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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 history.

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"/> Racing thoughts | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Impulsive behaviors | <input type="checkbox"/> Anxiety attacks |
| <input type="checkbox"/> Physical pain or disturbance | <input type="checkbox"/> Engaging in risky behavior | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Concentration/forgetfulness | <input type="checkbox"/> Decrease need for sleep | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Headaches or pain | <input type="checkbox"/> Increased irritability | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Crying spells | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Decreased libido | | |

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 feel like you want to die? () 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 1-10 (ten being strongest) how strong is your desire to kill yourself currently? () Yes () No

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 it?

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 gun? If yes, please explain: _____

Do you have access to刀? If yes, please explain: _____

Do you have access to other weapons? If yes, please explain: _____

Do you have access to other methods? If yes, please explain: _____

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