SHENANDOAH MEDICAL CENTER

Mental Health Intake Adults

Please fill out the following information to the best of your ability. It is okay if you do not know the answers to some questions. Skip any you are unsure about and we can discuss them during the session.

Demographics		
Legal Name:		Appointment Date:
Preferred Name:	DOB:	Race & Ethnicity:
Pronouns: ☐ She/Her ☐ He/him ☐ They/them ☐ _____		Birth Sex: ☐ Male ☐ Female
Gender Identity: ☐ Female ☐ Male ☐ Transgender MTF ☐ Transgender FTM ☐ Nonconforming ☐ Decline ☐ _____		
Affirmation Steps (if applicable): ☐ Medical/Surgical Interventions ☐ Legal Name Aligned ☐ Preferred Name Aligned ☐ Presentation aligned ☐ Legal Sex Aligned		
Referral Source:		
Primary Care Physician and Phone:		
Please List **ALL** Current Medications, Vitamins, and Supplements:		

Presenting Problem
Please describe what brings you in today.
Prior attempts to resolve problem:
Client's goals:

Mental and Physical Symptoms:

☐ Anxiety	☐ Feel worthless	☐ Low self-esteem	☐ Restless/Can't sit still
☐ Avoidance	☐ Flashbacks	☐ Mood swings	☐ Sadness
☐ Blackouts	☐ Gambling Problems	☐ Muscle Tension	☐ School/work problems
☐ Bullying/harassment	☐ Guilt	☐ Nausea	☐ Seeing things
☐ Can't concentrate	☐ Have special powers	☐ Nightmares (recurrent?)	☐ Self-harm
☐ Change in appetite	☐ Headaches	☐ No motivation	☐ Sexual problems
☐ Chest Pains	☐ Hearing Things	☐ No need for sleep	☐ Shame
☐ Chills/Hot Flashes	☐ Hopeless/helpless	☐ Numbness	☐ Shortness of Breath
☐ Decreased libido	☐ Impulsive	☐ Obsessive	☐ Sleep too much
☐ Depressed	☐ Increased libido	☐ Panic attacks	☐ Stomach aches
☐ Diarrhea	☐ Increased risky behaviors	☐ Paranoid	☐ Suicidal thoughts
☐ Dizziness	☐ Irregular Sleep	☐ Poor Memory	☐ Suspicious
☐ Easily startled	☐ Irritable/angry	☐ Problem falling asleep	☐ Sweating
☐ Fainting	☐ Isolating	☐ Problem staying asleep	☐ Talk too fast
☐ Family issues	☐ Joint/Muscle Pain	☐ Racing Thoughts	☐ Trembling/Shaking
☐ Fatigue/no energy	☐ Lack of Interest	☐ Rapid Heartbeat	☐ Trouble with Crowds
☐ Fears/phobia	☐ Loneliness	☐ Relationship issues	☐ Vision Changes
☐ Feel numb	☐ Loss/Bereavement	☐ Repetitive behaviors	☐ Wake up too early

Family Health History

Issue/Diagnosis	**Self**	**Father**	**Mother**	**Sibling** (who?)	**Child**	**Grandparent** (maternal/paternal?)	**Aunt/uncle** (maternal/paternal?)
Depression	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder (provider diagnosed)	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
ADHD (provider diagnosed)	☐	☐	☐	☐	☐	☐	☐
OCD/OCRD (provider diagnosed)	☐	☐	☐	☐	☐	☐	☐
Trauma History	☐	☐	☐	☐	☐	☐	☐
Abusive Behavior	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐
Suicide Attempt/Completion	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease/Problems	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Liver Disease/Problems	☐	☐	☐	☐	☐	☐	☐
Chronic Fatigue	☐	☐	☐	☐	☐	☐	☐
Kidney Disease/Problems	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Asthma/Respiratory Problems	☐	☐	☐	☐	☐	☐	☐
Stomach/Intestinal Problems	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Heart Disease/Problems	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Other:							

