United Family Medicine
Mental Health Client Intake Questionnaire

Please fill out information to the best of your ability

Today's Date_____

Name:_____ Gender: ___F ___M

Name of person completing questionnaire if not the client: _____

If not client, relationship to client: _____

Date of Birth_____

Home Phone: _____Work Phone: _____Cell phone: _____

May we leave a message at your home phone? ____Yes or ____No

May we leave a message at your work/cell phone? _____Yes or ___No

Occupation_____

Are you on disability? ___yes ___no

If yes, why are you on disability? _____

Highest Grade of Education _____

If you did not finish high school do you have your GED or Diploma? ____yes _____no

What is your marital status?

____Single ____Married ____Partnership ___Divorced ___Widowed ____Engaged

If you are in a relationship, what is the name of your partner and how long have you been together?

_____

Why are you coming for mental health services?_____

_____

_____

_____

_____

Names of friends or family currently being seen by UFM mental health_____

_____

_____

Please circle any of the problems listed below that you are currently experiencing.

Sad	Suicidal thoughts	Isolated	Poor attention
Depressed	Recent suicide attempt	Angry a lot	Memory problems
Not doing anything enjoyable	Injuring yourself	Unable to control anger	Can't concentrate
Feeling hopeless and worthless	Low self-esteem	Constantly in conflict	Can't focus
Overwhelmed	Racing thoughts	Feeling empty inside	Drinking too much alcohol
Eating too much	Hypomania or mania	Impulsive	Using marijuana
Eating too little	Excessive anxiety and worry	Gambling too much	Using crack, crank, other drugs
A lot less energy	Panic attacks	Spending too much	Mis-using prescription drugs
A lot more energy	Obsessive/ Compulsive	Hearing things or seeing things that aren't really there	Anorexia or restricting food
Energy is low then high	Restless	Recently became violent	Binging/purging
Not sleeping well	Easily startled, always looking over your shoulder	Recently experienced violence	Abusing laxatives or diet pills
Sleeping too much	Nightmares	Perfectionism	Can't deal with chronic pain
Tired all of the time	Flashbacks	Stress shows up in physical problems	Procrastination

List any other symptoms that you are experiencing. _____

_____

What are the main sources of stress in your life (check as many areas as apply to you)?

____Home ____Work _____Relationships _____Health _____Money

____ Children ____Legal Problems _____Housing Other _____

Do you have a history of physical, sexual, emotional abuse or trauma? _____yes _____no

Have you had any major losses in your life? ___Yes ____no. If so, what kind of loss?

_____

_____

Have you ever had any counseling? ____ yes ____no. If yes was it helpful and why?

_____

_____

Do you have any involvement with these services? ____yes _____no

____Court/Probation Services ____County Case manager _____Adult/Child Protection

Please list all of the people in your current household (If you have children who are not living with you, please note their age and where they are living. If you run out of room please use the back)

Name	Age	Relationship with you

Please list all the members of your family you grew up in. (If you run out of room use the back)

Name	Relationship to you	Age	No longer alive

Does anyone in the family you grew up in, have any kind of mental health or chemical dependency problems such as depression, anxiety, schizophrenia etc? If so, please list the kind of problem

_____

_____

_____

Have you ever been hospitalized for mental health problems? If so, the year you were you hospitalized, the name of the hospital and why?_____

_____

When were you last hospitalized for mental health?_____

Have you ever attempted suicide? ___ yes ____no. If yes what age_____

_____

Have you ever been hospitalized for medical problems? ___yes ____no. If yes when were you hospitalized, where and for what reason_____

_____

_____

What medical conditions do you have? Please include any allergies. _____

_____

_____

_____

Please list any medications prescribed by any doctors outside of United Family Medicine.

SELF CARE:

Exercise_____ E Cigs_____

Caffeine_____ Tobacco_____

Water Intake_____ Nicotine_____

Do you work with any medical providers outside this clinic? If so, please list their names and why you are working with them. _____

_____

_____

Primary language_____**Do you need an interpreter**_____

PATIENT IS RESPONSIBLE FOR ALL COSTS NOT COVERED BY INSURANCE

Primary Doctor _____

Psychiatrist Name_____
Address_____
_____
Phone _____