

Abby Road Psychiatric Services
7 Hendrickson Ave
Red Bank, NJ 07701
admin@abbyroadpsych.com
(732) 893-5316
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)

- | | |
|--|---|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Excessive energy |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Decreased Libido |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Excessive guilt |
| <input type="checkbox"/> Anxiety attacks | <input type="checkbox"/> Increased irritability |
| <input type="checkbox"/> Sleep pattern disturbance | <input type="checkbox"/> Crying Spells |
| <input type="checkbox"/> Increase risky behavior | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Avoidance | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Increased libido | |
| <input type="checkbox"/> Hallucinations | |
| <input type="checkbox"/> Concentration/forgetfulness | |
| <input type="checkbox"/> Decrease need for sleep | |

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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

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.

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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? _____

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? _____

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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? _____

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? _____

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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?

Signature _____ Date _____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____ Date _____

Reviewed by _____ Date _____

Upload this completed form to your Therapy Portal Account or email it as an attachment to admin@abbyroadpsych.com prior to your initial appointment.