



## **PATIENT INTAKE FORM**

*The therapy and counseling work we do is unique to you, just as it is to each one of our clients.  
Before your first visit, we need to collect some general information from you.*

### **GENERAL INFORMATION**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

GENDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_

ADRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

MAIN PHONE \_\_\_\_\_ OTHER PHONE \_\_\_\_\_

SUPPORTIVE LIVING ENTITY \_\_\_\_\_

PROGRAM MANAGER \_\_\_\_\_

PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

### **EMERGENCY CONTACT**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

### **INSURANCE INFORMATION**

PRIMARY INSURANCE \_\_\_\_\_ POLICY HOLDER \_\_\_\_\_

POLICY HOLDER DOB \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

POLICY HOLDER ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

SECONDARY INSURANCE \_\_\_\_\_ POLICY HOLDER \_\_\_\_\_  
POLICY HOLDER DOB \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
POLICY HOLDER ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
MAIN PHONE \_\_\_\_\_ OTHER PHONE/EMAIL \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_

**PRIMARY CARE PROVIDER**

NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

**PHARMACY**

NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

# iMind Mental Health and Wellness 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.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ PCP Phone: \_\_\_\_\_

Are you receiving mental health treatment at this time?  Yes  No If YES, where: \_\_\_\_\_

\_\_\_\_\_

What mental health services are you seeking?

Psychiatry  Therapy/counseling

Why are you seeking mental health treatment at this time?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What do you hope to gain from mental health treatment? What would you like to be different?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What do you like about yourself? What are your personal strengths? \_\_\_\_\_

\_\_\_\_\_

What are your interests and hobbies? \_\_\_\_\_

\_\_\_\_\_

What is important to you? \_\_\_\_\_

\_\_\_\_\_

What helps you to feel calm? \_\_\_\_\_

\_\_\_\_\_

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Depressed Mood             | <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Concentration/forgetfulness |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Loss of interest         | <input type="checkbox"/> Change in appetite          |
| <input type="checkbox"/> Increased need for sleep   | <input type="checkbox"/> Decrease in energy       |  |

## Please Check All Symptoms That Apply

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Excessive guilt          | <input type="checkbox"/> Anxiety attacks     | <input type="checkbox"/> Violent thoughts       |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Avoidance           | <input type="checkbox"/> Violence toward others |
| <input type="checkbox"/> Decreased libido         | <input type="checkbox"/> Hallucinations      | (anyone specific?)                              |
| <input type="checkbox"/> Increased libido         | <input type="checkbox"/> Suspiciousness      | _____   |
| <input type="checkbox"/> Racing thoughts          | <input type="checkbox"/> Suicidal thoughts   | _____   |
| <input type="checkbox"/> Impulsivity              | <input type="checkbox"/> Self-harm (explain, |   |
| <input type="checkbox"/> Risky behavior (explain, | _____)                                       |   |
| _____)  |  |   |
| <input type="checkbox"/> Excessive energy         | <input type="checkbox"/> Other, _____        |   |
| <input type="checkbox"/> Increased irritability   | <input type="checkbox"/> Other, _____        |   |
| <input type="checkbox"/> Crying spells            |  |   |
| <input type="checkbox"/> Excessive worry          |  |   |

### 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? \_\_\_\_\_

Would anything make it better? \_\_\_\_\_

Do you have a plan to kill yourself? \_\_\_\_\_

Is the method you would use readily available? \_\_\_\_\_

Is there anything that would stop you from killing yourself? \_\_\_\_\_

Do you feel hopeless and/or worthless? \_\_\_\_\_

Have you ever tried to kill yourself before? \_\_\_\_\_

Do you have access to guns, weapons, medications, or anything you can hurt yourself with?

Yes  No If YES, please, explain. \_\_\_\_\_

**Medical Information**

Allergies: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_

List ALL current prescription medications and how often you take them. A copy of your MAR is fine.

