THE REMEDY
A BETTER WAY FORWARD

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Psychiatric/Mental Health Intake Form

Please complete all information that is relevant to you on this form to the best of your ability and bring it to the first visit (or email back through secure email portal, fax or mail back)

Name_____Date_____
Date of Birth _____
Current Therapist:_____Phone:_____Fax:_____
Primary Care Physician:_____

What are the concerns for which you are seeking help?
_____
_____
_____
_____

What are your goals for treatment?
_____
_____

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

( ) Engage in self injurious behavior (cutting yourself, burning, hitting)
( ) Recent feelings or thoughts that you don't want to live
( ) Recent thoughts of suicide
( ) Recent thoughts of hurting someone else, if so, who?_____
( ) Plans to hurt yourself, if so, what has stopped you?
_____

( ) **Past suicide attempts**, if yes, what did you do and what happened? Did you want to die?
Were you hospitalized?
_____
_____
_____

Past Medical History:

Medication Allergies:

_____
_____
_____

Current Weight _____ Height _____

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

Medication: Name, Dosage, Estimated Start Date

_____
_____
_____
_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements/Vitamins:

_____
_____
_____
_____

Current medical problems:

_____
_____
_____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____
_____
_____
_____
_____

For women only: Date of last menstrual period _____ , Was it normal? _____
Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.
Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____

High risk sexual behaviors ( ) Yes ( ) No,
if yes, are you aware of PrEP/ has anyone discussed this preventive treatment with you?
What other strategies do you use to engage in safer sex?
_____

Do you have any concerns about your physical health that you would like to discuss with us?

( ) Yes ( ) No

Date and place of last physical exam:_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?
_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No.
If yes, Please describe nature of treatment, where it occurred and dates of treatment:
_____
_____
_____
_____

Psychiatric Hospitalization ( ) Yes ( ) No

If yes, describe for what reason, when, where, how long and what they did for you:
_____
_____
_____
_____

Past Psychiatric Medications:

If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were and any side effects (if you can't remember all the details, just write in what you do remember).

Antidepressants:

SSRIs
Prozac (fluoxetine)_____
Zoloft (sertraline)_____
Luvox (fluvoxamine)_____
Paxil (paroxetine)_____
Celexa (citalopram)_____
Lexapro (escitalopram)_____

SNRIs
Effexor (venlafaxine)_____
Cymbalta (duloxetine)_____
Fetzima (Levomilnacipran)_____

TCAs
Pamelor (nortrptyline)_____
Tofranil (imipramine)_____
Elavil (amitriptyline)_____
Anafranil (clomipramine)_____

MAOIs
Parnate (tranylcypromine)_____

Nardil (phenelzine)_____
Emsam (selegiline)_____

Misc.
Wellbutrin (bupropion)_____
Remeron (mirtazapine) _____
Serzone (nefazodone) _____
Buspar (buspirone)_____
Trintellix (vortioxetine)_____
Viibryd (vilazodone)_____
Other_____

Mood Stabilizers
Gabapentin_____
Lyrica (pregabalin)_____
Tegretol (carbamazepine) _____
Lithobid, Eskalith CR (lithium)_____
Depakote (valproate) _____
Lamictal (lamotrigine)_____
Topamax (topiramate)_____
Trileptal (oxcarbazepine)_____
Other_____

Mood Stabilizers/Antipsychotics/Augmenting agents
Seroquel (quetiapine)_____
Zyprexa (olanzepine)_____
Geodon (ziprasidone)_____
Abilify (aripiprazole)_____
Risperdal (risperidone)_____
Vraylar (cariprazine)_____
Cytomel (T3 thryoid hormone)_____
Other_____

Other depression Treatments
ECT (electroconvulsive therapy)_____
TMS (transcranial magnetic stimulation)
Brainsway (dTMS or deep TMS)_____
Neurostar (rTMS)_____
Ketamine Infusions_____
Spravato (esKetamine)_____
VNS (vagal nerve stimulation)_____
Other_____

Sedative/Hypnotics (sleep meds)
Ambien (zolpidem)_____
Sonata (zaleplon)_____
Rozerem(ramelteon)_____
Restoril (temazepam)_____
Desyrel (trazodone)_____
Sinequan/Silenor (doxepin)_____
Belsomra (suvorexant)_____
Other_____

