you experienced the death of an immediate family member? ( ) Yes ( ) No
If YES, who? _____

Trauma History:
Do you have a history of being abused emotionally, physically, sexually or by neglect? ( ) Yes ( ) No
If YES, please describe when, where and by whom: _____
_____
_____

Educational History:
Highest grade completed? _____ Where? _____
Did you attend college? ( ) Yes ( ) No If YES, Where? _____
Major? _____
What is your highest education level or degree? _____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in your present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? ( ) Yes ( ) No
Honorable discharge? ( ) Yes ( ) No If NO, other type of discharge? _____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed/Widower
How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If YES, how long? _____
What is your spouse or significant other's occupation? _____
Describe your relationship: _____
Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation:
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) asexual ( ) prefer not to answer ( ) Other: _____
Have you had any prior marriages? ( ) Yes ( ) No If YES, how many? _____
How long were you married? _____
Do you have children? ( ) Yes ( ) No

If YES, please list ages/gender: _____
_____
Describe your relationship with your children: _____
_____
Please list everyone who currently lives with you: _____
_____
_____

Legal History:

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Have you ever been arrested? ( ) Yes ( ) No
Do you have any pending legal problems? ( ) Yes ( ) No If YES, please explain: _____
_____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If YES, what is your level of involvement? _____

Other Information:
What do you consider to be some of your strengths? _____
_____
_____
_____

What do you like most about yourself? _____
_____
_____

What effective coping strategies have you learned? _____
_____
_____

What are your goals for therapy? _____
_____
_____

PROVIDERS: (please list name/contact information for all medical and mental health providers, not previously listed): _____
_____
_____
_____