Personal Medical & Mental Health History				
Allergies:		Last Physical:		
How would you rate your overall health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Presently seeing a psychiatrist/mental health nurse practitioner?			☐ Yes	☐ No
Presently seeing a psychotherapist?			☐ Yes	☐ No
Medical Problems:				
Were there any complications during your mother's pregnancy or your birth?	☐ Yes	☐ No		

Surgeries/Hospitalizations	Date

Inpatient Mental Health/Substance Abuse Treatment (Most recent if more than 3)	Date

Diet: How would you rate your diet?	☐ Good	☐ Fair	☐ Poor	
Weight: Height: Appetite:	☐ Good	☐ Fair	☐ Poor	
How many times do you eat in a 24-hour period?				
What does a typical meal look like?				
Do You Purge: ☐Y ☐N Restrict: ☐Y ☐N Overeat: ☐Y ☐N Binge: ☐ Y ☐ N				
Exercise: Do you exercise regularly? ☐Yes ☐No What kind of exercise? Duration: Frequency:				
Sleep: How many hours, on average do you sleep a night?				
Suicidal Behaviors: # of Suicide Attempts:				

Sexual and Contraceptive History			
Sexually Active? ☐Y ☐N	Have You Ever Had Vaginal Intercourse? ☐Y ☐N	Current Partners ☐1	☐ 2+
Sexual Orientation ☐Bisexual	☐Straight/heterosexual	☐Lesbian/Gay/Homosexual	☐_____
Birth Control Method?			

Women's Health		
# of Pregnancies:	# of Stillbirths:	# of Miscarriages:
Have you experienced the loss of a child?		
Are you planning/hoping to conceive now or in the future?		

Psychological History			
Stressful Events:	☐ Natural Disaster	☐ Fire or Explosion	☐ Transportation Accident
☐ Serious accident at work, home, or during recreational activities	☐ Caused serious injury or death to another	☐ Unwanted or Uncomfortable Sexual Experience	☐ Combat or exposure to war zone
☐ Sexual Assault	☐ Human trafficking	☐ Assault with a weapon	☐ Sudden Violent Death
☐ Exposure to Toxic Substance	☐ Sudden Accidental Death	☐ Life threatening Illness or Injury	☐ Victim of stalker
☐ Physical Assault	☐ Other:		

Abuse/neglect history:

Has client been abused or assaulted: ☐ Yes ☐ No Is client in danger now: ☐ Yes ☐ No

Type of Abuse/Violence	By Whom	Age	Was it Reported?
Sexual			☐ Yes ☐ No
Physical			☐ Yes ☐ No
Emotional			☐ Yes ☐ No
Verbal			☐ Yes ☐ No
Abandoned			☐ Yes ☐ No
Neglect			☐ Yes ☐ No

Please review the following list of psychiatric medications. Circle any you have previously taken.

