INTAKE FORM

DEMOGRAPHICS:

Name: _____ Birth Date: ____/_____/_____

Identified Gender: _____ **Race**: _____ **Marital Status**: _____

Address: _____ **Phone Number:** _____

_____ **Other Ph. Number:** _____

Parent/Guardian name: _____

Emergency Contact Name and Number: _____

Pharmacy (Name/Address): _____

IMPORTANT FAMILY MEMBERS:

NAME	RELATIONSHIP	AGE	IN SAME HOUSEHOLD? Y/N

CURRENT SYMPTOMS AND PAST HISTORY:

Symptoms	No	Yes (If yes, please explain)
Sleep Disturbance		
Weight Change		
Change in Appetite		
Lack of Motivation		
Sexual Problems		
Poor Concentration		
Hopelessness		

Have you or anyone in your family experienced the following?

Diagnosis/Concern	Self	Family	Comments
Anxiety			
Panic Attacks			
Bipolar Disorder			
Depression			
Suicidal Ideations or Attempts			
Hallucinations			

Diagnosis/Concern (Continued)	Self	Family	Comments
Paranoia			
Schizophrenia			
Thoughts of harming a living creature			
Anger Problems or violence			
Eating Disorder			
Emotional/Verbal Abuse			
Sexual Abuse			
Physical Abuse			
Attention Deficit Disorder			
Substance Abuse (please specify type of drug)			

PAST AND CURRENT MENTAL HEALTH SERVICES:

Services	Yes/No	Agency/Contact Person:	Dates:
Outpatient			
BHRS/Wraparound (MT; BSC; TSS)			
Family-Based			
Partial Hospitalization			
Inpatient Hospitalization or DAS			
RTF			
Drug and Alcohol			

PAST AND CURRENT MEDICATIONS:

Name of Medication	Dosage/Frequency	Condition	Prescribed by:	Dates:

Has there been any changes to your medication in the past 60 days? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Are you currently experiencing any side effects from your medication? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Have you had past side effects from specific medication? ☐ Yes ☐ No

If yes, please specify reaction and medication:

_____

_____

MEDICAL HISTORY:

PRIMARY CARE PHYSICIAN:

Name: _____ Date Last Seen: ____/_____/_____

Address: _____ Phone Number: _____

_____

Have you had a physical in the past year? ☐ Yes ☐ No **Are you pregnant?** ☐ Yes ☐ No ☐ N/A

Do you have any current physical problems or concerns? ☐ Yes ☐ No

If yes, please specify concerns:

_____

_____

Do you currently have any allergies to any foods, medications, or environmental conditions? ☐ Yes ☐ No

If yes, please specify:

_____

_____

Have you or a family member had a history of any of the following diseases/illnesses? (if yes, please indicate who in the family has experienced this condition):

Disease/Illness	No	Yes (If yes, please explain)
Heart Problems		
High or Low Blood Pressure		
Stroke		
Cancer (Type)		
Arthritis		
Epilepsy		
Diabetes		
Anemia		
Kidney Problems		
Eye/Ear Problems		
Liver Conditions		
Lung/Breathing Problems		
Thyroid Condition		
Sexual Transmitted Disease(s)		
Other:		

SAFETY ASSESSMENT:

Do you have current thoughts about harming or killing yourself? ☐ **No** ☐ **Yes (if yes, please describe):**

_____

_____

***** IF EXPERIENCING ACTIVE THOUGHTS TO KILL YOURSELF, PLEASE CONTACT 911 OR PROCEED TO THE NEAREST EMERGENCY ROOM**

Do you, or have you, had thoughts that you would be better off dead or wished you were dead? ☐ **No** ☐ **Yes (if yes, please indicate if the client has a current safety plan or able to contract for safety):**

_____

_____

Have you thought about, or tried, killing yourself in the past? ☐ **No** ☐ **Yes (if yes, please describe previous attempt/plan and outcome such as hospitalization, medication, treatment):**

_____

_____

Have you ever cut yourself or hurt yourself on purpose? ☐ **No** ☐ **Yes (if yes, please describe):**

_____

_____

Any past history or thoughts/attempts to hurt others? ☐ **No** ☐ **Yes (if yes, please describe):**

_____

_____

Do you have any history of violence or aggression? ☐ **No** ☐ **Yes (if yes, please describe):**

_____

_____

Have you ever experienced hearing or seeing things that others do not? ☐ **No** ☐ **Yes (if yes, please describe):**

