Grand Island Mental Health
& Medical Clinic, LLC

## New Adult Patient Intake

**Patient's Name**: (First) ____________________________________ (Last)____________________________________

### *Mental Health Questionnaire*

**Please describe your goals for treatment**: ___________________________________________________________________________

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

**Please describe what factors or events have lead you to seeking treatment at this specific time**: ______________________________

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

_____________________________________________________________________________________________________________

### *Race Background*

**Please circle one**: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiin or Other Pacific Islander

White / Other: ________________________________

### *Relationship Information*

**Please circle one**: Single (never married) / Married / Divorced / Widowed / Separated / Engaged

**Name of Current Spouse/Significant Other**: (First) ____________________________ (Last)____________________________

**Years married/togethe**r: ______

**Name of Previous Spouse**: (First) ________________________ (Last) _________________________ **Years married/together**: _______

**Name of Previous Spouse**: (First) ________________________ (Last) _________________________ **Years married/together**: _______

**Name of Previous Spouse**: (First) ________________________ (Last) _________________________ **Years married/together**: _______

### *Parental Information*

**Please indicate the current marital status of your parents** (circle all that apply):

Never Married / Divorced / Currently Married / Mother Remarried / Father Remarried

**Please describe your current relationship with your mother** (circle all the apply)?

Good / Mixed / Poor / Never Present / Deceased - *Mother deceased for*: _____________________ *Age of patient at mother's death:* ________

**Please describe your current relationship with your father** (circle all the apply)?

Good / Mixed / Poor / Never Present / Deceased - *Father deceased for:* _____________________ *Age of patient at father's death:* _________

**At what age did you leave home**? ___________

**What was your reason for leaving home** (circle all that apply)? School/College / Poor Home Environment / Got Married /

Needing Independance / Other: __________________________________________________________________________________

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## ***Childhood Information***

Please circle all that apply.

Outstanding Home Environment / Normal Home Environment / Chaotic or Poor Home Environment / Witnessed Abuse

Experienced Abuse / Moved Often / Neglected / Traumatic Event / Did Not Live With Parents / Foster Care / Homelessness

Other: ________________________________________________

## ***Social Questionnaire***

Please circle all that currently apply.

**Support System***:*

Supportive Friends / No or Few Friends / Unsupportive Friends / Substance-use-based friends / Supportive Family

Unsupportive Family / Distant from Family / Supportive Significant Other / Unsupportive Significant Other

**Sexual History**:

Homosexual / Bisexual / Heterosexual / Other: ________________________

**Social Activities**:

Enjoy Volunteering / Member of a Church / Attend Church Groups / Attend Support Groups / Friends / Attend Goodwill or Other Day Service

Other: ________________________________________ / Hobbies:_______________________________________________

## ***Child Information***

Please list information about all your children

**Child's Name**: ______________________________________ **Age** _________

**Other Biological Parent**:_______________________________________ **Does child live in your home?** Yes / No

**Child's Name**: ______________________________________ **Age** _________

**Other Biological Parent**:_______________________________________ **Does child live in your home?** Yes / No

**Child's Name**:______________________________________ **Age** _________

**Other Biological Parent**: ______________________________________ **Does child live in your home?** Yes / No

**Child's Name**: ______________________________________ **Age** _________

**Other Biological Parent**: ______________________________________ **Does child live in your home?** Yes / No

**Child's Name**:______________________________________ **Age** _________

**Other Biological Parent**: ______________________________________ **Does child live in your home?** Yes / No

**Child's Name**:______________________________________ **Age** _________

**Other Biological Parent**: ______________________________________ **Does child live in your home?** Yes / No

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**_Sibling Information_**

**Birth order**: I am the _________ (st/nd/rd/th) sibling in a line of _____________ siblings.

**Sibling Name**: ________________________________________________ (Circle One) Full Sibling / Half Sibling / Step Sibling