Medication Name	Reason	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements

Medication/ Supplement Name	Reason

**For women only:** Are you currently pregnant or do you think you may be pregnant?  Yes  No

Do you have any concerns about your physical health that you would like to discuss with us?  Yes  No

Date and place of last physical exam: \_\_\_\_\_

**Personal and Family Medical History/Status**

	You	Family Member(s)	Which Family Member(s)?
Anemia			
Asthma/respiratory problems			
Cancer (type)			
Chronic Fatigue			
Chronic Pain			
Diabetes			
Epilepsy or seizures			
Fibromyalgia			
Head trauma/ Traumatic Brain Injury			
Heart Disease			
High blood pressure			
High cholesterol			
Intellectual or Developmental Disability			
Kidney Disease			
Liver Disease/ problems			
Stomach or intestinal problems			
Thyroid Disease			
Other			

Past medical problems, non-psychiatric hospitalizations or surgeries: \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had an EKG?  Yes  No    Was the EKG  normal  abnormal  unknown

**Mental Health History/Status**

Have you participated in outpatient mental health treatment before?  Yes  No    If YES, describe.

Reason for outpatient mental health treatment	Dates Treated	By Whom (Where)	Was it a positive OR negative experience?

Have you been hospitalized for mental health treatment before?  Yes  No    If YES, describe.

Reason for inpatient mental health treatment	Dates Treated	By Whom (Where)	Was it a positive or negative experience?

Past psychotropic medications: If you have ever taken any of the following medications, please, indicate the dates and how helpful the medication was. (If you can't remember all the details just write in what you do remember.)

	Dates	Response/ Side-Effects
<b>Antidepressants</b>		
Anafranil (clomipramine)		
Celexa (citalopram)		
Cymbalta (duloxetine)		
Effexor (venlafaxine)		
Elavil (amitriptyline)		
Lexapro (escitalopram)		
Luvox (fluvoxamine)		
Pamelor (nortriptyline)		
Paxil (paroxetine)		
Prozac (fluoxetine)		
Remeron (mirtazapine)		
Serzone (nefazodone)		
Tofranil (imipramine)		
Wellbutrin (bupropion)		
Zoloft (sertraline)		
Other		
<b>Mood Stabilizers</b>		
Depakote (valproate)		
Lamictal (lamotrigine)		
Lithium		
Tegretol (carbamazepine)		
Topamax (topiramate)		
Other		

	Dates	Response/ Side-Effects
<b>Antipsychotics/Mood Stabilizers</b>		
Abilify (aripiprazole)		
Clozaril (clozapine)		
Geodon (ziprasidone)		
Haldol (haloperidol)		
Prolixin (fluphenazine)		
Risperdal (risperidone)		
Seroquel (quetiapine)		
Zyprexa (olanzepine)		
Other		
<b>Sedative/Hypnotics</b>		
Ambien (zolpidem)		
Desyrel (trazadone)		
Restoril (temazepam)		
Rozerem (ramelteon)		
Sonata (zaleplon)		
Other		
<b>ADHD medications</b>		
Adderall (amphetamine)		
Concerta (methylphenidate)		
Ritalin (methylphenidate)		
Strattera (atomoxetine)		
Other		
<b>Antianxiety medications</b>		
Ativan (lorazepam)		
Buspar (buspirone)		
Klonopin (clonazepam)		
Tranxene (clorazepate)		
Xanax (alprazolam)		
Valium (diazepam)		
Other		

**Substance Use**

Have you had treatment for alcohol or drug abuse?  Yes  No Which substances? \_\_\_\_\_

\_\_\_\_\_

In the past 3 months, what is the largest amount of alcohol you have consumed in one day? \_\_\_\_\_

Have you used street drugs in the past 3 months?  Yes  No Which drugs? \_\_\_\_\_



Have you ever abused prescription medication?  Yes  No

If YES, which one(s) and for how long? \_\_\_\_\_

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

Has anyone said that you may have a problem with alcohol or drug use?  Yes  No

Do you think you may have a problem with alcohol or drug use?  Yes  No

Have ever tried the following?

	Yes	No	If YES, how long and when did you last use?
Alcohol			
Cocaine			
Ecstasy			
Heroin			
LSD or hallucinogens			
Marijuana			
Methadone			
Methamphetamine			
Pain killers (not as prescribed)			
Stimulant (pills)			
Tranquilizer/ sleeping pills			
Other?			

### Tobacco and Caffeine

How many caffeinated beverages do you drink a day?