_____

_____

Have you ever had any concerns about your weight that have caused you to restrict your diet, exercise excessively, binge, make yourself vomit, or use diuretics or laxatives? ☐ **No** ☐ **Yes (if yes, please indicate type and most recent episode and any history of treatment):**

_____

_____

SUBSTANCE ABUSE:

Do you believe you have an alcohol or drug problem? ☐ Yes ☐ No

Have family/friends ever told you that they thought you had an alcohol or drug problem? ☐ Yes ☐ No

Have you experienced any consequences as a result of your substance usage? ☐ Yes ☐ No ☐ N/A **(Loss of employment, trouble in school, legal involvement, impact on relationships with family and others, impact on your health).**

If yes please explain:

_____

_____

Have you ever used more than intended? ☐ Yes ☐ No

Have you experienced withdrawal symptoms in the past? ☐ Yes ☐ No

If yes, circle all that you have experienced:

Diarrhea ☐ Chills/Sweats ☐ Tremors/Shaking ☐ Irritability ☐ Nausea/Vomiting ☐ Anxiety ☐

Weakness ☐ Hallucinations ☐ Tachycardia ☐ Increased Blood Pressure ☐

Other: _____

What is your longest period of clean time? _____

Have you ever received treatment for substance abuse in the past? ☐ **No** ☐ **Yes (if yes, please describe):**

_____

_____

Have you ever been treated with Suboxone, Buprenorphine, Naltrexone, or Campral ? ☐ **No** ☐ **Yes (if yes, please describe):**

_____

_____

SUBSTANCES USED	AGE OF 1ST USE	DATE OF LAST USE	FREQUENCY/AMOUNT OF USE	PATTERN OF USE OVER THE LAST 30 DAYS
ALCOHOL				
MARIJUANA/HASH				
OPIATES (Heroin/Methadone Percocet/Vicodin/OxyContin/IV use)				
COCAINE/CRACK				
BENZODIAZEPINES (Valium/Klonopin/Xanax/ Ativan)				
AMPHETAMINES (Speed/Ritalin/Adderall)				
INHALANTS (Glue, Nitrates/Lacquer/Thinner)				
HALLUCINOGENS (LSD/Acid/Mushrooms/PCP				
OTC (Diet Pills/Antihistamines/ Sleeping Aids/Cough Medication)				
CLUB DRUGS (GBH/Katmine/MDMA)				
CAFFEINE (Coffee/Tea/Soda/Energy Drinks)				
NICOTINE (Cigarettes/Snuff/Chew/Vaping)				

CHILDREN AND ADOLESCENTS:

CHILD DEVELOPMENT:

Pregnancy: ☐ Planned ☐ Unplanned ☐ Normal ☐ Complications ☐ Premature

☐ Stressors during pregnancy:_____

Delivery: ☐ Natural ☐ Prepared ☐ Unprepared ☐ Difficult Labor Was_____hours; Birth weight _____

Exposure to Toxins: ☐ Drugs ☐ Alcohol ☐ Disease ☐ None

Complications: ☐ Prenatal ☐ Perinatal ☐ Post-Natal

Developmental/Post Natal Difficulties: ☐ Weight gain ☐ Eating ☐ Sleeping

Delays? ☐ Crawling ☐ Walking ☐ Toilet Training ☐ Speech and Language ☐ None

☐ Other: _____

CURRENT PROBLEMS:

PROBLEM	N/A	PAST	PRESENT	COMMENTS
PARENT/CHILD CONFLICT				
SIBLING/PEER CONFLICT				
ATTENTION SEEKING				
TEMPER TANTRUMS				
NIGHTMARES				
LYING				
AGGRESSIVE BEHAVIOR				
CRUELTY TO ANIMALS				
FIRE SETTING				
RUNNING AWAY				
STEALING/SHOPLIFTING				
SUBSTANCE USE				
SELF-HARM				

EDUCATIONAL:

Child's School: _____ **Grade:** _____

Is your child involved in special education classes? ☐ No ☐ Yes

Has your child had any Suspensions/Expulsions/Poor Conduct Reports? ☐ **No** ☐ **Yes**

Does your child get along with teachers and peers? ☐ **No** ☐ **Yes**

Any areas of concerns with Academic Performance or homework completion? ☐ **No** ☐ **Yes**

Please expand upon current academic and peer concerns: