Behavioral Health Intake Form

***please answer all questions as completely as possible to expedite the process. Thank you.**

Date: _____

Referring Doctor_____

Name: _____

Address: _____ City& Zip_____

Home phone: _____ Cell phone: _____

Email address: _____

Date of birth_____ Age_____ Male_☐ Female_☐

Highest Education Level_____

Married_☐ Single_☐ Divorced_☐ Widowed_☐ Significant Other_☐

How long? (married, divorced, widowed, etc)_____

Number of children _____ Ages _____

Person to contact in case of an emergency: (Please print name, address, phone number and relationship)

_____

_____

I give permission for B4H associates to contact me using the following email address and phone number, understanding such correspondence may include personal information:

Email address(s) Phone number

_____

_____

Signature Date

Primary reason for seeking services:

☐ Pre-surgical psychological evaluation
☐ Pre-surgical education
☐ Post-surgical behavioral health evaluation
☐ Addictive Behaviors
☐ Depressive Symptoms
☐ Anxiety Symptoms
☐ Sleeping problems
☐ Behavior modification
☐ Weight issues
☐ Nutritional information
☐ Stress
☐ Eating Disorder
☐ Other (please specify) _____

Medical History

List any current health issues:

_____

_____

Current prescribed medications	Dose	Dates	Purpose	Side effects

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Are you currently taking any anti-depressant, anti-anxiety or anti-psychotic medication? ☐ Yes ☐ No
Which ones are you taking?

_____

If not, have you every taken any in the past? What for?_____

_____

_____

Current (OTC) over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? ____ Yes ☐ No
If Yes, describe: _____

_____

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

_____

Family history of medical problems: _____

Medical/Physical Health

____ Arrhythmias
☐ Alcoholism
____ Abdominal pain
____ Hysterectomy
____ Allergies
____ Anemia
☐ Fatigue
____ Arthritis
____ Asthma
____ Bowel Incontinence
____ Back Pain
____ Cancer
____ Chest pain
☐ Chronic pain
____ Constipation
____ Diabetes
____C-Pap,Bi-Pat
___ Other _____

____ Dizziness
☐ Stomach Ulcers
____Hear Attacks
____Gallbladder
☐ Eating problems
☐ Depression
☐ Anxiety
____ Frequent urination
____ Headaches
____ Heart Failure
____Hiatel Hernia
____ High blood pressure
____ Kidney disease
____Liver Disease
____Diverticulitis
____ Chronic Diarrhea

____Shortness of Breath
____Chronic Constipation
____Lymphedema
____ Reflux/GERD
____ Sleeping disorders
____Urinary Incontinence
____Thyroid Disease
____Food Allergies
____Vitamin Deficiencies
____ Stroke
____Elevated Triglycerides
____Lupus
____Blood Clots
____High Cholesterol
____Joint Pain
____Sleep Apnea

Please check if there have been any recent changes in the following:

____ Sleep patterns ☐ Eating patterns ____ Behavior ____ Energy level
____ Physical activity level ☐ General disposition ____ Weight_____ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

List any recent health or physical changes: _____

_____

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Do you drink alcohol? ☐ Yes ☐ No How often? Daily ☐ Weekly ☐ Monthly ☐ Only special occasions _____
How many alcoholic drinks do you have per event? _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes __ No
If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? ☐ Yes ☐ No
If Yes, please describe: _____

Past History

Traffic violations: ____ Yes ___ No DWI, DUI, etc.: ____ Yes ___ No
Criminal involvement: ____ Yes ___ No Civil involvement: ___ Yes ____ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Years of education: ☐ Currently enrolled in school? _____ Yes _____ No

☐ High school grad/GED
☐ Vocational: Number of years: _____ Graduated: _____ Yes ___No Major: _____
☐ College: Number of years: _____ Graduated: _____ Yes ___No Major: _____
____ Graduate: Number of years: _____ Graduated: _____ Yes _____ No Major: _____
Other training: _____
Special circumstances (e.g., learning disabilities, gifted): _____

Occupation

What is your current job, how long have you been employed there and describe your work environment?

_____
_____
_____

What was your previous job and how long were you employed there and describe why you left?

_____
_____

Describe your current stress level and what causes you stress? How do you react to stress?

_____
_____
_____

Military

Military experience? _____ Yes _____ No Combat experience? _____ Yes _____ No
Where: _____
Branch: _____ Discharge date: _____
Date drafted: _____ Type of discharge: _____
Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, volunteerism, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

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Development

Are there special, unusual, or traumatic circumstances that affected your development? ☐ Yes ☐ NO

Describe: _____

Has there been history of child abuse? ☐ Yes ☐ o If Yes, which type(s)?