**How is your current relationship with this sibling?** Good / Mixed / Poor / Deceased / Not Present

**Sibling Name**: ________________________________________________ (Circle One) Full Sibling / Half Sibling / Step Sibling

**How is your current relationship with this sibling?** Good / Mixed / Poor / Deceased / Not Present

**Sibling Name**: ________________________________________________ (Circle One) Full Sibling / Half Sibling / Step Sibling

**How is your current relationship with this sibling?** Good / Mixed / Poor / Deceased / Not Present

**Sibling Name**: ________________________________________________ (Circle One) Full Sibling / Half Sibling / Step Sibling

**How is your current relationship with this sibling?** Good / Mixed / Poor / Deceased / Not Present

**Sibling Name**: ________________________________________________ (Circle One) Full Sibling / Half Sibling / Step Sibling

**How is your current relationship with this sibling?** Good / Mixed / Poor / Deceased / Not Present

**Sibling Name**: ________________________________________________ (Circle One) Full Sibling / Half Sibling / Step Sibling

**How is your current relationship with this sibling?** Good / Mixed / Poor / Deceased / Not Present

**_Current Living Arrangements_**

**Please circle all that apply**: Housing Adequate / Overcrowded / Homeless / Dysfunctional / Dependent on others for housing

**Please list persons currently living in household**:

Name: ____________________________________ Age: __________ Relationship to Patient: ________________________________

Name: ____________________________________ Age: __________ Relationship to Patient: ________________________________

Name: ____________________________________ Age: __________ Relationship to Patient: ________________________________

Name: ____________________________________ Age: __________ Relationship to Patient: ________________________________

Name: ____________________________________ Age: __________ Relationship to Patient: ________________________________

Name: ____________________________________ Age: __________ Relationship to Patient: ________________________________

**_Previous Treatment History_**

**Have you had previous counseling or medication management?** Yes / No

**Name of therapist or clinic**: ____________________________________________________________________________________

**Was it beneficial?** Yes / No **Reason for termination**: ____________________________________________________________

**Name of therapist or clinic**: ____________________________________________________________________________________

**Was it beneficial?** Yes / No **Reason for termination**: ____________________________________________________________

**Have you had any inpatient treatment?** Yes / No

**When?** ______________________________ **Was it beneficial?** Yes / No

**Name of facility**: __________________________________________________________________________________________

**When?** ______________________________ **Was it beneficial?** Yes / No

**Name of facility**: __________________________________________________________________________________________

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***Mental Health Symptoms***

