NEUMIND CLINIC
P: 224-300-4268
F: 224-310-1633

Psychiatric/Mental Health Intake Form

Please complete all information that is relevant to you on this form to the best of your ability. Please email or fax back to the clinic.

Date _____

Legal Name _____ Preferred Name _____

Date of Birth_____ Cell Phone_____

Current Therapist: _____ Phone: _____ Fax: _____

Primary Care Physician: _____

How did you hear about us? ☐ Google/Search Engine ☐ Social Media ☐ Insurance ☐ Other: _____

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 ☐ Decreased 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? Were you hospitalized?
_____
_____
_____
_____

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Past Medical History:

Describe any allergies you may have (e.g. medications, foods):

_____
_____
_____

Current Weight _____ Height _____

List ALL current prescription medications (if none, write none) Medication: Name, Dosage, Frequency, Estimated Start Date

List ALL current over-the-counter medications or supplements/Vitamins: Name, Dosage, Frequency, Estimated Start Date

Current medical illnesses:

_____
_____
_____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____
_____
_____
_____

For women only: Date of last menstrual period _____, Was it regular? _____
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? _____
Have you been pregnant before? ☐ Yes ☐ No If yes, how many times? _____

Past Psychiatric History:

Outpatient treatment ☐ Yes ☐ No. If yes, please describe nature of treatment, where it occurred and dates of treatment:

_____
_____

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_____

_____

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).

Medication Start Date/Dosage	Good/Bad Effect	Medication Start Date/Dosage	Good/Bad Effect
Abilify		Desyrel	
Ambien		Effexor	
Adderall		Elavil	
Anafranil		Fetzima	
Antabuse		Geodon	
Asendin		Halcion	
Atarax		Haldol	
Ativan		Klonopin	
Buspar		Ketamine	
Campral		Lamictal	
Celexa		Latuda	
Clonidine		Lexapro	
Clozaril		Luvox	
Cymbalta		Marplan	
Cytomel		Mellaril	
Concerta		Methadone	
Dalmane		Nardil	
Depakote		Norpramine	
Dexedrine		Orap	
Parnate		Suboxone	
Paxil		Sonata	
Pristiq		Tofranil	
Prolixin		Trintellix	
Remeron		Tegretol	
Restoril		Trileptal	
Risperdal		Topamax	
Ritalin		Trazodone	
Serzone		Valium	
Sinequan/Silenor		Viibryd	
Strattera		Vraylar	
Spravato		Vraylar	
Seroquel		Wellbutrin	
Stelazine		Xanax	
Zoloft		Zyprexa	
Other (Name):		Other (Name):	

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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 outpatient?

_____

_____

_____

Have you used the following substances?

	Yes or No	Last time used?	How often? Amount?
Alcohol			
Tobacco			
Marijuana			
Cocaine			
Mushrooms			
PCP			
Opioids (e.g. Heroin, morphine, oxycodone, hydromorphone)			
Others			

Family History:

Please list any blood relatives that have been diagnosed with the following medical conditions.

Alcoholism:
Anxiety Disorders:
Bipolar Disorders:
Cancers:
Depression:
Diabetes:
Drug use:
Heart Disease/ Stroke:
Hypertension:
Seizures:
Schizophrenia:
Suicides:
Thyroid Disease:

Social History:

Which city and state do you live in? _____

Who lives with you? _____

Highest level of education completed? _____

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Current work history: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired For how long? _____

What is/was your occupation? _____

Have you ever served in the military? _____ If so, what branch and when? _____

Current relationship status: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed
For how long? _____

How would you describe your sexual orientation? (Optional)_____

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

Legal History: any arrests, charges, time in jail? If so, please describe.
_____
_____
_____

Have you ever been a victim of physical abuse? Emotional abuse? Sexual abuse? If so, please explain.
_____
_____
_____

Safety Concerns:
Do you have any thoughts of hurting yourself or anyone else? ☐ Yes ☐ No If yes, please explain.
_____
_____
_____

Have you ever tried to hurt yourself in the past or anyone else? ☐ Yes ☐ No If yes, please explain.
_____
_____
_____

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

Signature_____ Date_____