Sexual ☐

Physical ☐

Verbal ☐

Other childhood issues: Neglect ☐ Inadequate nutrition ☐ Very strict diet by parent ☐

Other (please specify): _____

Comments re: childhood development: _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Fight/argue often ____ Follower

☐ Friendly ☐ Leader ☐ Outgoing ☐ Shy/withdrawn ____ Submissive

____ Other (specify): _____

How difficult is it for you to ask for help? _____

Do you attend a church or other religious organizations?_____

Do you socialize with friends or family members? _____

Recreational Drug Usage

Do you have any history of addictions or treatment for substance abuse?

_____

Do you currently use recreational drugs ☐ Yes ☐ No

Describe when and where you typically use substances: _____

Reason(s) for use:

____ Addicted ____ Build confidence ____ Escape ____ Self-medication

____ Socialization ____ Taste ____ Other (specify): _____

Have drugs or alcohol created a problem for your job or your relationships? ☐ Yes ☐ No

If yes, describe: _____

Mental Health History

Have you had any counseling or psychotherapy? ☐ Yes ☐ No.

When, why and was it helpful?

_____

If you are currently being treated by a Psychiatrist, Psychologist or Therapist, please list their name, credentials, address and phone number:

_____

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Have you ever been diagnosed with any of the following:
____Depression
____Anxiety
____Panic Disorder/Panic attacks Last panic attack: _____
____Bi-Polar Disorder
____Personality Disorder
____Other Mental illness (please describe) _____

Do you feel depressed at this time? _____ Do you feel anxious at this time? _____
Do you feel suicidal at this time? ____ Yes ____ No
If yes, explain: _____

_____

_____

Have you ever been hospitalized for a psychiatric reason? ____Yes ____No

If yes, for what reason and how long? _____

Have you ever cut or hurt yourself and hidden this behavior?
_____
_____Has anyone in your family attempted or completed suicide?
_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression	____ Elevated mood	____Phobias/fears
____ Alcohol dependence	____ Fatigue	____Recurring thoughts
____ Anger	____ Gambling	____Sexual addiction
____ Antisocial behavior	____ Hallucinations	____ Sexual difficulties
____ Anxiety	____ Heart palpitations	____ Sick often
____ Avoiding people	____ High blood pressure	____ Sleeping problems
____ Chest pain	____ Hopelessness	____ Speech problems
____ Cyber addiction	____ Impulsivity	____ Suicidal thoughts
____ Depression	____ Irritability	____ Thoughts disorganized
____ Disorientation	____ Judgment errors	____ Trembling
____ Distractibility	____ Loneliness	____ Withdrawing
____ Dizziness	____ Memory impairment	____ Worrying
____ Drug dependence	____ Mood shifts	____ Other (specify): _____
____ Eating disorder	____ Panic attacks	_____

Have you experienced any of the following symptoms lasting one week or longer?

- ___Increased energy, activity, and restlessness
- ___Excessively “high,” overly good, euphoric mood
- ___Extreme irritability
- ___Racing thoughts and talking very fast, jumping from one idea to another
- ___Distractibility, can’t concentrate well
- ___Little sleep needed
- ___Unrealistic beliefs in one’s abilities and powers
- ___Poor judgment
- ___Spending sprees
- ___A lasting period of behavior that is different from usual
- ___Increased sexual drive
- ___Abuse of drugs, particularly cocaine, alcohol, and sleeping medications
- ___Provocative, intrusive, or aggressive behavior
- ___Denial that anything is wrong

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Have you experienced any of the following symptoms for 2 weeks or longer?

- ___Lasting sad, anxious, or empty mood
- ___Feelings of hopelessness or pessimism
- ___Feelings of guilt, worthlessness, or helplessness
- ___Loss of interest or pleasure in activities once enjoyed, including sex
- ___Decreased energy, a feeling of fatigue or of being “slowed down”
- ___Difficulty concentrating, remembering, making decisions
- ___Restlessness or irritability
- ___Sleeping too much, or can’t sleep
- ___Change in appetite and/or unintended weight loss or gain
- ___Chronic pain or other persistent bodily symptoms not caused by physical illness or injury
- ___Thoughts of death or suicide; or suicide attempts

Have you taken any of these prescription medications in the past?

Abililfy____Ativan____Buspar____Celexa____Effexor____Lamictal____Lexapro____Lithium____Paxil____

Prozac____Seroquel____Topamax____Trazadone____Wellbutrin____Zoloft____Zyprexa____Cymbalta____

Depakote____Elavil____Haldol____Klonopin____Limitrol____Pamelor____Risperdal____Serax____

Sinequan____Tegratol____Tranxene____Valium____Xanax____Imipramine____

Please circle on the scale below how frequently you experience the following problems:

	Never	Rarely	Sometimes	Often	Always
Lack of Motivation	1	2	3	4	5
Concentration Problems	1	2	3	4	5
Depressed Mood	1	2	3	4	5
Anxiety	1	2	3	4	5
Crying Episodes	1	2	3	4	5
Trouble Sleeping	1	2	3	4	5
Trouble Waking	1	2	3	4	5
Irritability	1	2	3	4	5
Fatigue	1	2	3	4	5
Appetite Changes	1	2	3	4	5
Trouble at Work	1	2	3	4	5
Trouble with Relationships	1	2	3	4	5
Trouble with Memory	1	2	3	4	5
Self Abusive Behavior	1	2	3	4	5