Abilify (Aripiprazole)	**Depakote (Valproic Acid)**	**Loxapine**	**Prozac (Fluoxetine)**	**Thorazine (Chlorpromazine)**
Adapin (Doxepin)	**Desyrel (Trazodone)**	**Luvox (Fluvoxamine)**	**Remeron (Mirtazapine)**	**Tofranil (Imipramine)**
Adderall/Adderall XR (amphetamine/ dextroamphetamine)	**Dexedrine (Dextroamphetamine)**	**Lybalvi**	**Restoril (Temazepam)**	**Topamax (Topiramate)**
Ambien (Zolpidem)	**Effexor/Effexor XR (Venlafaxine)**	**Metadate (methylphenidate)**	**Risperdal (Risperidone)**	**Tranxene (Clorazepate)**
Anafranil (Clomipramine)	**Elavil (Amitriptyline)**	**Methadone**	**Ritalin (Methylphenidate)**	**Trintellix (vortioxetine)**
Antabuse (Disulfiram)	**Focalin (Dexmethylphenidate)**	**Naltrexone**	**Rozerem (Ramelteon)**	**Valium (Diazepam)**
Ativan (Lorazepam)	**Geodon (Ziprasidone)**	**Nardil (Phenelzine)**	**Seroquel (Quetiapine)**	**Viibryd (vilazodone)**
Auvelity (dextromethorphan-buproprion)	**Halcion (Triazolam)**	**Norpramin (Desipramine)**	**Serzone (Nefazodone)**	**Vistaril (Hydroxyzine)**
Buprenorphine	**Haldol (Haloperidol)**	**Pamelor (Nortriptyline)**	**Sinequan (Doxepin)**	**Vraylar (cariprazine)**
Buspar (Buspirone)	**Invega (Paliperidone)**	**Parnate**	**Sonata (Zaleplon)**	**Vyvanse (Lisdexamfetamine)**
Campral (Acamprosate)	**Jornay**	**Paxil/ Paxil CR (Paroxetine)**	**Stelazine (Trifluoperazine)**	**Wellbutrin XL/SR – (Bupropion)**
Caplyta	**Klonopin (Clonazepam)**	**Phentermine**	**Strattera (Atomoxetine)**	**Xanax (Alprazolam)**
Celexa (Citalopram)	**Lamictal (Lamotrigine)**	**Pristiq (Desvenlafaxine)**	**Suboxone**	**Zoloft (Sertraline)**
Clozaril (Clozapine)	**Lexapro (Escitalopram)**	**Prolixin (Fluphenazine)**	**Symbyax (fluoxetine/olanzapine)**	**Zyprexa (Olanzapine)**
Concerta (Methylphenidate)	**Librium (Chlordiazepoxide)**	**Propranolol (Inderal)**	**Synthroid (Levothyroxine)**	
Cymbalta (Duloxetine)	**Lithium**	**Provigil (Modafinil)**	**Tegretol (Carbamazepine)**	

If you circled any of the above, was it effective, and what was the reason for discontinuation?

Chemical Abuse/Use:

Drug	Tried? (Y/N)	Age 1st Used	Age Heaviest Use	Frequency/Amount	Date Last Used
Caffeine					
Cigarettes					
Vape, Pipe, Chewing Tobacco					
Alcohol					
Marijuana/Cannabis					
Cocaine					
Stimulants					
Methamphetamine					
Hallucinogens					
Opioids					
Sedatives					
Abuse of Prescription Drug					

Consequences of Drug/Alcohol Use:

- ☐ Sleep problems
- ☐ Alcohol Poisoning
- ☐ Overdose
- ☐ Lost job
- ☐ Incarceration(s)
- ☐ DTs/shakes
- ☐ Increased tolerance
- ☐ Seizures
- ☐ DUI/DWI(s)
- ☐ Homicide
- ☐ Violent
- ☐ Blackouts
- ☐ Assaults
- ☐ Binges
- ☐ Liver disease
- ☐ School dropouts
- ☐ Arrests
- ☐ Relationship issues

Risky Behaviors	Addictive Behaviors	Notes
☐ Unprotected sex ☐ Gang involvement ☐ Shoplifting ☐ Drug dealing ☐ Reckless driving ☐ Carrying/using weapon ☐ Trespassing ☐ Fighting ☐ Other:	☐ Sex ☐ Gambling ☐ Internet ☐ Shopping ☐ Video gaming ☐ Plastic surgery ☐ Thrill seeking ☐ Food ☐ Other:	

Background & Current Living Conditions:

Living Situation: ☐ Apartment ☐ Correctional Facility ☐ Hospice Care ☐ House
☐ Nursing Home ☐ Mobile Home ☐ Residential/Group Home ☐ Extended Care ☐ Condo
☐ Assisted Living ☐ Shelter ☐ Independent Living ☐ Homeless

Significant Exposure ☐ None ☐ Noise ☐ Fumes ☐ Dust ☐ Smoke ☐ Airborne Particles ☐ Solvents

Family/Household Composition

Please list any children you have.

First Name	Gender	Age	Relationship to Client	Relationship Quality	Living with Client
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Please list anyone else who currently lives with you.

