**STARFISH EXPERIENCE INCORPORATED**

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# MENTAL HEALTH INTAKE FORM

Name:_____ Date:_____

Date of Birth:_____ Primary Care Physician:_____

Do you give permission to have your PCP receive updates? ( ) Yes ( ) No

What are the problems for which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals?

1. _____
2. _____
3. _____

**Current symptoms checklist: (Check once for any symptoms present, twice for major symptoms)**

**( ) Depressed mood**
**( ) Unable to enjoy activities**
**( ) Sleep pattern disturbance**
**( ) Loss of interest**
**( ) Concentration/forgetfulness**
**( ) Change in appetite**
**( ) Excessive guilt**
**( ) Fatigue**
**( ) Decreased libido**
**( ) Racing thoughts**
**( ) Impulsivity**
**( ) Increased risky behavior**
**( ) Increased libido**
**( ) Decrease need for sleep**
**( ) Excessive energy**
**( ) Increased irritability**
**( ) Crying spells**
**( ) Excessive worry**
**( ) Anxiety attacks**
**( ) Avoidance**
**( ) Hallucinations**
**( ) Suspiciousness**
**( )** _____
**( )** _____

**SUICIDE 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 as if 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, (10 being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought of 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? ( ) Yes ( ) No If yes, please explain: _____

_____

**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? _____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

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

If yes, please describe at what age(s), where and by whom: _____

_____

_____

_____

**EDUCATIONAL HISTORY**

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____ When? _____

**OCCUPATIONAL HISTORY**

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

Occupation: _____ How long in present position? _____

Where do you work? _____

Have you served in the Military? ( ) Yes ( ) No Honorable Discharge? ( ) Yes ( ) No

**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 describe your sexual orientation? _____

( ) Straight/heterosexual ( ) lesbian/gay/homosexual ( ) Bisexual ( ) Transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

_____

_____

Have you had any prior marriages? ( ) Yes ( ) No If yes, how many? _____

Do you have any children? ( ) Yes ( ) No If yes, list ages and genders: _____

_____

_____

_____

Describe your relationship with your children: _____

_____

List everyone who lives with you: _____

**SUBSTANCE USE:**

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, which substances? _____

If yes, where were you treated and when? _____

Have you ever attended a 12 step program? ( ) Yes ( ) No

**LIST ALL CURRENT PRESCRIPTION MEDICATIONS:**

* _____ * _____
* _____ * _____
* _____ * _____
* _____ * _____

**PAST PSYCHIATRIC HISTORY:**

OUT-PATIENT TREATMENT ( ) Yes ( ) No IF YES:

Reason Dates treated By whom

IN-PATIENT TREATMENT ( ) Yes ( ) No IF YES:

Reason Dates treated By whom