Feelings of Emptiness	1	2	3	4	5
Nervousness	1	2	3	4	5
Mood Swings	1	2	3	4	5
Emotional Pain	1	2	3	4	5
Feelings of unworthiness	1	2	3	4	5
Nightmares	1	2	3	4	5
Feeling overwhelmed	1	2	3	4	5

Describe your childhood:

_____
_____
_____Is there any family history of or mental health illnesses or addictions?
Describe:_____
_____

What behaviors will you have to change in order to accomplish your goals pertaining to counseling?

_____
_____
_____

Who would you list as part of your current supportive network and how do you think they will support you in your goals?

_____
_____
_____

Are you currently exercising? _____ List current exercises, duration and how many times per week or month:

_____
_____
_____
_____

_____ _____

Patient's signature **Date**

For Staff Use

Therapist's signature/credentials: _____ Date: _____/_____/_____

Comments: _____
_____

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BECK'S DEPRESSION INVENTORY

Instructions: Please circle the number by the response for each question that best describes how you have felt during the past seven (7) days. Please do not omit any questions. Make sure you check one answer for each question. If more than one answer applies to how you have been feeling, check the higher number. If in doubt, make your best guess.

0-I do not feel sad.
1-I feel sad.
2-I am sad all the time and I can't snap out of it.
3-I am so sad or unhappy that I can't stand it.

0-I am not particularly discouraged about the future.
1-I feel discouraged about the future.
2-I feel I have nothing to look forward to.
3-I feel that the future is hopeless and that things cannot improve.

0-I do not feel like a failure.
1-I feel I have failed more than the average person.
2-As I look back on my life, all I can see is a lot of failures.
3-I feel I am a complete failure as a person.

0-I get as much satisfaction out of things as I used to.
1-I don't enjoy things the way I used to.
2-I don't get real satisfaction out of anything anymore.
3-I am dissatisfied or bore with everything.

0-I don't feel particularly guilty.
1-I feel guilty a good part of the time.
2-I feel quite guilty most of the time.
3-I feel guilty all of the time.

0-I don't feel I am being punished.
1-I feel I may be punished.
2-I expect to be punished.
3-I hate myself.

0-I don't feel disappointed in myself.
1-I am disappointed in myself.
2-I am disgusted with myself.
3-I hate myself.

0-I don't feel I am any worse than anybody else.
1-I am critical of myself for my weaknesses or mistakes.
2-I blame myself all the time for my faults.
3-I blame myself for everything bad that happens.

0-I don't have any thoughts of killing myself.
1-I have thoughts of killing myself, but I would not carry them out.
2-I would like to kill myself.
3-I would kill myself if I had the chance.

0-I don't cry anymore than usual.
1-I cry more now than I used to.
2-I cry all the time now.
3-I used to be able to cry, but now I can't cry even though I want to.

0-I am no more irritated by things than I ever am.
1-I am slightly more irritated now than usual.
2-I am quite annoyed or irritated a good deal of the time.
3-I feel irritated all the time now.

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0-I have not lost interest in other people.
1-I am less interested in other people than I used to be.
2-I have lost most of my interest in other people.
3-I have lost all of my interest in other people.

0-I make decisions about as well as I ever could.
1-I put off making decisions more than I used to.
2-I have greater difficulty in making decisions than before.
3-I can't make decisions at all anymore.

0-I don't feel that I look any worse than I use to.
1-I am worried that I am looking old or unattractive.
2-I feel that there are permanent changes in my appearance that make me look unattractive.
3-I believe that I look ugly.

0-I can work about as well as before.
1-It takes an extra effort to get started at doing something.
2-I have to push myself very hard to do anything.
3-I can't do any work at all.

0-I can sleep as well as usual.
1-I don't sleep as well as I used to.
2-I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3-I wake up several hours earlier than I used to and cannot get back to sleep.

0-I don't get more tired than usual.
1-I get tired more easily than I used to.
2-I get tired from doing almost anything.
3-I am too tired to do anything.

0-My appetite is no worse than usual.
1-My appetite is not as good as it used to be.
2-My appetite is much worse now.
3-I have no appetite at all anymore.

0-I haven't lost or gained much weight, if any, lately.
1-I have lost or gained more than five pounds.
2-I have lost or gained more than 10 pounds.
3-I have lost or gained more than 15 pounds.

0-I am no more worried about my health than usual.
1-I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
2-I am very worried about physical problems and it's hard to think of much else.
3-I am so worried about my physical problems that I cannot think of anything else.

0-I have not noticed any recent change in my interest in sex.
1-I am less interested in sex than I used to be.
2-I am much less interested in sex now.
3-I have lost interest in sex completely.

Name_____Date_____Total_____

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