Name _____
ID #: _____

BETTER MOOD CLINIC OF SOUTH GEORGIA, LLC.
ADULT MENTAL HEALTH CLINICAL INTAKE

Please answer all questions accurately so we can provide you an optimal assessment, intervention and treatment plan.
How do you want us to refer to you, or what name or pronoun would you like us to use in referring to you_____?

Section I: Your concerns and Stressors

What reasons led you to seek help today? _____
_____
_____
What recent events made it important to seek treatment today? _____
_____
How long have you had these concerns and when did they start? _____
_____
Are the concerns or symptoms constant or intermittent? _____
What have you tried in the past to solve these issues? _____
_____
Have you sought help for these concerns/symptoms in the past? _____
Was it helpful? Yes / No, Please explain _____
_____
Have you ever been diagnosed with a psychological condition? Yes / No
Have you ever been hospitalized for psychological reasons? Yes / No
If yes; where and when? _____
Have you ever been prescribed psychiatric medications? Yes / No
If yes, please list:_____
_____
How did these meds affect *y*ou? _____
Does anyone in your family have a psychological condition? Yes / No
If yes, how are they related to you and what is their condition:_____
_____
List your present stressors: _____
_____
Have you experienced a significant life change(s) or event(s)? Yes / No
If yes, please explain:_____
What do you do to cope with stress?_____
What do you do for leisure or fun? _____

Shaded Area is for Clinicians only:

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Section II: Present Emotional State/ Psychiatric / Psychological Symptoms:

Are you having or have you experienced:

- Extreme or sudden depressed mood Yes / No
- Loss of interest in pleasurable things Yes / No
- Increased guilt or disappointment in yourself Yes / No
- Change in energy: energy increased or decreased? _____
- Difficulty in focusing or concentrating Yes / No
- Change in appetite Yes / No
- If yes, has there been a weight loss or gain & how much? _____
- Feelings of being run down and lethargic Yes / No
- Change in sleep: increased or decreased & how much? _____
- Mood swings Yes / No
- Rapid or pressured speech Yes / No
- Feelings of being keyed up or restless Yes / No
- Racing thoughts that you can't keep up with or stop Yes / No
- Engaging in impulsive or dangerous activities Yes / No
- Panic Attacks: If yes, how often _____ Yes / No
- Unusual or irrational fears. If yes, please explain Yes / No
  _____
- Repetitive thoughts (obsessions) Yes / No
- Hearing or seeing things that others do not Yes / No
- Beliefs that others are trying to harm/control you Yes / No
  If yes, who? _____
- Withdrawing from people and wanting to isolate yourself Yes / No
- Traumatic event (ex. Combat, rape, abuse, hurricanes…) Yes / No
- If yes, please describe: _____
- Unexplained Losses of time: If yes, how often? _____ Yes / No
- Emotional numbing / Absence of feelings Yes / No
- Flashbacks or intrusive memories Yes / No
- Body image problems Yes / No
- Eating uncontrollably or not much at all Yes / No
  Chronic physical discomfort Yes / No
- Violent episodes: breaking something or hitting someone? Yes / No
- If yes, what happened? Were you arrested? _____

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Section III: Lethality and Self Harm:

Has your situation distressed you that you wish you were not alive? Yes / No
Have you ever cut, hit or burned yourself on purpose? Yes / No
Have you ever had thoughts of hurting yourself or others? Yes / No
If yes, who and when? _____
What did you do? _____
Would you ask for help if the thoughts/feelings returned? Yes / No
Are you afraid to be alone? If yes, what would help? _____
Are you having any of these thoughts right now? Yes / No
If yes, please explain. _____

Section IV: Substance Abuse / Repetitive Behaviors:

Do you use tobacco? Yes / No

- If yes, how many packs/cartons per day? _____

Do you presently drink alcohol? If yes, answer the following questions.

