Jennifer Combs, PMHNP-BC

New Client Intake Form

Full name_____Date_____
Address_____
Email address_____Preferred contact method? Email / Phone
Cell#_____ Home#_____ Don't call before_____ after____
Restrictions for leaving messages?_____
Gender_____Age & Birthdate_____
Pronouns preferred _____
Drivers license #_____ Social security #_____
Emergency contact: Name / phone # / relationship_____
Briefly describe the specifics of the problem(s) w/ which you'd like help:_____
_____
_____

General Health & Medical History

List all surgeries & serious injuries:_____
_____
_____
Primary care provider name & # _____
Last physical?_____ last imaging (X-rays, MRI, EKG, etc)_____
Date of last iron level_____Normal / Low / High
Date of last thyroid levels_____Normal / Low / High
Date of last vitamin D level_____Normal / Low / High
Date of last vitamin B12 level_____Normal / Low / High
Date of last vitamin B9 (folate) level_____Normal / Low / High

Any history of the following conditions in you or your family?
Diabetes -Self ____ Family ____
Anemia / blood disorder -Self ____ Family ____
Smoking -Self ____ Family ____
Gastrointestinal issues -Self____ Family____
Chronic pain -Self____ Family ____
Autoimmune disorder -Self____ Family____
Lung disease -Self ____ Family____
Migraine headaches -Self____ Family ____
Heart disease -Self ____ Family ____
High blood pressure -Self ____ Family ____
Epilepsy / Seizures -Self____ Family____
High cholesterol -Self ____ Family ____
Sudden/unexplained death - Family _____
Thyroid problems -Self ____ Family ____
Kidney disease -Self ____ Family ____

Liver disease -Self ____ Family ____
Muscle/Bone problems -Self ____ Family ____
Cancer -Self ____ Family ____
Stroke -Self ____ Family ____
Other chronic illnesses (HIV, fibromyalgia, autoimmune disorders...)
_____

Ever had any kind of head injury?_____ when & how many?_____
Had gastric bypass surgery?_____ when?_____

For **women**: Periods - None / Regular / Irregular / Heavy / Light / Long / Short / Painful
Age of menarche?____ PMS/Mood changes?____ PCOS?____ Birth control?_____
Hysterectomy?_____ HRT?_____ Peri-menopause?_____ Menopause?_____
Endometriosis?_____ Miscarriages / abortions?_____ Pregnant or trying? _____
Nursing infant?_____ Postpartum depression?_____
Last time hormone levels were checked?_____Normal? _____

For **men**: Date of last testosterone level_____Normal / Low / High
Height_____ Weight_____ Health status: Excellent / Good / Fair / Poor
Do you exercise?____ type?_____ days per week?____ hours per day?____

Mental Health History
Currently in therapy?_____ therapy in the past?_____ how long ago?_____
Duration of therapy?_____ helpful?_____
Current therapist's name & #_____
Seen a PMHNP or Psychiatrist in the past?_____ when?_____
_____
Ever been diagnosed w/ a mental health disorder?_____
_____
Ever been hospitalized for a mental health crisis?_____
_____
Current thoughts of suicide?_____ in the past?_____ when?_____
Ever made a plan?_____ what was/is the plan?_____
How many attempts?_____ how long ago?_____
Current thoughts or plans of harming others?_____ in the past?_____

Medication History
List ALL CURRENT <u>mental health</u> medications you're taking (w/ dose & frequency) & for how long. _____
_____
_____
_____
_____
_____

How often do you miss doses?_____ are they effective?_____
List ALL PAST mental health medications you've taken (w/ dose & frequency),
when & for how long, & why you stopped the medication:_____

How often did you miss doses?_____ were they effective?_____

List ALL other CURRENT prescription medications, homeopathic & herbal treatments, over the counter medications (amino acids, vitamins, minerals, or other supplements), & what condition or symptoms you're taking them for: _____

List ALL allergies to medications, foods, or other substances & describe your reaction:

Names & phone #'s of ALL pharmacies that you use:_____