Jennifer Combs, PMHNP-BC

New Client Intake Assessment and Medication Evaluation Form

Full name_____Date_____

Address_____

Email address_____Preferred contact method? Email / Phone

Cell#_____ Home#_____ Don't call before_____ after____

Restrictions for leaving messages?_____

Gender_____ Race_____ Age & Birthdate_____

Sexual orientation? Bisexual / Gay / Heterosexual / Lesbian / Pansexual / Other

Drivers license #_____ Social security #_____

Emergency contact: Name / phone # / relationship_____

Whom may I thank for referring you?_____

Briefly describe the specifics of the problem(s) w/ which you'd like help:_____

_____

_____

Employment History

Hours worked: Over-time (over 40 hrs) / Full-time (35+ hrs) / Part-time (17-34 hrs)

Irregular (< 17 hrs) / Unemployed / Unable to work / On disability / Retired

Past occupations_____

Current occupation_____ Employer _____

Length of employment_____ Satisfied w/ your job?_____

Have problems maintaining employment (currently / past)?_____

Due to outside forces (i.e. economy) or difficulties with peers / supervisors / customers?

_____

Circle if applies: Late for work / Absenteeism / Diminished productivity / Quit / Fired

Educational History

In school now?_____ Full / Part time Highest grade completed?_____

How well did you do in school? Excellent / Good / Fair / Poor

Relationships w/ your teachers? Excellent / Good / Fair / Poor

Relationships w/ your peers? Excellent / Good / Fair / Poor

Mark the following experiences that were relevant to you while going to school:

___ Bullied / teased by others ___ Skipped classes often ___ You bullied / teased others

___ Refused to go to school ___ Afraid to go to school ___ Suspended / expelled

___ ADHD / dyslexia / other learning disability ___ Failed / repeated grade(s)

___ Talented & gifted (TAG) class ___ Moved frequently

___ Had an IEP / Attended special classes / alternative school

_____

_____

Developmental History

Where were you born?_____

Where did you grow up?_____

Who raised you? _____

Mark and circle the following experiences that were relevant to you while growing up:

____ Loving / supportive / stable / non-violent / home environment

____ Inconsistent / unstable / home environment

____ Chaotic / violent / home environment

____ Witnessed physical / verbal / emotional / sexual abuse / or neglect toward others

____ Experienced physical / verbal / emotional / sexual abuse / or neglect from others

____ You were physically / verbally / emotionally / or sexually abusive toward others

____ Depressed as a child / teen

____ Lived in home other than parents

____ Anxious as a child / teen

____ Frequently lied to family & others

____ ADD/ADHD as child / teen

____ Ran away from home

____ Wet the bed after age 7

____ Was cruel to animals

____ Teen pregnancy

____ Set fires

_____

_____

Trauma History

Ever been sexually assaulted / raped? _____

Know or suspect that you were ever given a date rape drug?_____

Experienced or witnessed traumatic events (ie. rape, assault, accident, natural disaster, murder, war, chronic abuse...)?_____

_____

_____

Relationships & Family History

Who lives w/ you in the home? _____

Relationship status: Single / Committed relationship / Married / Polyamorous / Separated / Divorced / Partner deceased / Other _____

If you're in a relationship, how long have you been together?_____

Feel safe in this relationship?_____ satisfied w/ relationship? _____

Been in an emotionally or physically abusive intimate relationship?_____

Mother's name & age_____ alive?_____

Where does she live?_____ her occupations_____

Health status_____

Mental health state _____

Relationship w/ her: Excellent / Good / Fair / Complicated / Bad / Nonexistent

Did she abuse alcohol or drugs?_____

Were you: neglected / verbally / emotionally / physically / sexually abused by her?_____

_____

_____

_____

_____

Father's name & age_____ alive? _____

Where does he live?_____ his occupations _____

Health status_____

Mental health state _____

Relationship w/ him: Excellent / Good / Fair / Complicated / Bad / Nonexistent

Did he abuse alcohol or drugs?_____

Were you: neglected / verbally / emotionally / physically / sexually abused by him? ____

_____

_____

_____

_____

Parents divorced?_____ your age at the time?_____ any step parents/siblings? _____

_____

List all full & half siblings (use the back of this page if necessary)

_____

First name, age, full or half sib? Mental health status

_____

First name, age, full or half sib? Mental health status

_____

First name, age, full or half sib? Mental health status

_____

First name, age, full or half sib? Mental health status

Did any of your full / half / step siblings: verbally / emotionally / physically / sexually abuse you?

