Psychiatric Arts of New Jersey
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 familyhistory.

Name_____ Date_____

Date of Birth_____ Primary Care Physician_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Current Therapist/Counselor_____ Therapist's Phone_____

What are the problem(s) for which you are seeking help?

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

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

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

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No.

If NO, please skip to the next section.

If YES, please answer the following:

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? _____

On a scale of 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? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? 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 or supplements:

Current medical problems:

Past medical problems, nonpsychiatric hospitalization, or surgeries:

Have you ever had an EKG? ☐ Yes ☐ No If yes, when _____
Was the EKG ☐ normal ☐ abnormal or ☐ unknown?

For women only:
Date of last menstrual period _____
Are you currently pregnant or do you think youmight be pregnant? ☐ Yes ☐ No.
Are you planning to get pregnant in the near future? ☐ Yes ☐ Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

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:

	You	Family	Which Family Member?
Thyroid Disease ----------	☐	☐	
Anemia----------	☐	☐	
Liver Disease ----------	☐	☐	
Chronic Fatigue ----------	☐	☐	
Kidney Disease ----------	☐	☐	
Diabetes ----------	☐	☐	
Asthma/respiratory problems ------	☐	☐	
Stomach or intestinal problems -------	☐	☐	
Cancer (type) ----------	☐	☐	
Fibromyalgia ----------	☐	☐	
Heart Disease ----------	☐	☐	
Epilepsy or 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 nature of treatment:

Reason	Dates Treated	By Whom

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 thedates, 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			

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects
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			

Your Exercise Level:

Do you exercise regularly? ☐ Yes ☐ No

How many days a week do you get exercise?

How much time each day do you exercise?

What kind of exercise do you do?

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	☐ Yes	☐ No	Schizophrenia	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Post-traumatic stress	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Alcohol abuse	☐ Yes	☐ No
Anger	☐ Yes	☐ No	Other substance abuse	☐ Yes	☐ No
Suicide	☐ Yes	☐ No	Violence	☐ Yes	☐ No

If yes, who had each problem?

Has any family member been treated with a psychiatric medication? ☐ Yes ☐ No

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 or abuse? ☐ Yes ☐ No

If yes, for which substances?

If yes, where were you treated and when?

How many days per week do you drink any alcohol?

What is the least number of drinks you will drink in a day?

What is the most number of drinks you will drink in a day?

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?

Have you ever felt you ought to 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? How often?

Have you ever abused prescription medication? ☐ Yes ☐ No

If yes, which ones and for how long?

Check if you have ever tried the following:

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

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

Tobacco History:

How you ever smoked cigarettes? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No How many packs per day on average? How many years?

In the past? ☐ Yes ☐ No How many years did you smoke? When did you quit?

Pipe, cigars, or chewing tobacco: Currently? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

What kind?

How often per day on average?

How many years?

Family Background and Childhood History:

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

List your siblings and their ages:

What was your father's occupation?

What was your mother's occupation?

Did your parents' divorce? ☐ Yes ☐ No If so, how old were you when they divorced?

If your parents divorced, who did you live with?

Describe your father and your relationship with him:

Describe your mother and your relationship with her:

How old were you when you left home?

Has anyone in your immediate family died?

Who and when?

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ Yes ☐ No.

Please describe when, where and by whom:

Educational History:

Highest Grade Completed? Where?

Did you attend college? Where? Major?

What is your highest educational level or degree attained?

Occupational History:

Are you currently: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired How long in present position?

What is/was your occupation?

Where do you work?

Have you ever served in the military? If so, what branch and when?

Honorable discharge ☐ Yes ☐ No ☐ Other type discharge

Relationship History and Current Family:

Are you currently: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed

How long?

If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long?

Are you sexually active? ☐ Yes ☐ No

How would you identify your sexual orientation?

☐ straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual ☐ transsexual
☐ unsure/questioning ☐ asexual ☐ other ☐ prefer not to answer

What is your spouse or significant other's occupation?

Describe your relationship with your spouse or significant other:

Have you had any prior marriages? ☐ Yes ☐ No. If so, how many?

How long?

Do you have children? ☐ Yes ☐ No If yes, list ages and gender:

Describe your relationship with your children:

List everyone who currently lives with you:

Legal History:
Have you ever been arrested?
Do you have any pending legal problems?

Spiritual Life:
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 during this illness, or does the involvement make things more difficult or stressful for you? ☐ more helpful ☐ stressful

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

When asked to provide a signature, you have the option of: [1] typing your name, [2] uploading an image of your signature, or [3] signing with your computer mouse.

Signature_____ Date_____

Guardian Signature (if under age 18)_____ Date _____

Emergency Contact_____ Telephone # _____

For Office Use Only:

Reviewed by_____ Date_____

Reviewed by_____ Date _____