PRIMROSE MENTAL HEALTH PLLC
1400 Madison Ave Ste 602, Mankato MN 56001 Tel. 507-613-3883 info@primrosementalhealth.com

INTAKE QUESTIONNAIRE (ADULT)

The following questionnaire is designed to assist you and me in developing and carrying out the type of service which seems most appropriate for you. If you don't wish to answer a question or if it doesn't apply to you, simply write the letters NA (Not Applicable). If you don't know or can't remember, write the letters DK (Don't Know). Please remember that this document, like all others in your file, is confidential and cannot be released without your written consent.

1. GENERAL INFORMATION

Full Name_____Age_____Today's Date_____

How did you hear about us?_____

Please describe your reason(s) for seeking assistance:

_____

_____

_____

_____

When did these issues become a problem?

_____

_____

What have you already tried? What was the result?

_____

_____

2. MENTAL HEALTH INFORMATION

Have you ever had mental health treatment before? YES NO

If so, please list names of therapists, dates of therapy, and which agencies you've used

_____

_____

Have you ever been hospitalized for a mental health problem? YES NO

If so, please list dates and hospitals_____

_____

Have you *recently* had thoughts of killing yourself? YES NO

Have you ever made *attempts* to kill yourself? YES NO

Are you currently taking a medication for mental health reasons? YES NO

If so, please list the medication name(s) and dosage(s)_____

_____

Prescriber of medication(s)_____

Any past mental health medications?_____

Is there a history of any of the following in your family?

☐ Anxiety	☐ Psychosis	☐ Substance abuse
☐ Depression	☐ ADHD	☐ Suicide
☐ Bipolar	☐ Eating disorder	☐ Psychiatric hospitalization

3. MEDICAL/HEALTH INFORMATION

Name of primary physician and clinic_____

Date of most recent physical exam_____

Are you wanting us to collaborate with your doctor?_____

Surgeries_____

Hospitalizations_____

Are you currently suffering from any medical conditions? YES NO

If so, what conditions_____

What medications are you currently on?_____

_____

How many hours of sleep do you get?_____

Describe your sleep. _____

How much physical activity do you get each day?_____

4. CHEMICAL USE HISTORY

Have you ever been treated for drug or alcohol abuse? YES NO

If so, where?_____When_____

	Current Amount Used	Used in Past	Age First Used
Caffeine	_____	_____	_____
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Marijuana	_____	_____	_____

Drug of choice (if any)_____

	YES	NO
Have you ever felt like you ought to cut down on your drinking or drug use?	☐	☐
Have you ever had people annoy you by criticizing your drinking or drug use?	☐	☐
Have you ever felt bad or guilt about your drinking or drug use?	☐	☐
Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started?	☐	☐
Have you struggles with any other compulsive behaviors (i.e., gambling, pornography, video games)?	☐	☐

5. CURRENT FAMILY

Current marital status (and partner's name, if applicable): _____

Children and ages: _____

Have you been married before? YES NO

I currently live with: _____

Have you experienced any abuse in your relationships? YES NO

6. FAMILY OF ORIGIN

Mother's name: _____ Age: _____

Occupation: _____ Marital status: _____

Father's name: _____ Age: _____

Occupation: _____ Marital status: _____

Number of siblings and ages: _____

While growing up were you:

Happy with the way you were raised?	YES	NO
Treated cruelly, beaten, or mistreated?	YES	NO
In foster care at any point?	YES	NO
Sexually abused?	YES	NO
Adopted?	YES	NO

Did your mother drink, smoke, or use drugs while pregnant with you? YES NO

Were there any medical difficulties for you when you were an infant? YES NO

If yes, what? _____

Did you experience any accidents causing injury to you? YES NO

If yes, what? _____

7. OCCUPATIONAL/EDUCATIONAL/RECREATIONAL INFORMATION

Highest grade completed/current grade _____ School _____

Your adjustment to school was: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Favorite subjects _____ Least favorite subjects _____

Current employer _____ Number of years there _____

Previous work _____

What do you do with your free time? _____

Do you have many friends or social groups? _____

Are you a veteran? _____

8. LEGAL HISTORY

Have you ever been: ☐ On probation ☐ In jail ☐ In prison ☐ On parole

If so, when and why?_____

9. RELIGION/SPIRITUALITY

Religious or spiritual identity:_____

Are you actively practicing? YES NO

10. OTHER IMPORTANT INFORMATION

Is there anything else important you feel we should know about who you are?

