MINDTHERAPY CLINIC
ADULT INTAKE EVALUATION (17 years and older)

(Attach additional sheets if needed)

Name: ____ **Age:** ________ **Date:** _____________
Others present: ____
Marital Status (circle one):
Married Divorced Separated Widowed Single In a Relationship
How long have you been with your partner/married? _______________________________
Do you have any children? ☐ Yes ☐ No
If yes, how many & what are their ages? ______________________________________

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Current living situation (relationship of person(s) with whom patient resides)? __________

____

Are you interested in natural approaches to your treatment? ☐ Yes ☐ No

Allergies to medication:
_________________________________ ☐ Allergy ☐ Adverse Reaction

Please Describe: ____

_________________________________ ☐ Allergy ☐ Adverse Reaction

Please Describe: ____

Reason for this appointment:

What are the reasons you scheduled an appointment with our office? _______________

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How long have you had these symptoms? ____

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Are these symptoms related to a life situation? ☐ Yes ☐ No
If yes, please explain: ____

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Name: ______________________________ Date: ____________

Do these symptoms seem to come and go regularly, as in a cycle?

☐ Yes ☐ No

If yes, please describe: ______________________________

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Do you currently, or have you in the past, experienced:

Depression? ☐ Yes ☐ No

Anxiety? ☐ Yes ☐ No

Panic attacks? ☐ Yes ☐ No

If yes, please describe when you experienced any of these: ______________________________

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If you have depression and anxiety, which affects you more? ______________

Have you had one or more severely stressful events that have affected your well-being?

☐ Yes ☐ No

If yes, please describe, including how long you have felt stressed: ______________

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Has your ability to handle stress and pressure decreased? ☐ Yes ☐ No

Do you experience constant stress in your life or work? ☐ Yes ☐ No

Are any of your relationships at work and/or home unhappy? ☐ Yes ☐ No

Do you feel overwhelmed and have little control over your life? ☐ Yes ☐ No

Do most events feel like a chore? ☐ Yes ☐ No

If you answered yes to any of the questions above, please describe: ______________

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Have you experienced any traumas or Post-Traumatic Stress Disorder (PTSD)?

☐ Yes ☐ No

If yes, please describe: ______________________________

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Name: ____ Date: _____________

Do you have feelings of hopelessness or despair? ☐ Yes ☐ No

If yes, please help us understand why: ______________________________________

Are you irritable, agitated or angry or do you have less tolerance or a short fuse?

☐ Yes ☐ No

If yes, have you reacted in a way that has caused problems? If so, please describe: ______

Current medications (IMPORTANT: Please list any prescription & non-prescription medications, vitamins, supplements or herbs; include name, dose & how often taken):

Who has been prescribing your meds? ____

Medical History:

Do you have any of the following medical conditions? (check all that apply, use the space provided next to each condition to elaborate if needed):

- ☐ High/Low blood pressure_______________________________
- ☐ High cholesterol _______________________________
- ☐ Heart disease _______________________________
- ☐ Cancer _______________________________
- ☐ Diabetes _______________________________
- ☐ Liver problems _______________________________
- ☐ Kidney problems _______________________________
- ☐ Respiratory problems _______________________________
- ☐ Asthma _______________________________
- ☐ Nervous system disorder _______________________________
- ☐ Seizures _______________________________
- ☐ Gastrointestinal problems _______________________________
- ☐ Blood disorder _______________________________
- ☐ Thyroid disorder _______________________________
- ☐ Other glandular disorder _______________________________
- ☐ Sleep disorder _______________________________
- ☐ Headaches/Migraines _______________________________
- ☐ Pain disorder _______________________________
- ☐ Other (please be specific) _______________________________

Name: ________________________________ Date: ______________

When was your most recent physical? ______________________________
Did you or your doctor have any concerns about your health? ☐ Yes ☐ No
If yes, please describe: ______________________________
Did you have any blood work done (i.e., thyroid testing)? ☐ Yes ☐ No
If yes, was anything abnormal? ______________________________
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Has your child or anyone in the genetic family had cardiovascular (heart) disease such as increased heart rate, irregular heart beat or a heart birth defect? If yes please describe:
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____

Check any significant **family medical illness** or history:

- ☐ High/Low blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Kidney problems
- ☐ Respiratory problems
- ☐ Asthma
- ☐ Nervous system disorder
- ☐ Seizures
- ☐ Gastrointestinal problems
- ☐ Blood disorder
- ☐ Thyroid disorder
- ☐ Other glandular disorder
- ☐ Sleep disorder
- ☐ Headaches/Migraines
- ☐ Pain disorder
- ☐ Glucose intolerance and/or diabetes
- ☐ Other ______________________________

Please answer the following questions by circling "Yes" or "No"

Has there ever been a period of time when you were not your usual self and...			
►	...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got in trouble?	Yes	No
►	...you were so irritable that you shouted at people or started fights or arguments?	Yes	No
►	...you were much more self-confident than usual?	Yes	No
►	...you got much less sleep than usual and found you didn't really miss it?	Yes	No
►	...you were much more talkative or spoke faster than usual?	Yes	No
►	...thoughts raced through your head or you couldn't slow your mind down?	Yes	No
►	...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	Yes	No
►	...you had much more energy than usual?	Yes	No
►	...you were much more active or did many more things than usual?	Yes	No
►	...you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night?	Yes	No
►	...you were much more interested in sex than usual?	Yes	No
►	...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	Yes	No
►	...spending money got you or your family into trouble?	Yes	No
Total number of questions answered "Yes"			

If you checked "Yes" to more than one of the questions above:

Have several of these ever happened *during the same period of time?*
☐ Yes ☐ No

Name: ____ Date: ______________

How much of a problem did any of these cause you, like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No Problem ☐ Moderate Problem
☐ Minor Problem ☐ Serious Problem

Have any blood relatives had manic-depression or bipolar disorder? ☐ Yes ☐ No

Has a health professional ever told you that you have manic-depression or bipolar disorder? ☐ Yes ☐ No

Do you suffer from anorexia, bulimia or any other eating disorder? ☐ Yes ☐ No

If yes, please describe: ____

How is your appetite? ____

Have you had any recent changes in weight? ☐ Yes ☐ No

If yes, please describe: ____

How are you functioning sexually? Are any of your medications causing sexual side effects? ___

Are there other medical symptoms we should know about (e.g. forgetfulness, weight changes, dry, coarse skin/hair, change in bowel habits etc)?

Support System:

Do you feel that you have a support system? Check all that apply:

☐ Family ☐ Coworkers
☐ Friends ☐ Other: ______________________

Sleep Habits:

Do you have any trouble falling asleep? ☐ Yes ☐ No

If yes, what prevents you from falling asleep? ______________________________

How is the quality of your sleep (e.g., light, deep, etc.)? ______________________

Do you snore? ☐ Yes ☐ No ☐ Don't know

Have you been told that you stop breathing or gasp for breath when asleep?

Name: ______________________________ Date: ____________

☐ Yes ☐ No ☐ Don't know

Do you wake up in the middle of the night? ☐ Yes ☐ No

If so, how often and are you able to fall back to sleep? ______________________________

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Do you feel rested in the morning? ☐ Yes ☐ No ☐ Sometimes

How long have you suffered with sleep problems? ______________________________

Have you ever had a sleep study? ☐ Yes ☐ No

If yes, when and what were the results? ______________________________

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If you have a problem with sleepiness or fatigue, please complete:

Please rate the following questions based on how likely you are to doze off or fall asleep in the following situations, in contrast to just feeling tired. Even if you haven't done some activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0= would never doze | 2= moderate chance of dozing
1= slight chance of dozing | 3= high chance of dozing

Situation:	**Chance of Dozing:**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (i.e., a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
Add all of your circled numbers together to get a total score:				

<u>Substance Use:</u>

Do you use alcohol? ☐ Yes ☐ No

If so, how many drinks do you have a night, and how many nights per week do you drink? ______________________________

When you drink do you drink to get buzzed, drunk, or black-out? ____________

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Do you use nicotine? ☐ Yes ☐ No

If so, how much/often? ______________________________

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Do you use any recreational drugs? ☐ Yes ☐ No

If so, which ones and how often? ______________________________

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Name: ______________________________ Date: ______________

Does your use of any of these substances play a part in the reason for your appointment today?

☐ Yes ☐ No

If yes, please explain: ______________________________

Do family or friends disagree with this? ☐ Yes ☐ No

Have you ever been treated for substance abuse in the past? ☐ Yes ☐ No

If so, when and what type of treatment did you receive? ______________________________

Do any genetic relatives have a history of problems with alcohol or substance abuse?