| | Just Recently | In the Last Year | Several Years | Most of My Life |
|---|---|---|---|---|
| Low energy | ◯ | ◯ | ◯ | ◯ |
| Depression | ◯ | ◯ | ◯ | ◯ |
| Waking up at night | ◯ | ◯ | ◯ | ◯ |
| Trouble falling asleep | ◯ | ◯ | ◯ | ◯ |
| Sleeping too much | ◯ | ◯ | ◯ | ◯ |
| Low self-esteem | ◯ | ◯ | ◯ | ◯ |
| Self-harm | ◯ | ◯ | ◯ | ◯ |
| Crying often | ◯ | ◯ | ◯ | ◯ |
| Feelings of guilt | ◯ | ◯ | ◯ | ◯ |
| Feeling worthless | ◯ | ◯ | ◯ | ◯ |
| Loss of interest | ◯ | ◯ | ◯ | ◯ |
| Withdrawing from others | ◯ | ◯ | ◯ | ◯ |
| Anxiety / Fears | ◯ | ◯ | ◯ | ◯ |
| Worries / Mind racing | ◯ | ◯ | ◯ | ◯ |
| Repeating actions | ◯ | ◯ | ◯ | ◯ |
| Loss of focus | ◯ | ◯ | ◯ | ◯ |
| Hyper - too much energy | ◯ | ◯ | ◯ | ◯ |
| Moodiness | ◯ | ◯ | ◯ | ◯ |
| Difficulty concentrating | ◯ | ◯ | ◯ | ◯ |
| Anger / Temper issues | ◯ | ◯ | ◯ | ◯ |
| Physical chronic pain | ◯ | ◯ | ◯ | ◯ |
| Weight change | ◯ | ◯ | ◯ | ◯ |
| Appetite change | ◯ | ◯ | ◯ | ◯ |
| Stomach issues | ◯ | ◯ | ◯ | ◯ |
| Frequent headaches | ◯ | ◯ | ◯ | ◯ |
| Constipation / Diarrhea | ◯ | ◯ | ◯ | ◯ |
| Gambling issues | ◯ | ◯ | ◯ | ◯ |
| Financial stress | ◯ | ◯ | ◯ | ◯ |
| Substance abuse issues | ◯ | ◯ | ◯ | ◯ |
| Sexual problems | ◯ | ◯ | ◯ | ◯ |
| Nightmares | ◯ | ◯ | ◯ | ◯ |
| Family violence | ◯ | ◯ | ◯ | ◯ |
| Physical abuse | ◯ | ◯ | ◯ | ◯ |
| Sexual abuse | ◯ | ◯ | ◯ | ◯ |
| Inappropriate sexual behaviors | ◯ | ◯ | ◯ | ◯ |
| Perpetrator of abuse | ◯ | ◯ | ◯ | ◯ |
| Employment issues | ◯ | ◯ | ◯ | ◯ |
| Troubles at school | ◯ | ◯ | ◯ | ◯ |
| Parent / Child conflict | ◯ | ◯ | ◯ | ◯ |
| Relationship issues | ◯ | ◯ | ◯ | ◯ |
| Family conflict | ◯ | ◯ | ◯ | ◯ |

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## *Diagnosis History*

| | Myself | Parent | Grandparent | Sibling | Child |
|---|---|---|---|---|---|
| Depression | ◯ | ◯ | ◯ | ◯ | ◯ |
| Anxiety | ◯ | ◯ | ◯ | ◯ | ◯ |
| ADD / ADHD | ◯ | ◯ | ◯ | ◯ | ◯ |
| PTSD | ◯ | ◯ | ◯ | ◯ | ◯ |
| Autism | ◯ | ◯ | ◯ | ◯ | ◯ |
| Conduct Disorder | ◯ | ◯ | ◯ | ◯ | ◯ |
| Eating Disorders | ◯ | ◯ | ◯ | ◯ | ◯ |
| Schizophrenia | ◯ | ◯ | ◯ | ◯ | ◯ |
| Substance abuse disorder | ◯ | ◯ | ◯ | ◯ | ◯ |
| Personality disorder | ◯ | ◯ | ◯ | ◯ | ◯ |
| Obsessive-Compulsive disorder | ◯ | ◯ | ◯ | ◯ | ◯ |
| Bipolar disorder | ◯ | ◯ | ◯ | ◯ | ◯ |
| Learning disorder | ◯ | ◯ | ◯ | ◯ | ◯ |
| Infertility | ◯ | ◯ | ◯ | ◯ | ◯ |
| Other: ______________________ | ◯ | ◯ | ◯ | ◯ | ◯ |

## *Suicide Risk Screen*

| | None | Yes, Recently | Yes, In The Past |
|---|---|---|---|
| Suicidal thoughts | ◯ | ◯ | ◯ |
| Suicidal attempts | ◯ | ◯ | ◯ |
| Suicidal threats | ◯ | ◯ | ◯ |

**If you responded "yes" to any of the previous questions, please explain the nature of the thoughts, attempts, and/or threats**:

______________________________________________________________________________________________

______________________________________________________________________________________________

## *Substance Abuse Risk Screen*

**Have you ever felt you should cut down on drinking or drug use?** Yes / No

**Have friends or family annoyed you by criticizing your drinking or drug use?** Yes / No

**Have you ever felt bad or guilty about drinking or drug use?** Yes / No

**Have you ever drank or used drugs in the morning to steady your nerves or get rid of a hangover?** Yes / No

**Have your relationships with friends or family members been negatively influenced by drinking or drug use?** Yes / No

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### ***Military Information***

Please circle the option that applies to you.