ADHD

Adderall (mixed amphetamine salt)_____
Vyvanse (lisdexamfetamine dimesylate)_____
Concerta (methylphenidate LA)_____
Ritalin (methylphenidate)_____
Focalin XR (dexmethylphenidate)_____
Dexedrine (dextro-amphetamine)_____
Strattera (atomoxetine)_____
Other_____

Antianxiety
Xanax (alprazolam)_____
Ativan (lorazepam)_____
Klonopin (clonazepam) _____
Valium (diazepam)_____
Buspar (buspirone) _____
Other_____

Substance Use Disorder History (SUD)

(have you been diagnosed or treated for SUD or think you have a problem with alcohol or other substances?)
_____
Have you been treated for SUD? If so, when, where, inpatient or out?
_____
_____
Were any of your treatments helpful? If so, which ones and what was helpful to you?
_____
_____
Have you participated in community support programs? (Smart Recovery, peer support groups, Buddhist recovery/Refuge recovery, Woman for Sobriety, AA/NA)_____
_____

Alcohol Use

Have you or others expressed concern about your drinking? If so, who?_____
_____
How often do you have more than 4 standard drinks-SD- (for a man) or 3 SD (for a woman)- (12 oz standard beer, 5 oz wine, 1.5 oz 80 proof spirits=1SD)?_____
_____
Have you ever felt the need to cut back or quit drinking?_____
Do you need to drink in the morning to take the edge off?_____

Do you ever have withdrawal symptoms after a bout of heavy drinking- shakes, sweats, anxiety, agitation, insomnia, nausea, vomiting, seizures- DTs- delirium tremens- disorientation, confusion, hallucinating- (DTs usually require hospitalization, often in the ICU)?_____
_____
Have you ever required medical treatment for withdrawal? "Detox"? ICU? If so, when and where?_____
_____
Have you drank and drove? If so, how often?_____
Have you had a DUI? If so, when?_____

Opioid Use (Pain pills, Heroin, Fentanyl, others)
What route of use?(Pills-oral, snort, smoke, IV- intravenous, shooting up)_____
_____

How often and for how long a period did you do this?_____
Have you had any overdoses? If so, do you think you were exposed to Fentanyl? Did you require medical attention, hospitalization or Narcan(naloxone)?_____
Do you have Narcan (Naloxone) and know how to use it?_____
Are you aware of safer using practices?_____
Have you ever shared needles? ( )yes ( )no . If so, have your been tested since for HIV, Hep C? If so, when?
_____
Are you aware of how to obtain clean needles?_____

Methamphetamine Use (crank, crystal meth)
What route of use?(oral, snort, smoke, IV- intravenous, shooting up)_____
_____
How often and for how long a period did you do this?_____
Have you had any overdoses? If so, do you think you were exposed to Fentanyl? Did you require medical attention, hospitalization or Narcan(naloxone)?_____
Do you have Narcan (Naloxone) and know how to use it?_____
Are you aware of safer using practices?_____
Have you ever shared needles? If so, have your been tested since for HIV, Hep C?_____
Are you aware of how to get clean needles?_____

Cocaine Use (powder, crack, free base)
What route of use?(snort, smoke, IV- intravenous, shooting up)_____
_____
How often and for how long a period did you do this?_____
Have you had any overdoses? If so, do you think you were exposed to Fentanyl? Did you require medical attention, hospitalization or Narcan(naloxone)?_____
Do you have Narcan (Naloxone) and know how to use it?_____
Are you aware of safer using practices?_____
Have you ever shared needles? If so, have your been tested since for HIV, Hep C?_____
Are you aware of how to get clean needles?_____

Other Stimulant Drug Misuse (Adderall, Ritalin, Vyanse or other)
_____

Benzodiazepine/Sedative Misuse (Xanax, "xanibars", Valium, Ativan, Rohypnol- "roofies", GHB, Nitrous, "whippets"or "poppers", etizolam, phenibut, others)

Which ones have you used? How much and how often?
_____
_____
_____
Any Overdoses or Fentanyl exposure?_____

Cannabis
What form do you use, how much and how often, what route of use?
_____
_____
Do you vape cannabis? If so, is this from a medical dispensary or other source?_____
_____

Hallucinogens (LSD, Psilocybin "magic mushrooms", Ecstacy/MDMA "molly", others)
Which ones have you used? How much and how often?
_____

_____
_____
Any Overdoses or Fentanyl exposure?_____

Dissociatives (Ketamine, PCP, DXM, DMT, MXE, others)
Which ones have you used? How much and how often?