_____ what ages did it start & stop?_____

List all of your children (use the back of this page if necessary)

_____

First name, sex, age Mental health status

_____

First name, sex, age Mental health status

_____

First name, sex, age Mental health status

_____

First name, sex, age Mental health status

Social Support Systems

Supportive friends: Many / Several / Few / None

Substance-use based friends?____

Supportive family members: Many / Several / Few / None

Religious/spiritual beliefs?_____ how important are they to you?_____

Participating in religious / spiritual activities / community activities?_____

Military History

Military service?_____ Branch?_____

Active / Reserve / Veteran / Retired Served in combat?_____

Honorable or dishonorable discharge?_____

Experienced disciplinary actions while serving?_____

Legal History

Been arrested or involved in any court proceedings?_____

Been to jail or prison?_____

Other legal problems_____

Alcohol & Drug Use History

Mark & circle any drugs you've ever taken, indicating present or past use, & note both when & how long you used each substance.

None at all (ever!)_____Tobacco (Present / Past) _____

Marijuana (Present / Past)_____

Rx opiates- hydrocodone/ oxycodone /other (Present / Past)_____

Street opiates- cocaine /crack /heroin /other (Present / Past)_____

Street amphetamines- meth /other (Present / Past) _____

Rx stimulants- ritalin /adderall /other (Present / Past)_____

Benzodiazepines- xanax /klonopin /other (Present / Past) _____

Psychedelics- LSD /mushrooms /mescaline /PCP /other (Present / Past) _____

Nitrous / MDMA (ecstasy) / GHB / Ketamine / Bath Salts / Other _____

_____

What is your alcoholic beverage(s) of choice? _____

Typical serving size for one drink (how many ounces)?_____

How many alcoholic drinks do you consume in an average day?_____ week? _____

How many days/weeks do you ever go without drinking?_____

What is the largest # of drinks you'll consume in one night?_____

Have you felt you should, or has anyone told you to cut down on your drinking?_____

Have others ever felt annoyed/bothered by your drinking?_____

Have you ever felt guilty/bad about your drinking? _____

Ever passed out / blacked out / had shakes / or drank in the morning to steady your nerves/get over a hangover?_____how often?_____

Do you drink & drive?_____ how many DUI's have you had?_____

Have you ever been treated for alcohol or drug abuse? _____

Hours per week spent on: TV?_____ video gaming? _____internet (not work)?_____ shopping?_____ gambling?_____ porn?_____ other addiction(s)?_____

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

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?____

Mark all that applies to describe the type of carbohydrates typically consumed: ____

Simple (white- bread, rice, pasta, processed and refined, high sugar foods) ____

Complex (brown- bread, rice, pasta, whole grains/minimally processed, low sugar) ____ Sugar-free products (nutrasweet / splenda / stevia) other:_____

Special diet?_____ Difficulties w/food?_____

Meals per day?_____ snacks per day?_____ ounces of water per day? _____

Ounces of caffeinated drinks a day: coffee?_____ tea?_____ pop?_____ energy?_____

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? _____

Sleep History

Do you have a nightly routine/ritual before bed?_____

What time (range) do you go to bed on weekdays?_____ weekends?_____

What time (range) do you get up on weekdays?_____ weekends?_____

Hours of sleep needed to feel your best?_____ do you sleep well?_____

Sleepy during the day?_____ take naps?_____ how long?_____ how often?_____

Trouble falling asleep?_____ how long does it take?_____ how often?_____

Problems waking up at night?_____ how many times per night?_____

How long to get back to sleep?_____ how often does it occur?_____

Ever gone all night w/out any sleep at all?_____

How often does this occur?_____

Longest you've gone w/out any sleep (consecutive nights)?_____

Are you anxious before you go to bed?_____

Does your mind race & you can't shut it off, keeping you from falling asleep?_____

