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 _____

iMind Mental Health and Wellness (731) 300-0810 168 W. University Parkway Suite C Jackson TN 30805

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 _____

ADRESS _____

CITY _____ STATE _____ ZIP _____

MAIN PHONE _____ OTHER PHONE/EMAIL _____

RELATIONSHIP TO PATIENT _____

PRIMARY CARE PROVIDER

NAME _____ PHONE NUMBER _____

PHARMACY

NAME _____ PHONE NUMBER _____

SAFEHands 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)

☐ Depressed Mood

☐ Unable to enjoy activities

☐ Increased need for sleep

☐ Decreased need for sleep

☐ Loss of interest

☐ Decrease in energy

☐ Concentration/ forgetfulness

☐ Change in appetite

Please Check All Symptoms That Apply

☐ Excessive guilt
☐ Fatigue
☐ Decreased libido
☐ Increased libido
☐ Racing thoughts
☐ Impulsivity
☐ Risky behavior (explain, _____ _____)
☐ Excessive energy
☐ Increased irritability
☐ Crying spells
☐ Excessive worry

☐ Anxiety attacks
☐ Avoidance
☐ Hallucinations
☐ Suspiciousness
☐ Suicidal thoughts
☐ Self-harm (explain, _____ _____)
☐ Other, _____
☐ Other, _____

☐ Violent thoughts
☐ Violence toward others (anyone specific?) _____ _____

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

	Dates	Response/ Side-Effects
Antipsychotics/Mood Stabilizers		
Abilify (aripiprazole)		
Clozaril (clozapine)		
Geodon (ziprasidone)		
Haldol (haloperidol)		
Prolixin (fluphenazine)		
Risperdal (risperidone)		
Seroquel (quetiapine)		
Zyprexa (olanzepine)		
Other		
Sedative/Hypnotics		
Ambien (zolpidem)		
Desyrel (trazaodone)		
Restoril (temazepam)		
Rozerem (ramelteon)		
Sonata (zaleplon)		
Other		
ADHD medications		
Adderall (amphetamine)		
Concerta (methylphenidate)		
Ritalin (methylphenidate)		
Strattera (atomoxetine)		
Other		
Antianxiety medications		
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: _____