Coffee \_\_\_\_\_ Sodas \_\_\_\_\_ Tea \_\_\_\_\_ Energy Drinks \_\_\_\_\_

Do you currently smoke?  Yes  No If YES, for how many years? \_\_\_\_\_

Pipe, cigars, or chewing tobacco: Currently use?  Yes  No

What kind? \_\_\_\_\_ For how many years? \_\_\_\_\_

### Family Background and Childhood History

Ethnic/ cultural background: \_\_\_\_\_

Were you adopted?  Yes  No Where did you grow up? \_\_\_\_\_

Who did you live with when you were a child? \_\_\_\_\_

What was your relationship like with the person or people who raised you? \_\_\_\_\_

How old were you when you left home? \_\_\_\_\_

### Trauma History or Trauma Witnessed

Have you experienced?

Physical Abuse:  Yes  No

Emotional abuse:  Yes  No

Neglect:  Yes  No

Sexual Abuse as Victim:  Yes  No

Sexual Abuse as Perpetrator:  Yes  No

Have you witnessed anyone being abused?  Yes  No

Has anyone in your immediate family died? \_\_\_\_\_

Have you experienced any distressful or painful events that still bother you?  Yes  No

Please, elaborate on any YES responses. \_\_\_\_\_

### Educational History

Highest grade completed? \_\_\_\_\_ Where? \_\_\_\_\_

Did you participate in Special Education?  Yes  No Describe. \_\_\_\_\_

Completed some college or vocational training?  Yes  No Describe. \_\_\_\_\_

Completed four year degree?  Yes  No Describe. \_\_\_\_\_

Completed graduate degree?  Yes  No Describe. \_\_\_\_\_

*Reading Level:*

Cannot read

Can read some

Can read very well

*Writing Level:*

Cannot write

Can write some

Can write very well

Do you need assistive technology?  Yes  No Describe. \_\_\_\_\_

Do you need an interpreter (sign language or language other than English)?  Yes  No Describe. \_\_\_\_\_

**Occupational History**

**Are you currently:**  Working  Unemployed, looking for work  Unemployed, not looking for work  
 Disabled  Retired  Student

Where do you work? \_\_\_\_\_ For how long? \_\_\_\_\_

What kind of work have you done in the past? \_\_\_\_\_

Have you ever served in the military?  Yes  No Describe. \_\_\_\_\_

**Relationships and Current Living Situation**

Are you currently:  Single  Married  Divorced  Widowed  Partnered

How long have you been married or partnered? \_\_\_\_\_

How long have you been divorced or widowed? \_\_\_\_\_

If you are not married or partnered, are you currently in a relationship?  Yes  No

Describe your relationship with your spouse/ significant other. \_\_\_\_\_

How would you identify your sexual orientation?

- straight/heterosexual  lesbian/ gay/ homosexual  bisexual  transgender
- unsure/ questioning  asexual  other, \_\_\_\_\_  prefer not to answer

Do you have children?  Yes  No How many? \_\_\_\_\_

Where do you live?  alone, without paid supports  alone, with paid supports

supported housing/living  with family/ significant other/ natural supports  Other, \_\_\_\_\_

Who lives with you?

Name	Relationship

**Legal**

Have you ever been arrested?  Yes  No Describe. \_\_\_\_\_

Do you have any pending legal problems?  Yes  No Describe. \_\_\_\_\_

**Spiritual/Religious**

What is your religious preference? \_\_\_\_\_

Do you find your involvement helpful during this time in your life?  Yes  No

How does practicing your religion help you?

Describe. \_\_\_\_\_

Is there anything else you would like us to know?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who helped you to complete this form? \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

**For Clinic Use Only:** Admission Date (the date of the FIRST appointment): \_\_\_\_\_

Intake form has been reviewed Clinician's initials: \_\_\_\_\_

Initial assessment session or initial psychiatric evaluation has been completed with the person to be served. (\*See session note or psych. eval.) Clinician's initials: \_\_\_\_\_

Based on review of this information and the initial assessment session or initial psychiatric evaluation with the person to be served, this person **CAN** be supported appropriately by iMind Mental Health and Wellness.

Clinician's initials: \_\_\_\_\_

**OR**

Based on review of this information and the initial assessment session or initial psychiatric evaluation with the person to be served, this person **CANNOT** be supported appropriately by iMind Mental Health and Wellness.

Clinician's initials: \_\_\_\_\_

Clinician's Printed Name and Title: \_\_\_\_\_

Clinician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_