ADULT MENTAL HEALTH INTAKE QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record. Please complete this form as thoroughly and as honestly as possible.

Name *(Last, First, M.I.):* ☐ M ☐ F ☐Other	**DOB:**	**AGE:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Who referred you:	**Primary Care Provider:**	
In your own words, what are you needing help with?		

MENTAL HEALTH HISTORY

When your mother was pregnant with you, were there any complications during the pregnancy or birth?	☐ Premature	☐ Exposed to drugs or alcohol
	☐ Small baby	☐ Birth trauma
	☐ Mom had postpartum depression	☐ Other:

Did you have any delays in learning to walk, talk or read?

☐ No

☐ Yes (Please explain)

Current Psychiatric Medications: Please list any CURRENT medications you are taking for your mood/sleep/mental health. Please include vitamins, supplements or herbal remedies.

Year started	Medication	Is it helpful?

Please list any past psychiatric providers you have seen, including therapists, hospitalizations and other psychiatric providers

Year	Agency/Dr. or Clinic name/Hospital name	Reason

Please turn to next page

List PAST medications and over-the-counter drugs, such as vitamins, supplements, herbs you have tried		
Name of Drug	Strength and Frequency	Reason for stopping

Allergies or Intolerances to medications or food	
Name the Drug/Food	Reaction You Had

HEALTH HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Stress Reduction	Do you have a mindfulness based practice of some kind? (Yoga, meditation, prayer etc..)				☐ Yes	☐ No
	How many times per week:					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
Drugs	Do you currently use recreational or street drugs? If yes, we can discuss more in person to protect your confidentiality.				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	(Females only) If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Date of last menstrual cycle:					

Trauma History: Please check if you have, or are experiencing any of the following:	Emotional abuse	☐ Yes	☐ No
	Physical abuse	☐ Yes	☐ No
	Sexual abuse	☐ Yes	☐ No
	Neglected as a child	☐ Yes	☐ No
	Domestic Violence	☐ Yes	☐ No
	Foster care as a child	☐ Yes	☐ No
	Homelessness	☐ Yes	☐ No
	Witnessing domestic violence growing up	☐ Yes	☐ No
	Living with someone with a drug or alcohol problem	☐ Yes	☐ No
	Living with someone with a mental illness	☐ Yes	☐ No
	Natural disaster or war	☐ Yes	☐ No
	Parents separating or divorced while growing up	☐ Yes	☐ No
	Were you adopted?	☐ Yes	☐ No
	Had a parent go to jail	☐ Yes	☐ No

FAMILY MENTAL HEALTH HISTORY

PLEASE INCLUDE: ANXIETY, DEPRESSION, OCD, BIPOLAR, SCHIZOPHRENIA, AUTISM, SUBSTANCE ABUSE, SUICIDE, ADHD, ANGER

	AGE	MENTAL HEALTH PROBLEMS		AGE	MENTAL HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

SOCIAL HISTORY

Have you ever served in the military?		☐ Yes	☐ No
If yes, which branch and how long?	Are you a combat veteran?	☐ Yes	☐ No
Are you currently employed?		☐ Yes	☐ No
If yes, what is your current occupation?			
If no, when were you last employed?	What was your last occupation?		
Are you disabled?		☐ Yes	☐ No
If yes, what is the disability for?			
Do you have any children?		☐ Yes	☐ No
If yes, how many? How many still living with you?	What are their names and ages?		
Do you belong to a spiritual or religious group?		☐ Yes	☐ No

SOCIAL HISTORY CONTINUED…

Highest level of education completed:		
Have you ever been arrested? :		
If yes, what for? Did you spend time in jail or prison?		
Any current legal issues?	☐ Yes	☐ No
If yes, please explain:		
Have you ever had an episode of anger or violence where you hurt someone or damaged property?	☐ Yes	☐ No
Do you feel safe where you currently live?	☐ Yes	☐ No
Place of birth:		
How long have you lived in WA?		
Are you open to alternative or complementary healing recommendations? (Therapeutic touch, acupuncture, herbal remedies, supplements, etc…) **Please answer yes/no or maybe**		

SLEEP

Have you ever had a period of time where you felt so energetic and excited that you went long periods of time without sleep and did things that were unusual for you?	☐ Yes	☐ No
Do you have issues with insomnia?	☐ Yes	☐ No
How many hours of sleep do you get at night on average?		
How long does it take for you to fall asleep?		
Have you been diagnosed with sleep apnea?	☐ Yes	☐ No
If yes, do you use a CPAP device?	☐ Yes	☐ No
Do you have a television in your bedroom?	☐ Yes	☐ No
Do you use electronic devices immediately before bed?	☐ Yes	☐ No
Do you have nightmares?	☐ Yes	☐ No
If yes, how often? Can you fall back to sleep if they wake you?		

HEAD TRAUMA

Have you been diagnosed with a traumatic brain injury?	☐ Yes	☐ No
Have you ever hit your head or been hit in the head?	☐ Yes	☐ No
Ever seen in Emergency Room following a head injury?	☐ Yes	☐ No
Ever lose consciousness following a head injury?	☐ Yes	☐ No
Have you experienced changes in focus, concentration, headaches, dizziness, difficulty reading or writing, poor judgment, increased anger episodes, since hitting your head? If yes, please circle which symptoms are applicable to you.		

DIET

Would you say you have a balanced diet that is minimal in processed foods?	☐ Yes	☐ No
Do you incorporate fruits or vegetables in your daily diet?	☐ Yes	☐ No
Do you use a microwave more than twice a day?	☐ Yes	☐ No
Are you usually constipated or bloated?	☐ Yes	☐ No

DIET CONTINUED...		
Do you take a probiotic?	☐ Yes	☐ No
Have you battled with chronic dieting?	☐ Yes	☐ No
Have you ever been diagnosed with celiac disease?	☐ Yes	☐ No
Do you have multiple food allergies or intolerances?	☐ Yes	☐ No
Do you **frequently** eat canned or prepackaged foods?	☐ Yes	☐ No
Do you eat any fermented foods? (Sauerkraut, Kimchi, Kefir, Yogurt, Kombucha, pickled foods)	☐ Yes	☐ No
Do you **frequently** crave sweets?	☐ Yes	☐ No
Do you drink at least 8 glasses of water daily?	☐ Yes	☐ No
Are you prone to binge eating?	☐ Yes	☐ No
Have you ever forced yourself to vomit?	☐ Yes	☐ No

SUICIDE RISK QUESTIONNAIRE—PLEASE CHECK THE STATEMENT THAT BEST APPLIES TO YOU

Have you ever thought about or attempted to kill yourself?

☐Never

☐It was just a brief passing thought

☐I have had a plan at least once to kill myself but did not try to do it

☐I have had a plan at least once to kill myself and really wanted to die

☐I have attempted to kill myself, but did not want to die

☐I have attempted to kill myself and really hoped to die

How often have you thought about killing yourself in the past year?

☐ Never ☐Rarely (1 time) ☐Sometimes (2 times) ☐Often (3-4 times) ☐Very often (5 times or more)

Have you ever told someone that you were going to commit suicide or that you might do it?

☐No

☐Yes, at one time, but did not really want to die

☐Yes, at one time, and really wanted to die

☐Yes, more than once, but did not want to do it

☐Yes, more than once, and really wanted to do it

How likely is it that you will attempt suicide someday?

☐Never

☐No chance at all

☐Rather unlikely

☐Unlikely

☐Likely

☐Rather likely

☐Very likely