Intake Form

Please fill out all applicable parts of this form and email it me at amy@amyhuberman.org or fax it to me 443-420-9150. Please attach additional sheets if necessary.

Name:_____ Birth date_____

Family Psychiatric History

Family Member:	Current age or age at death (specify year and cause of death, if known):	Please list any problems with mental health or substance abuse:
Father		
Mother		
Sibling (provide name)		
Sibling (provide name)		
Sibling (provide name)		
Sibling (provide name)		

Has there been any mental illness, substance abuse, or suicide in your extended family? If so, please provide details here:_____

_____

_____

Personal History

Where were you born and raised?_____

Were there any problems with your birth, development, or childhood health (please specify)?___

_____

Were there any problems at home when you were growing up (please specify)?_____

_____

_____

_____

Did you experience any significant disruptions while growing up (e.g., prolonged separation from one or both parents, significant geographical move)?_____

_____

How would you describe your race and ethnicity?_____

Have you ever been the target of oppression or discrimination for any reason? If so, what have you experienced?_____

_____

_____

Have you ever been bullied or sexually, physically, or emotionally abused? If so, how?

_____

_____

_____

How far have you gone in school so far? Please list all degrees, including date received, major, and institution from which you graduated. _____

_____

Did you ever repeat a grade or require special education?_____

Were you ever suspended or expelled from school, or did you get into any other significant trouble at school?_____

Did you get into any trouble outside of school (fights, fire setting, cruelty to animals, theft, etc.)?

_____

What jobs have you had in the past, and when?_____

_____

_____

Have you had any trouble finding or keeping long-term jobs?_____

Are you working or in school now? Please specify:_____

If you're currently working, how satisfied are you with your job?_____

What are your current sources of financial support?_____

Do you live alone? If not, with whom do you live?_____

Are you currently dating, sexually active, or in a relationship(s)?_____

If yes, is (are) your partner(s) ☐female ☐male ☐intersex ☐transsexual ☐transgendered ☐two-spirit ☐other? _____ ☐prefer not to answer

How long have you been together or dating? _____

How important/significant is this (are these) relationship(s) to you? ☐ not much ☐somewhat ☐very much

If you have had previous relationships, was (were) your partner(s) ☐female ☐male ☐intersex ☐transsexual ☐transgendered ☐two-spirit ☐other? _____☐prefer not to answer

How would you identify your sexual orientation?_____

Do you have any concerns about your sexual orientation, or do you ever feel awkward about your sexual orientation?_____

How would you identify your gender identity?_____

Do you have any concerns about your gender identity, or do you ever feel awkward about your gender identity?_____

Have you ever been married? If so, give dates of marriage and (if relevant) separation/divorce:_

_____

If you've had any relationship problems, including sexual problems, please specify:_____

_____

Please list your closest supports (friends, family, romantic partners, caretakers, mentors), if any:_____

_____

Have you ever been pregnant? If you terminated one or more pregnancies, please specify dates. If you have children, please list their names and ages and specify if they have any physical or mental health problems:_____

_____

Have you ever had problems with the law (please specify)?_____

_____

Do you have any financial problems, such as debt?_____

_____

Do you have a religion, and if so, how important is it to you?_____

_____

Please list any hobbies or activities that give you pleasure:_____

_____

Medical History

Please list current and past medical problems (with dates), including history of seizures, head trauma, or loss of consciousness:_____

_____

_____

_____

Please list names and doses of all current medications, including over-the-counter or herbal:____

_____

_____

_____

_____

For women only, please give date of last menstrual period and specify whether your periods are regular, whether they are associated with any pain, and whether they are associated with any changes in your mood . If you are on a birth control pill, please specify which one and indicate whether it has any effect on your mood:_____

_____

Please list any drug allergies (including your reaction to the drug):_____

_____

_____

Please check any of the following problems or tests you have had in the last year. If given a choice (weight loss or gain, e.g.), please circle applicable symptom(s). Where appropriate, please indicate what body part was tested (X-ray: chest, e.g.).

