Matthews-Vu
Healthcare for Children and Adults

Behavioral Health Intake Form

Name: _____ **DOB:** _____**Date:** _____
PCP: _____ **Insurance:** _____
What are your goals for psychiatric care? _____
_____

What are your current psychiatric diagnoses? _____
_____

What treatment have you had in the past? Medication Counseling Other: _____
When did symptoms begin? (e.g., childhood, adulthood, pregnancy) _____

Please identify which of the following symptoms you have experienced in the past or struggle with now:

A period over 4 or 7 days of:	**A period over 2 weeks of:**
o Increased energy o Rapid speech o Decreased sleep o Racing thoughts o Increased impulsivity with overspending, hypersexuality, risk-taking behaviors such as driving fast or using harmful substances	o Decreased energy o Sad or depressed mood o Reduced or increased appetite o Difficulty enjoying things you would typically enjoy o Obsessive or compulsive thoughts or behaviors that consistently occupy over an hour of a days' time

A history of traumatic experience(s) 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	Eating disorder symptoms such as binging, purging, or severely limiting diet
A period over 6 months where you felt anxious most of the time	Self-harm behaviors such as cutting, burning, hitting walls or hard objects	Thoughts of not wanting to be alive
Thoughts of wanting to harm others	Difficulty with focus, memory, or cognition	Paranoia

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

Serotonin Medications:	**Mood Stabilizers:**	**Atypicals:**	**GABA Medications:**
Sertraline/Zoloft	Lamotrigine/Lamictal	Aripiprazole/Abilify	Lorazepam/Ativan
Fluoxetine/Prozac	Lithium	Lurasidone/Latuda	Clonazepam/Klonopin
Citalopram/Celexa	Divalproex/Depakote	Olanzapine/Zyprexa	Alprazolam/Xanax
Escitalopram/Lexapro	Oxcarbazepine/Trileptal	Risperidone/Risperdal	Diazepam/Valium
Paroxetine/Paxil	Carbamazepine/Tegretol	Cariprazine/Vraylar	
Mirtazapine/Remeron			
Vortioxetine/Trintellix			
Vilazodone/Viibryd			

What other psychiatric medications have you tried, not listed above? _____

_____

Were any of these successful, or, cause severe side effects or worsened mental symptoms? Allergies? Please describe: _____

_____

What current psychiatric medications are you taking and their current doses? _____

_____

Do you need medication refills, if yes please specify which pharmacy? □ No □ Yes:

_____

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

Seizures	Head injuries with loss of consciousness	Concussions
Autoimmune diseases	Thyroid disease (hypo or hyper)	Migraines
Toxin exposures	Diabetes	PCOS
Peripartum mood disorder	Premenstrual dysphoria	Endometriosis

Any family history of mental illness or substance use? _____

_____

Briefly describe your living situation and work/school life: _____

_____

_____

Briefly describe your diet/exercise: _____

_____

Do you use tobacco/nicotine products?	Yes	No	If yes, how often/how much: _____		
Do you use cannabis products?	Yes	No	If yes, how often/how much: _____		
Do you have a history of drug use?	Yes	No	If yes, how often/how much: _____		
Do you consume alcohol?	Yes	No	If yes, how often/how much: _____		
Any firearms or weapons in the home?	Yes	No	If yes, are they secured?	Yes	No
Any history of legal convictions?	Yes	No			

In the past two weeks have you experienced the following symptoms:

Suicidal Ideation	Yes	No
Homicidal Ideation	Yes	No
Self-Harm	Yes	No

Would you like to share any personal preferences/identifies (e.g., sexual preferences, gender identifiers, religious beliefs, etc.)? _____

_____

Are you pregnant or breastfeeding?	Yes	No
Are you on birth control?	Yes	No

For MA/Provider use only WT _____ BP _____ HR _____ T _____ O2 _____