CLEAR MINDS
Family & Mental Health

PATIENT INTAKE FORM - Confidential

Please complete all the following information prior to your first visit. If there are questions you are unable to answer, or are uncomfortable answering, just leave them blank. Providing us with thorough information prior to your evaluation helps make your appointment time more efficient . If you wish to add supplementary information, please attach an extra page or add to the last page. Thank you for your time.

REFERRAL INFORMATION

Name _____ Today'sDate _____Date of Birth ____ Age_____

If someone referred you to this office, please list here: _____

What are the problem(s)/ issues that bring you to this office?

_____

_____

What are your treatment goals/ what do you hope to achieve from your appointment?

_____

_____

Depressed mood		Irritability		Paranoia/suspiciousness	
Fatigue		Anger problems		Hallucinations	
Lack of enjoyment in activities		Decreased sleep need		Eating disorder symptoms	
Decreased sex drive		Increased sex drive		Disorganized thoughts	
Feelings of hopelessness		Racing thoughts		Homicidal thoughts	
Sleep problems		Excessive energy		Self-harm thoughts	
Weight change		Impulsivity		Marital problems	
Avoidance of activities		Thoughts of hurting others		School problems	
Crying spells		Excessive worry		Problems with family	
Excessive guilt		Muscle tension		Problems with work/friends	
Lack of concentration		Anxiety Attacks		Legal problems	
Feelings of worthlessness		Obsessions or compulsions		Housing problems	
Memory problems		Flashbacks to trauma		Physical reactions to stress	
Mood swings		Nightmares		Other issues not listed	
Gambling		Mania		Sexual problems	
Substance abuse		Other addictions not listed		Purging	

List other history /symptoms here: _____

Suicide /SafetyRisk Assessment:

Have you ever harmed yourself on purpose? ( )YES ( ) NO
Have you ever assaulted anyone else? ( )YES ( ) NO
Do you have thoughts of harming anyone else? ( )YES ( ) NO
Do you have plans to harm anyone else? ( )YES ( ) NO

Have you ever had feelings that you don't want to live? ( )YES ( ) NO
If yes, answer the following. (If no, skip to next section.)

Do you currently feel that you don't want to live? ( )YES ( ) NO
Do you have a plan for suicide at this time? ( )YES ( ) NO
Is the method readily available? ( )YES ( ) NO
When was the last time you had thoughts of dying? _____
How often are these thoughts present?_____
Have you ever attempted suicide before?( )YES ( ) NO
If so, what was the method, and when did this occur? _____
Access to weapons in the home( )YES ( ) NO

MEDICAL HISTORY

Primary Care Physician: _____ Phone number: _____

Date of last physical exam: _____ Date of last labs: _____

Allergies: _____ Preferred Pharmacy: _____

List All Current Medications ***: (include psychiatric and medical)*** **Attach a list if necessary.**

Medication	Dose	Reason	Prescribed by

Current over the counter supplements: _____
Exercise level:
How frequently do you exercise? _____
What type of exercise do you do?_____

Do you eat a healthy diet? ( )YES ( )NO

Medical illnesses/surgeries please list:

History of head injury: ( )YES ( )NO
Details:
Seizures:( )YES ( )NO

Review of *current* physical symptoms:

General ( )YES ( ) NO
(Fever, weight changes, fatigue)

Cardiovascular ( )YES ( ) NO
(Chest pain, palpitations)

Eyes/Ears/nose
Throat/mouth ( )YES ( ) NO
(Vision change, hearing loss, dental)

Dermatologic ( )YES ( ) NO (Rash, sensitivities)

Genitourinary ( ) YES ( ) NO
Painful or frequent urination, impotence

Hematological( )YES ( ) NO
(Bruising, blood loss)

Gastrointestinal ( )YES ( )NO
(Diarrhea, constipation)

Musculoskeletal( )YES( ) NO
(Pain, injury, stiffness)

Respiratory ( )YES ( ) NO
(shortness of breath, wheezing)

Other physical symptoms- _____
Current birth control ( )YES ( ) NO If yes, which type _____

For women only: If not applicable , skip to next section.
Date of last menses: _____ Are you now pregnant? ( )YES ( ) NO
Are you planning to get pregnant? ( )YES ( ) NO

PSYCHIATRIC/SUBSTANCE ABUSE TREATMENT HISTORY

Patient History:

Outpatient treatment : ( )YES ( ) NO
Reason:_____
Dates: _____
By whom: _____

Current Therapist/counselor: _____Phone number: _____
How often do you see your therapist?_____

Inpatient Treatment history： ( )YES ( ) NO If no, skip to next section.