Does pain keep you from falling asleep or does it wake you up?_____

Use caffeinated products or tobacco w/in 5 hours of going to bed?_____

How much alcohol before bed?_____

Eat within 3 hours of going to bed?_____ wake up to eat?_____

Been told you hold your breath / stop breathing while asleep?_____

Had a sleep study?_____ when?_____ use a CPAP?_____

Get a creeping/crawling / restless / jerking feeling in legs while falling asleep?_____

How often?_____ improves w/ getting up & walking?_____

Circle if applies: Talk in your sleep / Grind teeth / Nightmares / Wake up in panic

Quiet room / TV or radio on / White noise / Dark room / Lights on / You snore

Partner snores / You toss & turn / Partner tosses & turns / Sleep walk / Other ____

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?_____

Ever engaged in self harm behaviors (cutting, burning, etc.)?_____

Mark only the symptoms you've experienced in the last 2 weeks, leave everything else blank.

Rate symptoms: 1 = Mild difficulty 2 = Moderate difficulty 3 = Severe difficulty

_____Sad most of the time

_____Self destructive behavior

_____Tearful / excessive crying Self harm (i.e. cutting, burning...)

_____Hopeless Blames others

_____Helplessness Impulsive / takes unnecessary risks

_____Worthlessness

_____Poor judgment

_____Lack of confidence / insecure

_____Inappropriate or odd social behaviors

_____Feelings of guilt & / or shame

_____Increased sex drive / risky sex

_____Social isolation

_____Grandiose (way over the top) ideas

_____Loneliness

_____Overly energetic

_____Loss of interest in friends & activities

_____Excessive happiness

_____Difficulty relating to others

_____Decreased need for sleep & feels rested

_____Unable to keep friends

_____Increased sleep w/out feeling rested

_____Grief / loss

_____Difficulty falling & / or staying asleep

_____Poor attention to hygiene
_____Nightmares / bizarre / vivid dreams
_____Low motivation / procrastination
_____Startles easily
_____Low energy / fatigue / exhaustion
_____Can’t stop remembering past events
_____Poor concentration
_____Can’t turn mind off / racing thoughts
_____Easily distractible
_____Anxious / fearful / excessive worry
_____Difficulty comprehending things
_____Muscle tension
_____Difficulty w/ memory
_____Physically restless / can’t sit still / pacing
_____Frequently loses objects
_____Upset stomach / nausea
_____Chronically late
_____Rapid breathing / trouble breathing
_____Interrupts others frequently
_____Chest pain / pounding heart
_____Overly talkative / rapid speech
_____Sense of impending doom
_____Sexual difficulties / decreased sex drive
_____Panic attacks
_____Poor appetite / weight loss
_____Fearful to leave your house
_____Increased appetite / weight gain
_____Preoccupation w/ death
_____Bingeing - food / alcohol / drugs / spending $ $)
_____Phobias
_____Purging (self induced vomiting)
_____Repetitive / obsessive intrusive thoughts
_____Dangerous calorie restriction
_____Repetitive / obsessive behaviors

_____Excessive exercise
_____Hair pulling / skin picking / nail biting
_____Mood changes w/ weather
_____Secretive
_____Mood swings
_____Overly suspicious / paranoid
_____Irritability / agitation / impatience
_____Lying
_____Argumentative
_____Hearing voices others do not
_____Anger / yelling / rage
_____Seeing things others do not
_____Road rage
_____Homicidal thoughts / plans
_____Verbally or physically abusive to others
_____Suicidal thoughts / plans
_____Destructive to property
Access to weapons circle Y / N

Medication History

List ALL CURRENT mental health 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 & #'s of ALL pharmacies that you use:_____

_____

_____

_____

_____