Mental Health Intake Form

This form must be completed by patient or guardian of patient (18 years and older). Please email to info@remediuminc.com prior to initial assessment. The answers to these questions are very important and help our providers determine if Remedium is the appropriate level of care for treatment.

Patient Name_____ Date of Birth____/____/_____ Phone_____

Gender: ◯ Male ◯ Female ◯ Non-Binary ◯ Other *If other, please specify:*_____

How did you hear about us? ◯ Therapist ◯ Insurance ◯ Friend/Family: _____

Do you have health insurance? ◯ Yes ◯ No Insurance Name_____

Primary Care Physician_____ Physician's Phone_____

Current Therapist_____ Therapist's Phone_____

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

_____

_____

_____

What are your treatment goals?

☐ Talk Therapy ☐ Medication Management ☐ Second Opinion ☐ Other_____

Current Symptoms Checklist: *(check any symptoms present)*

☐ Depressed mood	☐ Unable to enjoy activities	☐ Sleep pattern disturbance
☐ Loss of interest	☐ Difficulty concentrating	☐ Forgetfulness
☐ Excessive guilt	☐ Fatigue	☐ Change in sex drive
☐ Racing thoughts	☐ Impulsivity	☐ Change in appetite
☐ Increased risky behavior	☐ Overthinking	☐ Decreased need for sleep
☐ Excessive energy	☐ Increased irritability	☐ Crying spells
☐ Excessive worry	☐ Anxiety attacks	☐ Avoidance
☐ Suspiciousness	☐ Panic attacks	☐ Hearing voices
☐ Other		

Suicide Risk Assessment

Have you ever had thoughts or feelings that you didn't want to live? ◯ Yes ◯ No

Do you **currently** feel that 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? _____

Past Medical History

Allergies: _____

List ALL current prescription medications and how often you take them: (If none, write none)

Medication Name/Total Daily Dosage/Estimated Start Date:

_____

_____

_____

_____

Current over-the-counter medications, vitamins, or supplements:

_____

_____

Current medical problems:

_____

_____

Past medical problems, non-psychiatric hospitalization, or surgeries:

_____

_____

Past Psychiatric History

Outpatient treatment? ◯ Yes ◯ No *If yes, please describe when, by whom, and nature of treatment:*

_____

_____

Psychiatric Hospitalization? ◯ Yes ◯ No *If yes, describe for what reason, when and where:*

_____

_____

Substance Use

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

If yes, for which substance(s)? _____

If yes, where were you treated and when? _____

How many alcoholic drinks do you have per week? _____

Do you think you may have a problem with alcohol or drug use? ◯ Yes ◯ No

Have you used any street drugs in the past 3 months? ◯ Yes ◯ No

If yes, which ones? _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Do you smoke cigarettes? ◯ Yes ◯ No

Do you use a pipe, cigars, or chewing tobacco: ◯ Yes ◯ No

Family Background and History

Were you adopted? ◯ Yes ◯ No

Are you currently: ◯ Married ◯ Partnered ◯ Divorced ◯ Single ◯ Widowed

If not married, are you currently in a relationship? ◯ Yes ◯ No

How would you identify your sexual orientation? ◯ heterosexual ◯ homosexual ◯ bisexual ◯ transsexual ◯ unsure ◯ asexual ◯ prefer not to answer

Do you have children? ◯ Yes ◯ No

If yes, list ages and gender:_____

Are you currently on leave of absence (LOA), using FMLA benefits, or seeking documentation to support LOA or a disability claim? ◯ Yes ◯ No *If yes, please explain:*

_____

Legal History

Have you ever been arrested? ◯ Yes ◯ No

Do you have any pending legal problems? ◯ Yes ◯ No *If yes to the above questions, please explain:*

_____

_____

Is there anything else that you would like us to know?

_____

_____

_____

_____

Signature_____ Date_____