WESTON
— PSYCHIATRIC —

Mental Health Intake Questionnaire

Please review and check any symptoms which pertain to you:

Current	Past		Current	Past	
☐	☐	Depressed mood	☐	☐	Inflated self-esteem
☐	☐	No longer enjoying usual activities	☐	☐	Don't seem to need sleep
☐	☐	Weight change without trying	☐	☐	Excessive talking
☐	☐	Sleeping too much or not enough	☐	☐	Racing thoughts
☐	☐	Feeling agitated or sluggish	☐	☐	Highly distractible
☐	☐	No energy/always tired	☐	☐	Trying to do way too much
☐	☐	Feeling guilty or worthless	☐	☐	Impulsive behavior
☐	☐	Can't think or concentrate	☐	☐	See/hearing things that may not be real
☐	☐	Thoughts of death or suicide	☐	☐	Believing things that may not be real
☐	☐	Decreased sexual desire	☐	☐	Increased sexual desire
☐	☐	Often tense/unable to relax	☐	☐	Can't prevent repetitive thoughts
☐	☐	Excessive worry	☐	☐	Can't prevent repetitive behaviors
☐	☐	Panic attacks	☐	☐	Intrusive memories of past event(s)
☐	☐	Afraid/unable to leave home	☐	☐	Always being on guard/never feeling safe
☐	☐	Extreme or unreasonable fears	☐	☐	Body overreacts to stress
☐	☐	Intense fear of social situations	☐	☐	Nightmares

Past Psychiatric History:

Have you ever been treated by a mental health provider? ☐ Yes ☐ No Age of first contact: _____

Name of last provider: _____ Date last seen: _____

# of mental health hospitalizations: ☐ 0 ☐ 1 ☐ 2 ☐ 3+ Date of last hospitalization: _____

History of: ☐ Suicidal thoughts ☐ Suicide attempts ☐ Cutting ☐ Burning ☐ Eating disorder

Past Medication Trials (check all that apply):

☐ Prozac (fluoxetine)
☐ Zoloft (sertraline)
☐ Paxil (paroxetine)
☐ Celexa (citalopram)
☐ Lexapro (escitalopram)
☐ Effexor (venlafaxine)
☐ Pristiq (desvenlafaxine)
☐ Cymbalta (duloxetine)
☐ Wellbutrin (bupropion)
☐ Remeron (mirtazapine)

☐ Seroquel (quetiapine)
☐ Zyprexa (olanzapine)
☐ Geodon (ziprasidone)
☐ Abilify (aripiprazole)
☐ Risperdal (risperidone)
☐ Saphris (asenapine)

☐ Clozaril (clozapine)
☐ Haldol (haloperidol)
☐ Prolixin (fluphenazine)

☐ Lithium
☐ Tegretol(carbamazepine)
☐ Trileptal (oxcarbazepine)
☐ Depakote (valproate)
☐ Lamictal (lamotrigine)
☐ Topamax (topiramate)

☐ Ambien (zolpidem)
☐ Lunesta (Eszopiclone)
☐ Sonata (zaleplon)
☐ Rozerem (ramelteon)
☐ Restoril (temazepam)
☐ Desyrel (trazodone)

☐ Adderall (amphetamine)
☐ Concerta (methylphenidate)
☐ Vyvanse (lisdexamfetamine)
☐ Ritalin (methylphenidate)
☐ Dexedrine (dextroamphetamine)
☐ Focalin (demethylphenidate)
☐ Strattera (atomoxetine)

☐ Xanax (alprazolam)
☐ Ativan (lorazepam)
☐ Klonopin (clonazepam)
☐ Valium (diazepam)

☐ Buspar (buspirone)
☐ Gabapentin (neurontin)
☐ Lyrica (Pregabalin)
☐ Other: will discuss in session

Family Psychiatric History:

Diagnosis	Your Child	Sibling	Mother's Side	Father's Side
Bipolar Disorder	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
ADHD	☐	☐	☐	☐
Alcohol/Drugs	☐	☐	☐	☐
Suicide	☐	☐	☐	☐

Alcohol and Other Drugs of Abuse (AODA):

Current alcohol use: ☐ Yes ☐ No Number of drinks per week: ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Have you ever attended an alcohol abuse, detox, or rehab program: ☐ Yes ☐ No

Have you ever had a DUI: ☐ Yes ☐ No If yes, how many: ☐ 1 ☐ 2 ☐ 3 ☐ 4+

History of withdrawal symptoms: ☐ Yes ☐ No If yes, circle the symptoms experienced:

shakes sweats blackouts seizure hallucinations delirium tremens

Drug Type	Past Use or Trial	Used in Last 12 Mos.	Considered a Problem
Marijuana	☐	☐	☐
Cocaine	☐	☐	☐
Opiates	☐	☐	☐
Stimulants	☐	☐	☐
Meth	☐	☐	☐
Hallucinogens	☐	☐	☐

Currently smoke: ☐ Yes ☐ No If yes, how many packs per day: ☐ 1/4 ☐ 1/2 ☐ 1 ☐ 2 ☐ 3+

Vape: ☐ Yes ☐ No Chew Tobacco: ☐ Yes ☐ No Caffeine # of cups per day: ☐ 0 ☐ 1-2 ☐ 2-4 ☐ 5+

Medical History:

Have you ever lost consciousness: ☐ Yes ☐ No Have you ever had a seizure: ☐ Yes ☐ No

Sleep Problems? ☐ Yes ☐ No If yes, problem: ☐ falling to sleep ☐ staying asleep CPAP: ☐ Yes ☐ No

How many hours do you sleep at night? ☐ 1-2 ☐ 3-4 ☐ 4-5 ☐ 6-7 ☐ 8-9 ☐ 10+

Current pain level: ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-8 ☐ 9-10 Females only: are you pregnant? ☐ Yes ☐ No

Social History:

Where were you born: _____ Where were you raised: _____

Are you adopted: ☐ Yes ☐ No Number of brothers: _____ sisters: _____

Lived with: ☐ Mom ☐ Dad ☐ Both ☐ Other History of abuse: ☐ Physical ☐ Sexual ☐ Verbal

Education: ☐ Elementary ☐ High School Graduate ☐ GED ☐ Some College ☐ College Graduate ☐ Post Graduate

Currently married: ☐ Yes ☐ No ☐ Widowed # of marriages? _____ # of children? _____

Employed: ☐ Yes ☐ No ☐ Retired ☐ Disability Current legal issues: ☐ Yes ☐ No

Military service: ☐ Yes ☐ No Combat: ☐ Yes ☐ No Are there firearms in your home: ☐ Yes ☐ No

Past Medical History:

Do you now or have you ever had:

- ☐ Diabetes
- ☐ Heart attack
- ☐ Asthma
- ☐ COPD or emphysema
- ☐ Acid reflux or GERD
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Blood clots in your leg
- ☐ Peripheral vascular disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Stroke
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Angina
- ☐ Congestive heart failure
- ☐ Degenerative disk disease
- ☐ Hearing impairment
- ☐ Vision impairment
- ☐ Glaucoma
- ☐ Cancer (please describe):

_____

_____

- ☐ Other significant illness:

_____

_____

_____

Please list any surgeries you have had:

_____

_____

Current Medications:

Please list all medications and prescriptions you are taking (include vitamins, aspirin, decongestants, birth control pills, over the counter medications, supplements, etc.):

_____

_____

_____

_____

Medication Allergies:

_____

_____

Primary Care Provider Name: _____

Print Name: _____

Sign Name: _____ **Date:** _____