First Name	Gender	Age	Relationship to Client	Relationship Quality

Education/ Employment: Highest Grade Completed: | Degree(s):

Currently Employed: ☐ Yes ☐ No | ☐ Satisfied ☐ Unsatisfied | Been Fired: ☐ Yes ☐ No

☐ Never employed ☐ Student ☐ Problems with Employer ☐ Problems with co-workers

☐ Full-time ☐ Part-time ☐ Self-employed ☐ Temporary/seasonal

☐ Retired ☐ Disabled Other:

Military History: ☐ Yes ☐ No | Branch of Service: | Combat: ☐ Yes ☐ No

Type of Discharge: ☐ Honorable ☐ General ☐ Medical ☐ Dishonorable ☐ Other Than Honorable

Overall perspective of time in service:

List current disability status and services client is receiving from the Veterans Administration:

Legal Situation: ☐ Current Legal Problems ☐ Past Legal Problems

☐ DUI/DWI ☐ Detention ☐ Arrest ☐ Conviction ☐ Jail ☐ Probation ☐ Prison

Explanation:

Social History & Support:	Additional Notes
Are your parents divorced? ☐ Yes ☐ No	
Are childhood events contributing to current problems? ☐ Yes ☐ No	
Briefly describe your childhood (happy, chaotic, troubled):	
Briefly describe what school was like for you (Good/bad subjects, special education classes, gifted and talented, etc):	
Satisfied with current family life? ☐ Yes ☐ No	
Satisfied are you with the support received from family and friends? ☐ Yes ☐ No	
Satisfied with your quality of life? ☐ Yes ☐ No	
Are you spiritual/Religious? ☐ Yes ☐ No	

Leisure & Recreation: ☐ Reading ☐ Time with Friends ☐ Time with Family

☐ Watch TV/Movies ☐ Gaming ☐ Crafting ☐ Walking

☐ Bars ☐ Listen to Music Other:

Screeners

Over the last 2 weeks, how often have you been bothered by the following problems?				
	Not at all	**Several Days**	**Over half the days**	**Nearly every day**
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

SCOFF

Do you make yourself sick because you feel uncomfortable full?	**Yes**	**No**
Do you worry you have lost control over how much you eat?	**Yes**	**No**
Have you recently lost more than 20 pounds in a 3 months period?	**Yes**	**No**
Do you believe yourself to be fat when others say you are too thin?	**Yes**	**No**
Would you say that food dominates your life?	**Yes**	**No**

CSSI

1. In the past month, have you wished you were dead or wished you could go to sleep and not wake up?	**Yes**	**No**
2. In the past month, have you actually had any thoughts about killing yourself?	**Yes**	**No**
If Yes to question 2, answer ALL remaining questions. **If No to question 2, skip to question 6.**		
3. In the past month, have you been thinking about how you might kill yourself?	**Yes**	**No**
4. In the past month, have you had these thoughts and had some intention of acting on them?	**Yes**	**No**
5. Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**Yes**	**No**
6. Have you ever in your lifetime, done anything, started to do anything, or prepared to do anything to end your life? *(Examples: took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills, but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc)*	**Yes**	**No**
If yes to question 6, was this within the past 3 months?	**Yes**	**No**

DAST-20

Preliminary Comments: The following questions concern your potential involvement with drugs other than alcohol. When you answer the questions, remember that the term "drug abuse" does not include alcohol. Instead, it refers to your use of prescribed or over the counter drugs in excess of the recommended dosage. For example, if you were given a prescription for pain killers, but took more than you were supposed to, that would be included. The phrase "drug abuse" also includes any non-medical drug use, including illegal drugs. This includes substances like marijuana, valium, cocaine, amphetamines, LSD, and heroin. Remember that the term "drug abuse" does not include alcohol. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.

