UNIFIED COMMUNITY SERVICES
INTAKE HISTORY

NAME _____ DATE _____

Please answer the following questions. Your answers will help us develop a comprehensive understanding of your concerns. If you need more space, please use the back of the page.

I. Briefly describe the problem that brought you here today: _____

_____

_____

_____

II. Please describe any <u>past</u> mental health treatment you've had. Include where you received treatment, date, and type of treatment: _____

_____

_____

_____

Have you ever been hospitalized for emotional problems? _____ If yes, please describe:

_____

_____

Please list medications you have <u>previously</u> taken for mental health problems. Indicate any side effects, whether or not the medication was helpful, and how long you took the medication: _____

_____

_____

_____

III. Please describe any significant life events that may be influencing your current problem (for example, past abuse, family problems, loss of family member, divorce, etc.): _____

_____

_____

_____

_____

_____

Please list the people living in your home, including each person's age and relationship to you: _____

_____

_____

NAME _____ DATE _____

IV. Please describe your current or past legal problems: _____

_____

_____

_____

V. Please describe any problems you had or are having in school: _____

_____

_____

If currently attending school, what grade are you in? _____

If you are not in school, what was the highest grade you completed? _____

VI. Please tell us about your blood relatives who have had mental health and/or substance abuse problems. Include suicides and significant legal problems. Describe the nature of the problem: _____

_____

_____

_____

_____

VII. Name of your primary medical doctor: _____

Name(s) of other doctors you see: _____

Date of last complete physical: _____

Current health concerns: _____

Allergies: _____

List all prescription, over-the-counter, and herbal medications you are currently taking. Include dosage and side effects: _____

_____

_____

_____

Has a doctor recommended or prescribed medicine that you are not taking? ____ If yes, please explain:

_____

Current height and weight: _____

Please circle any physical health problems that you or your blood relatives have encountered:

Diabetes	Heart disease	High blood pressure		Cancer	Stroke
Seizures	Thyroid disorder	Migraines	TB	Asthma	Ulcers

NAME _____ DATE _____

How much and what type of caffeinated beverages do you drink each day? _____

_____

Describe the frequency, amount and how long you used the following substances:

Marijuana: _____

Street drugs (e.g. Cocaine, speed, acid, angel dust): _____

_____

Alcohol: _____

Tobacco: _____

Other: _____

Are you currently having problems related to these substances? _____

_____

Have you ever been treated for problems with alcohol or drugs? _____

_____

Have you ever been hospitalized for problems with alcohol or drugs? _____

_____

Have you ever been placed in detox? _____

VIII. Below is a list of concerns that people report. Please circle any that are problematic for you:

Sleeping	Eating	Alcohol	Concentration
Memory decline	Shame	Guilt	Decision making
Anxiety	Depression	Fear	Worries
Feeling down	Over spending	Irritability	Anger outbursts
Hitting others	Suicidal thoughts	Verbal abuse	Poor frustration tolerance
Hallucinations	Being hit/hurt	Mood swings	Sexual difficulties
Nightmares	Panic attacks	Hopelessness	Sadness
Mind racing	Unwanted thoughts	Breaking things	Hurting yourself
Communication	Flashbacks	Hoarding/collecting	Being picked on

IX. Please share any other information that will help us understand your problems:

_____

_____

Signature of Person Who Completed This Form _____ 7/2014