[ ] Fatigue	[ ] Fever	[ ] Weight loss or gain
[ ] Night sweats	[ ] Enlarged lymph nodes	[ ] Heat or cold intolerance
[ ] Excessive urination	[ ] Excessive thirst	[ ] Excessive appetite
[ ] Hair loss	[ ] Vision problems	[ ] Light hurts your eyes
[ ] Hearing problems	[ ] Ear pain or discharge	[ ] Severe nosebleeds
[ ] Mouth ulcers	[ ] Persistent hoarseness	[ ] Daily cough
[ ] Shortness of breath	[ ] Asthma/wheezing	[ ] Chest pain/discomfort
[ ] Skipped/irregular heartbeat	[ ] Fainting episode/black-out	[ ] Swollen legs or feet
[ ] Leg pain with walking	[ ] Difficulty swallowing	[ ] Heartburn
[ ] Frequent belly pain	[ ] Abdominal bloating	[ ] Nausea and/or vomiting
[ ] Diarrhea	[ ] Constipation	[ ] Change in bowel habits
[ ] Blood in stool	[ ] Black or tarry stools	[ ] Light or clay-colored stools
[ ] Loss of appetite	[ ] Jaundice (yellow skin or eyes)	[ ] Trouble urinating
[ ] Blood in urine	[ ] Dark or cola-colored urine	[ ] Abnormal vaginal bleeding
[ ] Missed menstrual periods	[ ] Vaginal/penile discharge	[ ] Anemia
[ ] Easy bruising or bleeding	[ ] Persistent rash or itching	[ ] Moles with changed appearance
[ ] Lump or swelling of testicle	[ ] Breast lump or new discharge	[ ] Joint or muscle pain
[ ] Limb weakness	[ ] Persistent loss of sensation/numbness	[ ] Headaches
[ ] Dizzy spells	[ ] Memory problems	[ ] Coordination problems
[ ] Seizures	[ ] X-Ray of:	[ ] CT scan of:
[ ] MRI of:	[ ] EKG	[ ] EEG
[ ] Other:	[ ] Other:	

Please list past surgeries (including dates):_____

_____

Current height_____ Current weight_____ Date of last physical exam_____

Have you had any recent labs, and were the results normal?_____

_____

Substance History

Substance:	Current use (specify amount/frequency):	Maximum use (specify dates):	Last use:	Age of onset:	Have you ever tried to quit?
Alcohol					
Nicotine					
Caffeine					
Marijuana					
Other street drug (please specify)					
Other street drug (please specify)					

Past Psychiatric History

Dates of past outpatient mental health treatment	Names and contact information of past providers	Why you sought treatment and nature of the treatment	Was it helpful?

Approximate Dates of Past Psychiatric Hospitalizations	Name of hospital	Reason for admission

Approximate Dates of Past Emergency Room Visits for Mental Health	Name of Hospital	Reason for visit

Approximate Dates of Past Treatment with Psychiatric Medication	Name of medication	How well did the medicine work for you (please include benefits and side effects)?

Have you ever intentionally hurt yourself before? If so, please give approximate dates and describe what you did: _____

_____

Have you ever attempted suicide before? If so, please give approximate dates and describe what you did:_____

Have you ever been violent toward another person or intentionally hurt a person or pet before? If so, please give approximate dates, and describe what you did:_____

_____

Do you have access to a gun or other means to kill or injure yourself or another person? If so, what do you have, and where is it?_____

Are you currently having any thoughts of hurting or killing yourself or someone else? If so, please specify:_____

Have you ever experienced 2 weeks or more of sad mood or emotional numbness and changes in your energy level, self-attitude, sleep, appetite, concentration, or ability to experience pleasure? If so, please what you experienced, when, and for how long:_____

_____

Have you ever had thoughts of suicide or of not wanting to go on with life?_____

Have you ever experienced a few days or more during which you've had remarkably more energy than usual and have felt that you could get by on less sleep? If so when, and for how long?_____

Are you concerned that you worry too much?_____

Did you experience anxiety when you had to be apart from your parents as a child (e.g., for summer camps, sleepovers, etc.)? If so, in what settings?_____

Have you ever experienced habits such as eye-blinking, nose-twitching, sniffing, throat-clearing, grunting, tapping or touching, or other "tics?" If so, what and when?_____

Do you experience intrusive thoughts or images that you recognize as being absurd or extreme, but that keep coming into your head like a broken record? If so, what are the specific thoughts or images?_____

_____

Do you have any fears that get in the way of your life? If so, describe your fears and how they affect you:_____

Have you ever had the sudden onset of the following symptoms: shortness of breath, racing heart, nausea, dizziness, sweating, feeling that things are unreal, fear of dying or going crazy? If so, describe your experience. When and how frequently have you experienced this?_____

_____

Have you ever experienced a traumatic situation such as sexual or physical abuse, a natural disaster, an accident, or other terrifying experience? If so, what and when?_____

If you've experienced a traumatic situation in the past, how does it affect your life today?_____+_____

Have you ever heard sounds or seen things that were hard to explain? If so, describe:_____

_____

Have you ever worried that people are out to get you, or that you're guilty of something terrible? If so, describe your worries:_____

Do you have concerns about your weight or body image? If so, what?_____

_____

Have you ever restricted calories, binged, induced yourself to vomit, or used diuretics or laxatives? If so, what have you done?_____

Sleep Quality

Do you have difficulty falling or staying asleep?_____

Do you have any other problems with sleep?_____

Do you snore?_____

Are you excessively sleepy during the day?_____

Personality

How would you describe your personality?_____

_____

Goals for treatment

What do you hope will be different for you at the end of our work together?_____

_____

_____

What goals do you have for the future?_____

_____

Is there anything I haven't asked you about that would be important for me to know to best help you?_____

_____

THANK YOU FOR COMPLETING THIS FORM!