Date	Name of Facility	Location	Reason

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Patient Name: _____

Past psychiatric medications:

Antidepressants	Helpful	Not helpful	Never took
Celexa			
Cymbalta			
Effexor			
Lexapro			
Luvox			
Paxil			
Pristiq			
Prozac			
Remeron			
Serzone			
Tricyclics			
Viibryd			
Wellbutrin			
Zoloft			
Other			

Mood stabilizers	Helpful	Not helpful	Never took
Depakote			
Lamictal			
Lithium			
Tegretol			
Topamax			
Trileptal			
Gabapentin			
Other			

Stimulants	Helpful	Not helpful	Never took
Ritalin			
Adderall			
Strattera			
Concerta			
Intuniv			
Vyvanse			
Wellbutrin			
Other			

Other	Helpful	Not helpful	Never took
Vivitrol			
Methadone			
clonidine			
Suboxone			

Antipsychotics/Mood Stabilizers	Helpful	Not helpful	Never took
Abilify			
Clozaril			
Geodon			
Haldol			
Invega			
Latuda			
Prolixin			
Risperdal			
Seroquel			
Saphris			
Zyprexa			
Other			

Sedatives/ Hypnotics-	Helpful	Not helpful	Never took
Ambien			
Doxepin			
Lunesta			
Restoril			
Rozerem			
trazodone			
Seroquel			
Sonata			
Other			

Anxiolytics	Helpful	Not helpful	Never took
Xanax			
Ativan			
Klonopin			
Valium			
Buspar			
clonidine			
Lyrica			
gabapentin			
Other			

Other:

SOCIAL HISTORY

Substance Use History:

Have you ever been treated for alcohol or drug abuse? ( ) YES ( ) NO
If yes, for which substance, when and where was the treatment? _____
Do you think that you may have a problem with alcohol or drugs? ( ) YES ( ) NO
If yes, which ones?_____
How many days weekly do you drink alcohol? _____
Longest period of sobriety_____
History of IV use: ( )YES ( ) NO

Substance	No Use	Last Use	Amount	Frequency	Duration (years)	Other Information
Alcohol						
Opiates						
Benzodiazepines						
Amphetamines						
Marijuana						
Cocaine						
Nicotine						
Hallucinogens						
Designer Drugs						
Inhalants						
Other						

Family background and Childhood History :

Where were you born? _____
Where did you grow up? _____
Were you adopted? _____
Did you have any problems with early development (learning to walk and talk, etc.)? ( )YES ( ) NO
Did you or any family members suffer from any major illness while you were growing up?
( )YES ( ) NOPlease describe:
List your siblings and their ages._____

What was your mother's occupation?_____
Describe your mother and your relationship with her. _____

What was your father's occupation? _____
Describe your father and your relationship with him.
_____

Did your parents divorce? ( )YES ( ) NO
If so, who did you live with and what was your age at the time of the divorce?_____

Trauma history:
Do you have a history of emotional, physical, sexual abuse or neglect? ( )YES ( ) NO
If so, please describe when, where and by whom. _____
Have you lived through an experience that you or others consider to be traumatic? ( )YES ( ) NO
If so, what and when?_____
Has anyone close to you died? ( )YES ( ) NO
If so, who and when? _____

Family Mental Health History:
Has anyone in your family been diagnosed with a psychiatric illness? ( ) YES ( ) NO
If yes, who had what problems?_____

Have any family members been treated with psychiatric medications? ( ) YES ( ) NO
If so which medications? _____
Is there any family history of suicide? ( ) YES ( ) NO
Is there any family history of substance abuse/ dependence?( ) YES ( ) NO
If yes, who had what problems?_____
Educational History :
If a currently student, where do you attend school and which grade are you in?
_____
For adults:
Did you attend college? ( )YES ( ) NO If so where, and what was your major?
What is the highest level of education you have achieved?

Occupational History :
Are you currently ( ) a full time student ( ) working ( ) not working by choice ( ) unemployed ( ) disabled ( ) retired?
If applicable what is or was your occupation?
Where do you work and for how long?
For adults:
Relationship History and Living Situation:
Are you currently ( ) married ( ) divorced ( ) single ( ) widowed For how long? _____
How many marriages have you had?_____
If not married, are you currently in a relationship? ( )YES ( ) NO For how long? _____
If in a relationship what is or was your spouse's/partner's occupation?_____
Describe your relationship._____
What is your sexual orientation? _____
If you have children, list ages and gender._____
Describe your relationship with your children._____
_____
For children and Adults:

Who lives in your home with you at this time? _____
Do you have someone who you can confide in when you are under stress? ( )YES ( ) NO
Do you have any pets? ( )YES ( ) NOIf yes, what type?_____

Legal history :
Have you ever been arrested? If so, for what and when?_____
Do you have any pending legal issues? _____

Spirituality:

If you were raised practicing any religion, which one ?_____
Do you belong to any spiritual group or religion now? _____
Which religion _____
Is your spiritu al life important to you? _____
Do you practice your faith regularly? _____
Is your spirituality/faith available and helpful to you when you are in difficu lt situations?
( )YES ( ) NO

Additional information that you would like the doctor to know:

SIGNATURE_____ **DATE**_____