- How much and how often? _____
- Have you experienced blackouts or have you passed out? Yes / No

Have you ever tried to or wanted to stop smoking or drinking? Yes / No
If yes, what happened? _____
Have you ever/ do you presently use marijuana, heroin, crack, cocaine or other street drugs? If yes, please explain: _____
Have you ever /do you misuse or overuse Oxycotin, Lortab, Vicadin or other prescribed medications? If yes, please explain: _____

How often do you view pornography in a given week? _____

- If yes, how is it viewed? (ex. internet, DVD's, magazines): _____

How often do you surf the internet, monitor Facebook, follow Twitter or play games in a given week? _____
Do you block disturbing thoughts / stress by using the internet? Yes / No
If yes, when and how often? _____
Have you ever denied or minimized any of the above behaviors? Yes / No
Do you feel angry, resentful or guilty if asked these behaviors? Yes / No
Have you received treatment for any of the above behaviors? Yes / No
If yes, where and when? _____
_____

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Section V: Social History and Support Systems

Where were you born and raised? _____
Where does your family of origin / extended family reside?_____
How many brothers or sisters do you have? _____
Were there significant events in your family?(Ex. adoption, divorces, unwed, transgender parents…) Please describe: _____
What is your highest level of education _____
What is your occupation? _____

Describe your current living situation? _____
If married, how many times have you been married? _____

- What is the name and age of your spouse? _____
- Spouse employed? If yes, what is their occupation? _____
- Where are they employed? _____

Do you have children? If yes, what are their names and ages: _____
_____

- Do these children live with you? If not where do they live? _____
  _____

Race / Ethnicity (circle all that apply): Caucasian or white American / African or African - American / Asian or Asian-American / Hispanic / British / German / Italian / Filipino / Korean / Mixed / Other: _____

Are you experiencing any concerns at home such as:

- Interracial or intercultural concerns? If yes, please describe:
  _____
- Blended family concerns? If yes, please describe: _____
  _____
- Feeling rejected? If yes, please describe:_____
- Increased conflicts and arguments? If yes, please describe:_____
- Not feeling safe or feeling at risk? If yes, please describe_____
- Being geographically separated from family/close friends? _____
- Another concern not listed? _____

Do you have someone to confide in? If yes, who? _____
Do you belong to any groups, churches or organizations? If yes, please list:
_____
Do you have any cultural/religious beliefs that shape your life (for better or worse?) If yes, please describe:_____

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Section VI: Legal / Medical History:

Have you / are you experiencing any legal problems? Yes / No
If yes, please describe: _____
Have you / are you involved with the Department of Family / Children Services?
If yes, please explain: _____

How would you describe your physical health? Poor / Good / Very Good
Do you have any chronic or serious illnesses? _____
Do you have a disability? If yes, please describe:_____
Do you have a history of a head injury? _____
Have you had any recent surgeries or operations? _____
Are there other problems not listed here affecting your ability to function?
_____

Does your birth gender, gender identity & gender expression match? Yes /No
If no, have you, are you or do you plan to transition? Please explain? _____
_____

Please list medications you take related to your sex, gender or to counteract natural occurring hormonal conditions, such as Viagra, hormones, Propecia, thyroid stimulating medications…_____

For women:

Are you currently pregnant or think you are pregnant? Yes / No
Are you planning on conceiving in the near future? Yes / No
How many times have you been pregnant? _____

For men:

Have you ever been diagnosed with any male specific condition? Yes / No
If yes, please describe the condition: _____

Treatment Goals (Please circle those that apply to you) :

Reduce sadness / depression
Reduce nervousness / anxiety
Reduce stress / racing thoughts
Stop recurrent / ongoing thoughts or behaviors
Decrease/stop drinking / smoking / street drugs /prescription medications…
Improve marital / couple / family relationships
Other:

Signature of Patient/ Guardian: **Date:**	**BMC of SGA Provider:** **Date:**

Name ______________________________
ID #: ______________________________