Matthews-Vu
Healthcare for Children and Adults

Matthews-Vu Medial Group
Behavioral Health Intake Form

Date: _____ Name: _____ Date of Birth:_____

Who referred you to our psychiatric service? _____

What are your goals for psychiatric care? _____

_____

What treatments have you had in the past? Medication Counseling Other _____

Have you had any psychiatric diagnoses in the past? Please list, if any _____

When did symptoms begin? e.g. childhood, adulthood, pregnancy _____

What makes symptoms worse? _____

What makes them better? _____

How do you cope? e.g. hobbies, family/friends, work, spirituality, exercise, diet. _____

_____

Please mark which individual or group of symptoms you have had in the past or struggle with now:

A period over 4 or 7 days of:

- increased energy
- rapid speech
- decreased sleep
- racing thoughts
- increased impulsivity with overspending, hypersexuality, risk-taking behaviors such as driving fast or using harmful substances

A period over 6 months where you felt anxious most of the time

Difficulty with focus, memory, problem solving or learning

A period over 2 weeks of:

- decreased energy
- sad or depressed mood
- reduced or increased appetite
- difficulty enjoying things you would typically enjoy

Thoughts of not wanting to be alive

Self-harm behaviors such as cutting, burning, hitting walls or hard objects

Thoughts of wanting to harm others

Eating disorder symptoms such as bingeing, purging, or severely limiting diet

Obsessive or compulsive thoughts or behaviors that consistently occupy over an hour of a day's time.

A history of traumatic experience that causes flashbacks or nightmares

Feeling like your mind plays tricks on you making you hear or see things that no one else can hear or see

Paranoia

What medications have you tried in the past? (Circle all that apply)

Serotonin Medication:
Sertraline/Zoloft
Fluoxetine/Prozac
Citalopram/Celexa
Escitalopram/Lexapro
Paroxetine/Paxil
Mirtazapine/Remeron
Vortioxetine/Trintellix
Vilazodone/Viibryd

Mood Stabilizers:
Lamotrigine/Lamictal
Lithium
Divalproex/Depakote
Oxcarbazepine/Trileptal
Carbamazepine/Tegretol

Atypicals:
Aripiprazole/Abilify
Lurasidone/Latuda
Olanzapine/Zyprexa
Risperdal
Cariprazine/Vraylar

GABA Medications:
Lorazepam/Ativan
Klonazepam/Klonopin
Alprazolam/Xanax
Diazepam/Valium

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Other Medications tried, not listed above: _____

Did any of these medications work well, or, cause severe side effects or worsened mental symptoms? Allergies?
Please describe: _____
_____

Any family history of mental illness or substance use? _____
_____

Do you have any of the following medical conditions? (Circle all that apply)

Seizures	Head injuries with loss of consciousness	Concussions
Autoimmune diseases	Hypothyroidism	Migraines
Toxin exposures	For women, peripartum mood and anxiety disorders	

Are you taking any birth control medication? (If Yes, please list) _____

Have you ever drank alcohol to excess? (Circle One) Yes No

Do you use Cannabis products? (Circle One) Yes No

Do you use Tobacco or Nicotine products? (Circle One) Yes No

Please briefly describe your living/job situation: _____
_____

Any firearms in the home? (Circle One) Yes No

Any history of legal convictions? (Circle One) Yes No

Would you like to share any cultural, faith-related, or sexual preferences or identities? _____
_____

What specific questions do you have for your psychiatric provider today? _____
_____
_____

Thank you, we look forward to meeting you!