Janet Muehe-Hayward
LCSW #23749
9067 Foothills Blv. suite #1
Roseville CA 95747

Adult 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 family history. Thank you!

Name _____ Date _____

Date of Birth _____ Primary Care Physician: _____ _____

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

_____

_____

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

1._____

_____

2._____

_____

3._____

_____

What are your treatment goals?

_____

_____

_____

_____

_____

_____

Current Symptoms Checklist

( ) Depressed mood ( ) Racing thoughts ( ) Excessive worry ( ) Unable to enjoy activities ( ) Impulsivity ( ) Anxiety attacks ( ) Sleep pattern disturbance ( ) Increase risky behavior

( ) Avoidance ( ) Loss of interest ( ) Increased libido ( ) Hallucinations ( ) Concentration/ forgetfulness ( ) Decrease need for sleep ( ) Suspiciousness ( ) Change in appetite ( ) Excessive energy ( ) Excessive guilt ( ) Increased irritability ( ) Fatigue ( ) Crying spells ( ) Decreased libido

Other:

_____

_____

_____

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 put a line through this section and move onto 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?

_____

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 or weapons? 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, non-psychiatric hospitalization, or surgeries:

_____

_____

_____

For women only:

Date of last menstrual period _____

Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Are you planning to get pregnant in the near future? ( ) Yes ( ) No

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 me? ( ) Yes ( ) No

Date and place of last physical exam:

_____

Personal and Family Medical History:

You mark with a check/family member indicate which one

( ) 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_____

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:

Dates	Dosage	Response/Side-Effects

Current Psychiatric Medications:

Dates	Dosage	Response/Side-Effects

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:

Please circle any mental health conditions which one of your blood family members has/had

Bipolar disorder Schizophrenia Depression Post-traumatic stress
Anxiety Alcohol abuse Anger Substance abuse Suicide Attempt
Completed Suicide Violence

If yes please indicate your relationship to each person ?

_____

_____

_____

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?

_____

_____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long?

_____

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? ( ) Yes ( ) No

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?

_____

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 religious or spiritual group? ( ) Yes ( ) No

If yes, what is the level of your involvement? _____

Do you find your involvement helpful or does the involvement make things more difficult or stressful for you?

_____

_____

_____

Support System:

Please tell me about your support system. This can include people you live with, family members, friends, mentors, neighbors, professionals … anyone you can reach out too during difficult times.

_____
_____
_____
_____
_____

What else should I know so I can help you?

_____
_____
_____
_____
_____

Signature_____
Date_____

Emergency Contact _____

Relationship _____

Telephone # _____