GEORGIA MOUNTAINS HEALTH

Behavioral Health Intake Form

This form must be completed before your first visit. This information is confidential and can only be shared with your medical and behavioral health treatment team.

Name_____Date_____

Date of Birth _____ Primary Care Physician_____

What are the problem(s) for which you are seeking help? (Treatment Plan)

1._____
2._____
3._____

What are your treatment goals? (Treatment Plan)

_____
_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No Ever seen a counselor or therapist?

Reason (Diagnosis) Approximate Year About how many sessions total?

_____
_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason (Diagnosis) Approximate Year

_____
_____

Trauma History:

Have you ever been traumatized and/or abused emotionally (psychologically), sexually, physically or neglected? ( ) Yes ( ) No Describe: _____

_____
_____

Family Psychiatric History:

Has anyone in your family been diagnosed or treated for mental illness? If so, who and for what?

_____
_____

Substance Use History:

Have you ever had an alcohol or drug use problem? ( ) Yes ( ) No

If yes, for which substances?

_____

Please list the frequency of use in the past 6 months with drugs or alcohol? _____

Current Symptoms Checklist: (check for any symptoms present more days than not)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Insomnia/Waking Frequently
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Weight changes
( ) Excessive guilt
( ) Fatigue
( ) Change in sex drive
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Anger outbursts
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Change in sex drive
( ) Other _____
( ) Excessive worry
( ) Anxiety attacks
( ) Social avoidance
( ) Hallucinations
( ) Suspiciousness
( ) Suicidal thoughts
( ) Homicidal thought
( ) Social anxiety

Describe any Additional Concerning Symptoms_____
_____
_____

Past Psychiatric/ADHD Medications: If you have ever taken any of the following medications, or are currently taking, please indicate how long, how helpful they were/are and if there any side-effects.

( ) Prozac (fluoxetine)
( ) Paxil (paroxetine)
( ) Effexor (venlafaxine)
( ) Escalith (Lithium)
( ) Zyprexa (olanzepine)
( ) Desyrel (trazodone)
( ) Xanax (alprazolam)
( ) Buspar (buspirone)
( ) Zoloft (sertraline)
( ) Celexa (citalopram)
( ) Cymbalta (duloxetine)
( ) Depakote (valproate)
( ) Abilify (aripiprazole)
( ) Adderall (amphetamine)
( ) Ativan (lorazepam)
( ) Others _____
( ) Elavil (amitriptyline
( ) Lexapro (escitalopram)
( ) Wellbutrin (bupropion)
( ) Seroquel (quetiapine)
( ) Risperdal (risperidone)
( ) Ritalin (methylphenidate)
( ) Klonopin (clonazepam)

Which medications worked best? _____

Any additional psychiatric medications? _____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up? _____
List your siblings and their ages: _____
_____
Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
Describe your father and your relationship with him: _____
Describe your step-father and your relationship with him: _____
Describe your mother and your relationship with her: _____
Describe your step-mother and your relationship with her: _____
Any significant family dynamics you want to address in therapy? _____
Relationship History and Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? Is there relationship conflict you wish to address in therapy? _____
_____
_____

List everyone who currently lives with you: _____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many for how long? _____
_____

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

Describe your relationship with your children: _____
_____
_____

Educational History:
Highest Grade Completed? _____ Were you a good student academically? _____
Did you attend college? _____ Where? _____Major? _____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No Other type discharge _____

Legal History:
Have you ever been arrested; what for/when? _____
Describe any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____

Medical Diagnoses, Developmental History
Please list any significant medical issues/concerns _____
_____

Please list any medications you take for your physical health/conditions: _____
_____

Please list any delays in developmental milestones, such as walking, talking, feeding, potty training that have been concerns in the past.
_____

Social Functioning:
Do you have friends/supports or connections that are important in your life? What is the frequency of your contact and what sort of activities do you do together?
_____
_____

Personal Interests/Hobbies:
Do you have interests/hobbies/activities past or present that you have developed over time or wish to do more of?
_____
_____