_____
_____
_____
Any Overdoses or Fentanyl exposure?_____

"Research Chemical" Use (Synthetic Cannabis, "Bath Salts", and many others)
Which ones have you used, how much and how often?_____
_____

Tobacco/Nicotine products (Cigarettes, Chew, snuff, vaping)

How much do you chew/smoke per day?_____
Have you tried to quit in the past? How long did you go?_____
Did you use any medications to help you quit? If so, which ones and how helpful were they?
_____

Medications for Substance Use Disorder You Have Been Treated With (dose, duration, benefit)

Alcohol Use Disorder
Revia (naltrexone)_____
Vivitrol (injectable naltrexone LA)_____
Gabapentin_____
Antabuse (disulfiram)_____
Baclofen_____
Topamax (topiramate)_____
Chantix (varenicline)_____
Campral (acomprosate)_____

Opioid Use Disorder
Suboxone/Subutex (Buprenorphine)_____
Sublocade (LA injectable buprenorphine)_____
Probuphine (LA implantable buprenorphine)_____
Methadone_____

Smoking/chewing Cessation
Nicotine replacement (patch, gum, lozenge, puffer, intra-nasal,vaping)_____
_____
Chantix (varenicline)_____
Zyban/Wellbutrin (bupropion)_____

Psychotherapy (style- Mostly talk therapy, CBT-cognitive-behavioral, DBT -dialectical-behavioral, psychodynamic, somatic- body based ,Trauma-EMDR, Brain spotting, Prolonged exposure-other. Frequency/duration, how helpful was it?)

_____
_____
_____

Family Psychiatric History (children, sibs, parents, aunts/uncles, grandparents)

Depression_____
Bipolar disorder_____
Schizophrenia/Psychosis_____
Anxiety (worriers, panic, social anxiety)_____
Post-traumatic stress_____
ADHD (inattentive, hyperactive, behavior problems)_____
Death by Suicide_____
Alcohol/Drug Use Disorder_____

Self-Care

Meditation- What kind/how often and duration?_____
Nutrition- How healthy is your diet?_____
How do you recharge your batteries? -hobbies, avocations, interests_____
_____
Do you feel connected, have community/friends?_____
_____
_____
Spiritual Practices_____
Religious Practices_____
Pets- what kind and how many?_____

Your Physical Activity Level

Are you physically active regularly? ( ) Yes ( ) No
How many days a week are you physically active?_____
How much of each day are you physically active? _____
What type of physical activity do you engage in?_____

Caffeine Intake

Type, amount per day, any impact on mood, sleep, anxiety?_____
_____

Family Background and Childhood History

Where were you born and or raised?_____
_____
Were you adopted or have any adopted siblings?_____
List your siblings and their ages:
_____
_____
_____
Were/are you close to your siblings?_____
_____
Were your parents married, ever divorced, step or ½ siblings?_____
_____
_____
What was your mother's occupation?_____
_____

What was your father's occupation?_____
_____
How would you, briefly, describe your family?_____
_____
_____
Did you feel loved and cared about growing up?_____
_____
If not, did you have a mentor or parent figure in your life?_____
_____

Trauma History
Any traumatic or difficult things happen to you growing up it would be important for us to know about? (Feel free to be brief and discuss this further in our session)

Do you have a history of being abused emotionally, sexually, physically or by neglect?
_____
_____
_____

Educational History
Highest Grade Completed? _____
Did you attend college? _____
Where?_____
Major?_____
What is your highest educational level or degree attained?_____

Work History
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when?_____
_____
Honorable discharge ( ) Yes ( ) No . Other type discharge_____
_____

Relationship History and Current Family

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed- How long?_____
_____
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? (Optional)_____
_____

What are your preferred pronouns? (She/Her/Hers, He/Him/His, They/Them/Theirs etc.)
(Optional)_____

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

Briefly describe your relationship with your spouse or significant other_____
_____
_____
Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____ How long?_____
_____
Do you have children? ( ) Yes ( ) No.
If yes, please list age, son/daut, living at home?_____
_____

Legal History

Have you ever been arrested? _____
Do you have any pending legal problems? _____

Is there anything else that we skipped or did not cover that you would like us to know?

_____
_____
_____
_____

Signature_____**Date**_____