Abby Road Psychiatric Services LLC
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(908) 433-7263
Abbyroadpsych.com

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? _____

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
( ) 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
( ) Decreased Libido
( ) Excessive guilt
( ) Increased irritability
( ) Crying Spells
( ) Fatigue
( ) _____
( ) _____

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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? _____

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

_____

_____

_____

_____

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Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric 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 us? ( ) Yes ( ) No

Date and place of last physical exam: _____

Personal and Family Medical History:

Is there any personal or family medical history (diabetes, heart disease, cancer, etc.) ? If yes, please explain:

_____

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No

If yes, Please describe when, by whom, and nature of treatment. Reason Dates Treated By Whom

_____

_____

_____

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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 antidepressants, mood stabilizers, anti-anxiety, antipsychotic, ADHD, or other medications to help mood or anxiety, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

_____

_____

_____

_____

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

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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? _____

Please list all street drugs or prescription medications you were not prescribed that you have used in the past. Include dates, length of use, and response. If you can not remember all details, please include as much as you can.

_____

_____

_____

_____

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

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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?_____

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.

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____Major? _____

What is your highest educational level or degree attained? _____

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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? _____

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: _____

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

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

_____

_____

_____

_____

_____

_____

_____

Signature_____Date_____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____Date _____

Reviewed by _____Date _____