Mental Health Intake Questionnaire – Adult Version

Name: ____ Today's Date: ______________________

What challenges or problems are you having which prompted you to seek services?

What are your goals and/or expectations for your care at Bluebonnet Trails Community Services?

Please review the following and check any symptoms you are currently experiencing:

☐ Depressed mood
☐ Racing Thoughts
☐ Lack of enjoyment in usual activities
☐ Increased distractibility
☐ Trying to do too much
☐ Unintended changes in weight
☐ Agitated mood
☐ Sluggishness
☐ Sleeping too much or not enough
☐ Lack of energy/Fatigue
☐ Feeling guilty or worthless
☐ Seeing or hearing things that others do not see or hear
☐ Excessive worrying
☐ Inability to concentrate
☐ Intense fear of social situations
☐ Anger outbursts
☐ Inability to relax
☐ Attempts to hurt, harm, or mutilate self
☐ Panic attacks
☐ Too anxious to leave home
☐ Repetitive or obsessive thoughts
☐ Unreasonable fears
☐ Always on guard
☐ Repetitive actions
☐ Inflated self-esteem
☐ Lack of need for sleep
☐ Excessive or pressured speech
☐ Impulsivity
☐ Thoughts of death or suicide
☐ Violent thoughts or behaviors
☐ Inability to stay sober
☐ Recent drug / alcohol use
☐ Trauma

Past behavioral health treatment:

Inpatient psychiatric hospitalization? ☐ Yes, # of admissions:______ ☐ No

Detoxification? ☐ Yes, # of admissions:______ ☐ No

Rehabilitative treatment? ☐ Yes, # of admissions:______ ☐ No

Intensive outpatient treatment? ☐ Yes, # of admissions:______ ☐ No

If yes, when and where?

Current or past outpatient psychiatric or substance use treatment:

Psychiatrist or Nurse Practitioner office visits? ☐ Yes ☐ No

Therapy with a Psychologist or Counselor? ☐ Yes ☐ No

If yes, when and where?

Prior Diagnoses:

Health Screening

Name of Primary Care Provider:

When was the last time you saw your primary care physician?

Are you allergic or sensitive to any medications? ☐ Yes ☐ No

If yes, please list:____

Height:____’____” Weight: _________ Current Pulse Rate: ________ Temperature: _________

Blood Pressure (if able to provide):______ _______

Please list all ***current*** psychiatric and medical medications:

Name	Dose	Frequency	Provider's Name	Date started

Please list all psychiatric medications ***previously*** taken:

Name	Benefits	Side Effects	Reason discontinued

Health Insurance Information (if applicable):

Name of Healthplan:___________________Name of Insured Person: ________________________

Policy #:______________________________Effective Date: ________________________

Additional information we need to know about you or your situation at this time: