MENTAL HEALTH PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of MAO Medical Clinic. . This form is used to collect information about new clients and for internal purposes only. The information you provide is confidential and will be treated accordingly.

PERSONAL INFO

Name: _____ **Date**: _____ **Date of Birth**: _____

Current Physicia:/Clinic/Hospital: _____
Phone: _____

☐ ☐

REASONS FOR VISIT

What are the problems for which you are seeking help?

Current Symptoms: (check all that apply)

- ☐ Racing thoughts
- ☐ Depressed mood
- ☐ Impulsivity
- ☐ Sleep pattern disturbance
- ☐ Avoidance
- ☐ Excessive worry
- ☐ Forgetfulness
- ☐ Unable to enjoy activities
- ☐ Fatigue
- ☐ Suspiciousness
- ☐ Loss of interest
- ☐ Change in appetite
- ☐ Anxiety attacks
- ☐ Excessive guilt
- ☐ Increased risky behavior
- ☐ Increased irritability
- ☐ Increased libido
- ☐ Hallucinations
- ☐ Excessive energy
- ☐ Decreased libido
- ☐ Decreased need for sleep
- ☐ Crying spell
- ☐ _____
  _____

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
-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
-On a scale of 1 to 10, how strongly do you feel these thoughts? _____
-Would anything make it better? ☐ Yes ☐ No
-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? ☐ Yes ☐ No
-Do you feel hopeless and/or worthless? ☐ Yes ☐ No
-Have you tried to kill or harm yourself before? ☐ Yes ☐ No
-Do you have access to firearms? If yes, please explain below. ☐ Yes ☐ No

_____

PAST MEDICAL HISTORY

Do you have any allergies? If yes, specify them: _____

Current Weight: _____ **Current Height:** _____

List any prescription medication that you are currently taking and how often you are taking them:

Medication	Total Daily Dosage	Estimated Start Date

Current over-the-counter medication or supplements: _____

Current medical problems: _____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____

Have you ever had an EKG? ☐ Yes ☐ No
If yes, when? _____ How was the EKG? ☐ Normal ☐ Abnormal ☐ Unknown

For women only

Date of last menstrual period: _____ **Birth control method**: _____

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

How many times have you been pregnant? _____ **How many live births?** _____

Any concerns about your physical health that you would like to discuss? ☐ Yes ☐ No
If yes, please specify:

Date of last physical exam: _____ **Location**: _____

PERSONAL AND FAMILY MEDICAL HISTORY

Check any that apply to you or a member of your family (specify who if selected):

Thyroid disease	☐ You ☐ Family member (_____)
Anemia	☐ You ☐ Family member (_____)
Liver disease	☐ You ☐ Family member (_____)
Chronic fatigue	☐ You ☐ Family member (_____)
Kidney disease	☐ You ☐ Family member (_____)
Diabetes	☐ You ☐ Family member (_____)
Asthma/respiratory problems	☐ You ☐ Family member (_____)
Stomach or intestinal problems	☐ You ☐ Family member (_____)
Cancer	☐ You ☐ Family member (_____)
Fibromyalgia	☐ You ☐ Family member (_____)
Heart disease	☐ You ☐ Family member (_____)
Epilepsy or seizures	☐ You ☐ Family member (_____)
Chronic pain	☐ You ☐ Family member (_____)
High cholesterol	☐ You ☐ Family member (_____)
High blood pressure	☐ You ☐ Family member (_____)
Head trauma	☐ You ☐ Family member (_____)
Liver problems	☐ You ☐ Family member (_____)
Other: _____	☐ You ☐ Family member (_____)

Any other additional personal or family medical history?

