Mithrah Holistic Services

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General Mental Health Intake Form for Mithrah Holistic Services

Please complete the information on this form and bring it to the first visit. Please be advised that you do not have to provide any information if you do not want to share. However, not sharing some information may act as a barrier during therapy between client and therapist.

If you have any doubts and/or concerns or do not want to provide any information required, you can leave them and discuss them with your therapist about your concerns. You do not have to provide any information you are not comfortable with.

It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask permission from family members about the family history or leave that section if you do not want to share. Thank you!

Primary Name_____
Surname:_____
Date_____
Date of Birth _____
Primary Care Physician (GP)_____
Do you give permission for ongoing regular updates to be provided to your primary care physician? (circle the right one) _____Yes No____
Current Therapist/Counsellor (if any)_____
Therapist's Phone_____
What are the problem(s) for which you are seeking help?
1._____
_____
2._____
_____
3._____
_____
What are your treatment goals?
_____
_____
_____
_____

Your Medicare details:
_____
_____
_____

Your private insurance
details:_____
_____
_____

Are you covered or supported by NDIS? Please provide the details if you want.
_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)
( ) Depressed mood ( ) Racing thoughts ( ) Excessive worry
( ) Unable to enjoy activities ( ) Impulsivity ( ) Anxiety attacks
( ) Sleep pattern disturbance ( ) Increase risky behavior ( ) Avoidance
( ) Loss of interest ( ) Increased libido ( ) Hallucinations
( ) Concentration/forgetfulness ( ) Decrease need for sleep ( ) Suspiciousness
( ) Change in appetite ( ) Excessive energy ( ) _____
( ) Excessive guilt ( ) Increased irritability ( ) _____
( ) Fatigue ( ) Crying spells
( ) Decreased libido

Suicide Risk Assessment
Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts?
_____
When was the last time you had thoughts of dying?
_____
Has anything happened recently to make you feel this way?
_____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better?
_____

Have you ever thought about how you would kill yourself?
_____
Is the method you would use readily available?
_____
Have you planned a time for this?
_____
Is there anything that would stop you from killing yourself?
_____
Do you feel hopeless and/or worthless?
_____
Have you ever tried to kill or harm yourself before?
_____
Do you have access to guns? If yes, please explain.
_____

Past Medical History:
Allergies_____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)
Medication Name Total Daily Dosage Estimated Start Date
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_

Current over-the-counter medications or supplements:
_____
_____
_____
Current medical problems:
_____
_____
_____
Past medical problems, nonpsychiatric hospitalization, or surgeries:
_____
_____
_____
Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ .
Was the EKG ( ) normal ( ) abnormal or ( ) unknown**?**

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you
might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant? _____ How many live births? _____
Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam:
_____

Personal and Family Medical History: (Please share only if you want and think it may help)

Health issue	**You**	**Family**	**Which member**
Thyroid Disease			
Anaemia			
Anaemia			
Chronic Fatigue			
Kidney Disease			
Diabetes			

Asthma/respiratory problems			
Stomach or intestinal problems --- ( )			
Cancer (type) ---------- ( )			
Fibromyalgia			
Heart Disease			
Epilepsy or seizures			
Chronic Pain			
High Cholesterol			
High blood pressure			
Head trauma			
Liver problems			
Other			

Is there any additional personal or family medical history you want to say? ( ) Yes ( ) No If yes, please explain:

_____
_____
_____
_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____
_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

_____
_____
_____
_____

_____
_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____
_____
_____
_____
_____
_____

Past Psychiatric Medications (share only if relevant or you want): If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Dates Dosage Response/Side-Effects

Antidepressants

Prozac (fluoxetine)

_____
_____

Zoloft (sertraline)

_____
_____

Luvox (fluvoxamine)

_____
____

Paxil (paroxetine)

_____
_____

Celexa (citalopram)

_____
_____

Lexapro (escitalopram)

_____
__

Effexor (venlafaxine)

_____
____

Cymbalta (duloxetine)

_____
___

Wellbutrin (bupropion)
_____
__
Remeron (mirtazapine)
_____
__
Serzone (nefazodone)
_____
___
Anafranil (clomipramine)
_____
Pamelor (nortrptyline)
_____
___
Tofranil (imipramine)
_____
___
Elavil (amitriptyline)
_____
____
Other
_____
_____

Mood Stabilizers

Tegretol
(carbamazepine)_____
_____
Lithium_____
_____
Depakote (valproate) _____
_____
Lamictal (lamotrigine)
_____
___
Tegretol (carbamazepine)
_____
Topamax (topiramate)
_____
___
Other
_____
_____