☐ Yes ☐ No

If yes, which relative(s)? ______________________________

Psychiatric History:

Have you had any past psychiatric treatment or psychotherapy? ☐ Yes ☐ No

If yes, please list the names of the psychiatrists or therapists you've seen, why you were you seen, when and for how long you were treated. ______________________________

Have you had any hospitalizations for a psychiatric condition? ☐ Yes ☐ No

If yes, please explain: ______________________________

Where and when were you hospitalized? ______________________________

Name: ______________________________ Date: ____________

Are you currently in psychotherapy? ☐ Yes ☐ No

If yes, who is your therapist and how long have you seen him/her? ____________

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If no, do you think psychotherapy would be of benefit? ☐ Yes ☐ No

Do you feel that your current or past psychiatric care/psychotherapy has been helpful to you?

☐ Yes ☐ No ☐ N/A

Why or why not? ______________________________

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Is there any <u>family genetic psychiatric history</u>? ☐ Yes ☐ No

If yes, please be specific (who has what problem? on mother's or father's side?). If no formal diagnoses were made, what is your "gut" feeling about your family genetic psychiatric history? ______________________________

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Are any relatives on medications? ______________________________

Which medications? ______________________________

Were they helpful? ______________________________

Do you have any current thoughts of harming yourself or anyone else (thoughts, plans, attempts, cutting, passive thoughts of wishing you weren't here, etc.)? ☐ Yes ☐ No

If yes, please describe: ______________________________

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Do you have a suicide plan? ☐ Yes ☐ No

If yes, please describe. Would you take anyone with you? ____________

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Name: ______________________________ Date: ______________

Has there been any past history of suicidal attempts, cutting, or self-mutilation?

☐ Yes ☐ No

If yes, please explain: ______________________________

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Head Injuries:

Have you ever had any head injury, sports injury to the head, falls, concussions or car accidents?

☐ Yes ☐ No (If no, skip to next section)

If yes:

Describe where on the head the injury occurred and at what age: ______________________________

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Was there any loss of consciousness or amnesia? ☐ Yes ☐ No ☐ Don't know

Has there been any change in mood or memory since the head trauma occurred?

☐ Yes ☐ No

If yes, please describe: ______________________________

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Were you hospitalized for the head injury? ☐ Yes ☐ No

If yes, please describe: ______________________________

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Was any type of scan performed (CAT scan, MRI, EEG, etc.)?

☐ Yes ☐ No ☐ Don't know

If yes, what did it show? ______________________________

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Pain:

Do you have any problems with pain? ☐ Yes ☐ No (If no, skip to next section)

If yes:

Describe your pain: ______________________________

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What is your average daily pain level, using the pain scale from 1 to 10, 10 being excruciating pain: ______________________________

How long have you been suffering with this level of pain? ______________________________

Are you being treated for this problem? ☐ Yes ☐ No

If yes, by whom? ______________________________

Name: ____ Date: __________

Female Patients:

Do you have regular periods? ☐ Yes ☐ No ☐ N/A

If no, please describe: ____

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Are you taking contraceptives? ☐ Yes ☐ No ☐ N/A

If so, did you notice a change in your mood when you started or stopped birth control?

☐ Yes ☐ No

If yes, please describe: ____

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Have you noticed any perimenopausal/ menopausal symptoms (i.e., hair falling out, dry eyes, irregular periods, irritability, vaginal dryness, etc.)?

☐ Yes ☐ No ☐ N/A

If yes, have you consulted a doctor about this? ☐ Yes ☐ No

Did the doctor do any additional tests other than blood work, or how did the doctor treat your condition? ____

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Do you have any PMS symptoms? ☐ Yes ☐ No

If yes, please describe, including how many days of your cycle the symptoms last:

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Childhood/Cultural History:

Describe your childhood, including whether or not your parents divorced and if so, how old you were, any siblings and their ages, any trauma, physical, emotional or sexual abuse, and birth history. ____

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Are there any cultural or spiritual factors that you would like to tell us about? __________

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Name: ____ Date: __________

Legal History:

Have you ever had any legal problems including jail, prison, lawsuits, bankruptcy, etc.?

☐ Yes ☐ No

If yes, please explain: ____

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Are you presently on diversion or probation? ☐ Yes ☐ No

If yes, what are the requirements of your diversion or probation? ____________

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Have you ever served in the military? ☐ Yes ☐ No

If yes, what branch of the military? ______________________________

What type of discharge did you receive? ______________________________