_____

_____

11. SYMPTOM REVIEW

Please check any of the following that have applied to you in the past two weeks. Use a question mark if you're not sure.

- ☐ Weight loss without dieting
- ☐ Significant weight gain
- ☐ Cry often and easily
- ☐ Feel so good/hyper, others say I'm not myself
- ☐ I'm usually very talkative
- ☐ I've been more talkative than normal
- ☐ Speaking faster than usual
- ☐ Sleeping much less and not missing it
- ☐ Racing thoughts
- ☐ More energy than usual
- ☐ More social/outgoing than usual
- ☐ Taking risky or regrettable actions
- ☐ Problems from spending money
- ☐ More sexual than usual
- ☐ Inattentive/easily distracted
- ☐ Impulsive
- ☐ Often fidget
- ☐ Fail to finish things
- ☐ Bad memory/forget things a lot
- ☐ Bad at organizing
- ☐ Procrastinate
- ☐ Get in physical fights
- ☐ Infections
- ☐ Vision problems
- ☐ Severe headaches
- ☐ Chronic pain
- ☐ Sexual difficulties
- ☐ Hearing problems
- ☐ High blood pressure
- ☐ Seizures
- ☐ Sleep walking
- ☐ Dizziness
- ☐ Nervous habits
- ☐ Nail biting
- ☐ Skin picking
- ☐ Chronic neck/back tension or pain
- ☐ Panic attacks
- ☐ Fear of large public places
- ☐ Flashbacks
- ☐ Easily startled
- ☐ Tics
- ☐ Many physical complaints
- ☐ Quick mood changes
- ☐ Often daydreaming
- ☐ Difficulty making decisions
- ☐ Sometimes confused about who I am
- ☐ Sometimes confused about where I am
- ☐ Stubborn
- ☐ Too few friends
- ☐ Withdrawn
- ☐ Overly shy
- ☐ Tense
- ☐ Touchy
- ☐ Submissive
- ☐ Show off/center of attention
- ☐ Follower
- ☐ Easily embarrassed
- ☐ Clumsy/careless
- ☐ Odd/strange behavior
- ☐ Repeated actions I can't stop
- ☐ Repeated thoughts I can't stop
- ☐ Nightmares
- ☐ Perfectionistic
- ☐ Seeing things others don't
- ☐ Hearing things others don't
- ☐ Eat non-food items

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by the following problem? (Circle your answer.)	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

Column totals _____ + _____+ _____

Total:

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

GAD-7 Anxiety

Over the **last 2 weeks**, how often have you been bothered by the following problem? (Circle your answer.)	**Not at all**	**Several days**	**More than half the days**	**Nearly everyday**
1. Feeling nervous, anxious or on the edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so relentless that it is hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3

Column totals _____ + _____ + _____ + _____

Total score:

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

0-4: minimal anxiety 5-9: mild anxiety 10-14: moderate anxiety 15-21: severe anxiety

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Medication Management Intake/ Referral

Date: _____ Referred by: _____

Name: _____

Mobile # _____ Home # _____

Address: _____

Date of Birth: _____ Email _____

Insurance: _____

Are you currently on medications? YES NO

Current Psychiatric Provider: _____ Clinic name: _____

How long have you been getting medication from this provider? _____

Previous Psychiatric Provider: _____ Clinic name: _____

Psychiatric Provider: _____ Clinic name: _____

Primary Care Provider: _____

Hospitalization: (related to mental health)

Location: _____ Date: _____

Location: _____ Date: _____

Location: _____ Date: _____

Chemical Dependency treatment? YES NO

Location: _____ Date: _____

Location: _____ Date: _____

Location: _____ Date: _____

Date Scheduled _____

Date paperwork sent _____