Past Psychiatric medications (continued)
Antipsychotics/Mood Stabilizers Dates Dosage Response/Side-Effects
Seroquel (quetiapine)
_____
____
Zyprexa (olanzepine)
_____
____
Geodon (ziprasidone)
_____
____
Abilify (aripiprazole)
_____
____
Clozaril (clozapine)
_____
_____
Haldol (haloperidol)
_____
____
Prolixin (fluphenazine)
_____
__
Risperdal (risperidone)
_____
__
Other
_____
_____
Sedative/Hypnotics
Ambien (zolpidem)
_____
_____
Sonata (zaleplon)
_____
_____
Rozerem
(ramelteon)_____
_____

Restoril (temazepam)

_____

Desyrel (trazodone)

_____

Other

_____

ADHD medications

Adderall (amphetamine)

_____

Concerta (methylphenidate)

_____

Ritalin (methylphenidate)

_____

Strattera (atomoxetine)

_____

Other

_____

Antianxiety medications

Xanax (alprazolam)

_____

Ativan (lorazepam)

_____

Klonopin (clonazepam)

_____

Valium (diazepam)

_____

Tranxene (clorazepate)

_____

Buspar (buspirone)

_____

Other
_____
_____

Your Exercise Level:
Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise?
_____
How much time each day do you exercise?
_____
What kind of exercise do you do?
_____

Family Psychiatric History:
Has anyone in your family been diagnosed with or treated for:
Bipolar disorder ( ) Yes ( ) No Schizophrenia ( ) Yes ( ) No
Depression ( ) Yes ( ) No Post-traumatic stress ( ) Yes ( ) No
Anxiety ( ) Yes ( ) No Alcohol abuse ( ) Yes ( ) No
Anger ( ) Yes ( ) No Other substance abuse ( ) Yes ( ) No
Suicide ( ) Yes ( ) No Violence ( ) Yes ( ) No
If yes, who had each problem?
_____
_____
_____
Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what
medications did they take, and how effective was the treatment?
_____
_____
_____

Substance Use:
Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances?
_____
If yes, where were you treated and when?
_____
_____
_____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a
hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones?

_____
_____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long?

_____
_____
_____

Check if you have ever tried the following:

Yes No If yes, how long and when did you last use?
Methamphetamine
Cocaine
Stimulants (pills)
Heroin
LSD or Hallucinogens
Marijuana
( )
( )
( )
( )
( )
( )
( )
( )
( )
( )
( )
( )

_____
_____
_____
_____
_____

_____
Pain killers (not as prescribed) ( ) ( )
_____
Methadone ( ) ( ) _____
Tranquilizer/sleeping pills ( ) ( )
_____
Alcohol ( ) ( ) _____
Ecstasy ( ) ( ) _____
Other _____
How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____
Tobacco History:
How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? **( )** Yes **( )** No How many packs per day on average? _____ How many years? _____
In the past? **( )** Yes **( )** No How many years did you smoke? _____ When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? **( )** Yes **( )** No In the past? **( )** Yes **( )** No
What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up?
_____
List your siblings and their ages:
_____
_____
_____
What was your father's occupation?
_____
What was your mother's occupation?
_____
Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him:
_____
_____
_____

Describe your mother and your relationship with her:
_____
_____
_____
How old were you when you left home?
_____
Has anyone in your immediate family died?
_____
Who and when?
_____
_____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom:
_____
_____
_____

Educational History:
Highest Grade Completed? _____ Where?
_____
Did you attend college? _____ Where? _____Major?
_____
What is your highest educational level or degree attained?
_____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position?
_____
What is/was your occupation?
_____
Where do you work?
_____
Have you ever served in the military? _____ If so, what branch and when?
_____
Honorable discharge ( ) Yes ( ) No Other type discharge
_____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed
How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long?
_____

Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer
What is your spouse or significant other's occupation?
_____
Describe your relationship with your spouse or significant other:
_____
_____
Have you had any prior marriages? ( ) Yes ( ) No. If so, how many?
_____
How long? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender:
_____
_____
_____
Describe your relationship with your children:
_____
List everyone who currently lives with you:
_____
_____
_____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____
Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or
stressful for you? ( ) more helpful ( ) stressful
Is there anything else that you would like us to know?
_____
_____
_____
_____
_____
_____
_____
_____

Signature_____Date_____

Guardian Signature (if under age 18) _____ Date _____

Emergency Contact _____ Telephone # _____

For Office Use Only:

Reviewed by _____Date _____

Reviewed by _____Date _____