Center for Sexual Health
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CLIENT PSYCHIATRIC INTAKE FORM

Clients please fill out as completely as possible

Today's date: ________________________

Full name: (First) (Middle) (Last)	**DOB:** **Age:**	**Gender/Gender Identity:**

1. PRESENTING PROBLEM: Please define briefly the problems, challenges, and/or concerns for which you are seeking our services.

2. HISTORY: Are there any mental health related issues that have occurred in your family? With either your parents, grandparents or siblings? Please check any that have occurred.

A) Bipolar Disorder

B) Attempted/completed suicide

C) Schizophrenia

D) Psychiatry hospitalization

E) Depression

F) Substance use

3. Below are a number of common mental health concerns for which people seek help. Please indicate which have been a concern for you WITHIN THE LAST SIX (6) MONTHS, by checking "yes" if any of the words describe a concern for you. Check "No" only if any of the words have not been an issue for you.

Emotional Functioning			**Physical Functioning**			**Sexual Functioning**		
__yes	__no	Feel flat, empty, numb	__yes	__no	Eating problems	__yes	__no	Loss of sexual desire
__yes	__no	Depressed, hopeless	__yes	__no	Fatigue, tiredness	__yes	__no	Performance difficulties
__yes	__no	Suicidal thoughts and/or behavior	__yes	__no	Sleeping difficulties	__yes	__no	Unsafe sexual behavior
__yes	__no	Sadness and/or crying	__yes	__no	weight loss	__yes	__no	Sexual compulsivity
__yes	__no	Irritable/moody	__yes	__no	overweight	__yes	__no	History of sexual abuse

Emotional Functioning			Physical Functioning			Sexual Functioning		
__yes	__no	Anger and/or rage	__yes	__no	Alcohol abuse	__yes	__no	Sexual orientation concerns
__yes	__no	Anxiety/worry	__yes	__no	Drug abuse	__yes	__no	Genital image/size concerns
__yes	__no	Fear and/or dread	__yes	__no	Pain and/or nausea	__yes	__no	Gender concerns
__yes	__no	Nervous, shaky	__yes	__no	Serious illness and/or health problems	__yes	__no	STD, HIV, AIDS concerns
__yes	__no	Self-harm thoughts/behaviors				__yes	__no	Disturbing fantasies/dreams
Self-Image and Coping Issues			**Mental Functioning**			**Relationship and Life**		
__yes	__no	Avoidance/Denial	__yes	__no	Memory problems	__yes	__no	Conflict, fighting
__yes	__no	Compulsivity	__yes	__no	Easily distracted	__yes	__no	Isolation, loneliness
__yes	__no	Shy or sensitive	__yes	__no	Buzzing in ears	__yes	__no	Being honest about myself
__yes	__no	Low self-esteem	__yes	__no	Voices inside head	__yes	__no	Death and dying concerns
__yes	__no	Self-hatred, guilt, shame	__yes	__no	Troubling thoughts	__yes	__no	Living more effectively
__yes	__no	Feel ugly, poor body image	__yes	__no	Feel paranoid	__yes	__no	Grieving
			__yes	__no	Troubling dreams	__yes	__no	Work or family problems

Other current concerns (Please specify) ____
____

PSYCHIATRIC/MENTAL HEALTH/CHEMICAL DEPENDENCY HISTORY

4. *PREVIOUS THERAPISTS (most recent first)*:

☐ ***NONE***

Name of therapist/clinic: ____
Address and Phone: ____
Date Therapy Began: ________________ Date Therapy Ended: ________________
Diagnoses Given: ____
Issues Addressed and outcome:
____
____

Name of therapist/clinic: ____
Address and Phone: ____
Date Therapy Began: ________________ Date Therapy Ended: ________________
Diagnoses Given: ____
Issues Addressed and outcome:
____
____

Name of therapist/clinic: ____
Address and Phone: ____
Date Therapy Began: ________________ Date Therapy Ended: ________________
Diagnoses Given: ____
Issues Addressed and outcome:
____
____

***5. PSYCHIATRY SERVICES*:**

NONE

Name of psychiatrist/clinic: ____

Address and Phone: ____

Date Therapy Began: ________________ Date Therapy Ended: ________________

Diagnoses Given: ____

Issues Addressed and outcome:

____

____

8. PSYCHIATRIC HOSPITALIZATIONS NONE

Approx Dates & Duration:		Where:		Reason/Outcome:	
Approx Dates & Duration:		Where:		Reason/Outcome:	
Approx Dates & Duration:		Where:		Reason/Outcome:	

9. PSYCHIATRIC MEDICATIONS NONE

Current Prescriptions	**Dosage**	**Purpose of Medication**	**Approximate dates/Duration**	**Prescribed by *(physician/ clinic)***
Past Prescriptions	**Dosage**	**Purpose of Medication**	**Approximate dates/Duration**	

Please list any over-the-counter Medications: ____

____

____

Medication Allergies __ Yes __ No	**Type of reaction**

MEDICAL HISTORY

6. Primary Physician/Clinic: ____

Address and Phone: ____

____

MEDICAL PROBLEMS (DESCRIBE BELOW) ☐ **NO MEDICAL PROBLEMS**	
Surgeries	

Medications	
Medical Problems/Illnesses	
Contraceptive Use	

21. MAJOR CHANGES IN THE LAST YEAR

Move/relocation	__ Yes __ No Describe:
Blended family issues	__ Yes __ No Describe:
Death of a family member or friend	__ Yes __ No Describe:
Childbirth/Adoption	__ Yes __ No Describe:
Job changes	__ Yes __ No Describe:
Relationship issues	__ Yes __ No Describe:
Other:	__ Yes __ No Describe:

Thank you for taking the time to complete this form. It will be helpful in your assessment and treatment.