Have you used drugs other than those required for medical reasons?	**Yes**	**No**
Have you abused prescription drugs?	**Yes**	**No**
Do you abuse more than one drug at a time?	**Yes**	**No**
Can you get through the week without using drugs?	**Yes**	**No**
Are you always able to stop using drugs when you want to?	**Yes**	**No**
Have you had "blackouts" or "flashbacks" as a result of drug use?	**Yes**	**No**
Do you ever feel bad or guilty about your drug use?	**Yes**	**No**
Does your spouse (or parents) ever complain about your involvement with drugs?	**Yes**	**No**
Has drug abuse created problems between you and your spouse or your parents?	**Yes**	**No**
Have you lost friends because of your use of drugs?	**Yes**	**No**
Have you neglected your family because of your use of drugs?	**Yes**	**No**
Have you been in trouble at work (or school) because of drug abuse?	**Yes**	**No**
Have you lost your job because of drug abuse?	**Yes**	**No**
Have you gotten into fights when under the influence of drugs?	**Yes**	**No**
Have you engaged in illegal activities in order to obtain drugs?	**Yes**	**No**
Have you been arrested for possession of illegal drugs?	**Yes**	**No**
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	**Yes**	**No**
Have you had medical problems as a result of your drug use? (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)	**Yes**	**No**
Have you gone to anyone for help for a drug problem?	**Yes**	**No**
Have you been involved in a treatment program specifically related to drug use?	**Yes**	**No**

AUDIT

These questions refer to the past 12 months.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ Times per week
How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2	3-4	5-6	7-9	10+
How often do you have five or more drinks on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
I:0-3, II:4-9, III:10-13, IV:14+					

Have you ever been in treatment for an alcohol problem? ☐ **Never** ☐ **Currently** ☐ **In the past**

Sleep apnea screener

Do you **S**nore loudly (loud enough to be heard through closed doors or your bed partner elbows you for snoring at night)?	**Yes**	**No**
Do you often feel **T**ired, fatigued, or sleepy during the daytime (such as falling asleep during driving or talking to someone)?	**Yes**	**No**
Has anyone **O**bserved you stop breathing or choking/gasping during your sleep?	**Yes**	**No**
Do you have or are you being treated for High Blood **P**ressure?	**Yes**	**No**

CIDI (Created by Ronald C Kessler, PhD)

Some people have periods lasting several days when they feel much more excited and full of energy **than usual**. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this **lasting several days or longer**?	**Yes**	**No**
Have you ever had a period **lasting several days or longer** when most of the time you were so irritable or grouchy that you either started arguments, shouted at people, or hit people?	**Yes**	**No**
IF NO to both questions above, STOP HERE. If yes to either of the above, continue.		
People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in many ways they would normally think inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy?	**Yes**	**No**
If no, stop here. If yes, please continue.		

Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following did you experience?

☐ Were you so irritable that you either started arguments, shouted at people, or hit people?	☐ Did you try to do things that were impossible to do, like taking on large amounts of work?	☐ Did you constantly keep changing your plans or activities?
☐ Did you become so restless or fidgety that you paced up and down or couldn't stand still?	☐ Did you find it hard to keep your mind on what you were doing	☐ Did you sleep far less than usual and still not get tired or sleepy?
☐ Did you do anything else that wasn't usual for you – like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?	☐ Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them?	☐ Did you spend so much more money than usual that it caused you to have financial trouble?

ISI (Created by Charles M. Morin, PhD)

Please rate the current (LAST 2 WEEKS) severity of your insomnia problems.

Difficulty falling asleep	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
Difficulty staying asleep	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
Problems waking up too early	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
How satisfied/dissatisfied are you with your current sleep pattern?	**Very Satisfied**	**Satisfied**	**Moderately Satisfied**	**Dissatisfied**	**Very Dissatisfied**
How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life?	**Not at all**	**A Little**	**Somewhat**	**Much**	**Very Much**
How worried/distressed are you about your current sleep problem?	**Not at all**	**A Little**	**Somewhat**	**Much**	**Very Much**
To what extent do you consider your sleep problem to interfere with you daily functioning (ex: daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) currently?	**Not at all**	**A Little**	**Somewhat**	**Much**	**Very Much**