When your mother was pregnant with you, were there any complications during the pregnancy or birth? ☐ Yes ☐ No
If yes, please specify:

PSYCHIATRIC HISTORY

Outpatient Treatment? ☐ Yes (if yes, specify the details below) ☐ No

Reason	Date Treated	By Whom

Psychiatric Hospitalization? ☐ Yes (if yes, specify the details below) ☐ No

Reason	Date Hospitalized	Where
nini		

List any psychiatric medication you have taken, the dates, dosage, and any side effects:

Medication	Date	Dosage	Side Effects

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family been treated for:

☐ Bipolar disorder ☐ Depression ☐ Anxiety ☐ Anger ☐ Suicide ☐ Schizophrenia
☐ Post-traumatic stress ☐ Alcohol abuse ☐ Violence ☐ Other: _____

If any of the options were selected, specify the family member and the corresponding problem:

Has any family member been treated with psychiatric medication? If yes, who was treated, what medications did they take, and how effective was the treatment?

SUBSTANCE USE

Have you ever been treated for alcohol or drug use? ☐ Yes ☐ No
-If yes, for which substances? _____
-If yes, where were you treated and when? Date: _____ Location: _____

How many days per week do you drink alcohol? ____

What is the least and the most # of drinks you will drink in a day? Least: ____ Most: ____

What is the most alcohol you have consumed in a day in the last 90 days? _____

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 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? _____

Have you ever tried any of the following?

Substance	If so, how long and when did you last use?
☐ Methamphetamine	_____
☐ Cocaine	_____
☐ Stimulants (pills)	_____
☐ Heroin	_____
☐ LSD or Hallucinogens	_____
☐ Marijuana	_____
☐ Painkillers (not as prescribed)	_____
☐ Methadone	_____
☐ Tranquilizer/sleeping pills	_____
☐ Alcohol	_____
☐ Ecstasy	_____
☐ Other: _____	_____

PERSONAL HABITS

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

Have you ever smoked cigarettes? ☐ Yes ☐ No
-Currently? ☐ Yes ☐ No
If yes, how many packs per day on average? ____ How many years have you smoked? _____

-In the past? ☐ Yes ☐ No
If yes, how many years did you smoke? _____ When did you quit? _____

Do you exercise regularly? ☐ Yes ☐ No
-How many days a week? _____ How much time each day? _____
-What kind of exercise do you do? _____

PERSONAL DETAILS

Were you adopted? ☐ Yes ☐ No **Where did you grow up?** _____

List your siblings and their ages:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

What is/was your parent's occupation? Father: _____ Mother: _____

Did your parents divorce? ☐ Yes ☐ No
-If yes, what age were you? _____ Who did you live with? _____

Describe your father and your relationship with him:

Describe your mother and your relationship with him:

How old were you when you left home? _____

Has anyone in your immediate family died? If yes, specify who and when:
_____

Do you have a history of being abused emotionally, sexually, physically, or by neglect? If yes, describe when, where, and by whom:

Highest education level attained? _____

Employment status: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
-How long have you been in your present position? _____
-If working or retired, what is/was your occupation? _____
-What location do/did you work? _____

Have you ever served in the military? ☐ Yes ☐ No
-If yes, what branch? _____ When did you serve? _____
-Were you honorably discharged? ☐ Yes ☐ No ☐ Other: _____

Marital status: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed
-How long have you been in your present status? _____
-If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long? _____
-If you have a partner or spouse, what is their occupation? _____
-Describe your relationship with your partner or spouse:

Have you had any prior marriages? ☐ Yes ☐ No
-If so, how many? ____ How long were/was the marriage(s)? _____

Are you sexually active? ☐ Yes ☐ No **What is your sexual orientation?** _____

Do you have any children? ☐ Yes ☐ No
If yes, specify their age and gender:

Age	Gender
____	_____
____	_____
____	_____
____	_____

Describe your relationship with your children:

List everyone who currently lives with you:

Have you ever been arrested? ☐ Yes ☐ No **Any pending legal problems?** ☐ Yes ☐ No

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 towards your mental health, or does the involvement make things more difficult or stressful for you? ☐ Helpful ☐ Stressful

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

ACKNOWLEDGMENT

Signature: _____ Date: _____

Print Name: _____

Guardian Signature (if required) _____ Date: _____

Print Name: _____

Emergency Contact: _____ Phone Number: _____