No History / Currently Serving / Honorably Discharged / Other Than Honorably Discharged / General Discharge / Bad Conduct Discharge

**How many years did you serve?** _______________

### ***Employment/Disability Information***

**Are you currently**: Employed / Disabled for a Physical Disability / Disabled for a Mental Disability

Disabled for Both Physical and Mental Disabilities / Unemployed With No Disability / None of These

**Who is your current employer?** _________________________ **What is your current position at your job?** _________________________

**How long have you been unemployed and/or disabled?** ______________________

### ***Legal Information***

**Please circle all that apply**:

No Legal History / Substance Related Charges / Court Ordered Therapy / Felony Charges / Domestic/Assault Charges

Arrested - *Number of times*: __________ / Jail Time Served - *Number of times*: __________

Currently on parole or probation - *Name of probation officer*: ___________________________________________

### ***Education Information***

**Learning Disabilities**: Yes / No **Special Education**: Yes / No

**Alternative School**: Yes / No **If Yes, Name of School**: ______________________________________________________________________

**Suspended, Expelled, or Retained**: Yes / No **Last Grade Completed**: ______________________

**Name of High School Attended**: ____________________________________________ **Did you graduate?** Yes / No

**Name of High School Attended**: ____________________________________________ **Did you graduate?** Yes / No

**Name of College Attended**: ___________________________________________ **Degree Obtained**: _________________________________

**Name of College Attended**: ___________________________________________ **Degree Obtained**: _________________________________

**Name of College Attended**: ___________________________________________ **Degree Obtained**: _________________________________

### ***Medical Information***

**Developmental Milestones:**

◯ Above Average (ex: walked and talked before most)
◯ Average (ex: walked and talked at the same level as peers)
◯ Below Average (ex: walked and talked later than most)

**Do you smoke?** Yes / No **How much per day:** _________________________________

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**Have you or any family member been diagnosed with any of the following:**

| | Myself | Parent | Child | Grandparent |
|---|---|---|---|---|
| Diabetes | ◯ | ◯ | ◯ | ◯ |
| Head Injury / TBI | ◯ | ◯ | ◯ | ◯ |
| Thyroid Disease | ◯ | ◯ | ◯ | ◯ |
| HIV / AIDS | ◯ | ◯ | ◯ | ◯ |
| Stroke | ◯ | ◯ | ◯ | ◯ |
| Birth Defects | ◯ | ◯ | ◯ | ◯ |
| Cancer | ◯ | ◯ | ◯ | ◯ |
| Heart Disease | ◯ | ◯ | ◯ | ◯ |
| High Blood Pressure | ◯ | ◯ | ◯ | ◯ |
| Alzheimer's / Dementia | ◯ | ◯ | ◯ | ◯ |

**Are you currently taking any medications?** Yes / No

**Allergies:** ______________________________________________________________________________

**Please list all medications you are currently taking:**

| Medication | Dose (mg) | Prescribing Dr | What is it for? | Any side effects? | Is it beneficial? |
|---|---|---|---|---|---|
| ______________ | ______ | ________________ | _______________ | _________________ | Yes / No |
| ______________ | ______ | ________________ | _______________ | _________________ | Yes / No |
| ______________ | ______ | ________________ | _______________ | _________________ | Yes / No |
| ______________ | ______ | ________________ | _______________ | _________________ | Yes / No |
| ______________ | ______ | ________________ | _______________ | _________________ | Yes / No |
| ______________ | ______ | ________________ | _______________ | _________________ | Yes / No |
| ______________ | ______ | ________________ | _______________ | _________________ | Yes / No |
| ______________ | ______ | ________________ | _______________ | _________________ | Yes / No |
| ______________ | ______ | ________________ | _______________ | _________________ | Yes / No |

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