Dera Health Intake Form: Behavioral Health

Name____Date______________

What are the problem(s) for which you are seeking help?

1.____

2.____

3.____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

Depressed mood
() Unable to enjoy activities
() Sleep pattern disturbance
() Loss of interest
Concentration/ forgetfulness
Change in appetite
Excessive guilt
() Fatigue
() Decreased libido

() Racing thoughts
() Impulsivity
() Increase risky behavior
() Increased libido
() Decreased need for sleep
() Excessive energy
() Increased irritability
() Crying spells

() Poor focus
() Distractibility
() Interrupting others
() Getting off task
() Mood Swings
() Checking Behaviors
() Difficulty in crowds
() Nightmares

() Excessive worry
Anxiety attacks
Avoidance
Hallucinations
Suspiciousness
Other:

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? () Yes () No

No. If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? () Yes () No

How often do you have these thoughts? ____

When was the last time you had thoughts of dying? ____________________

Has anything happened recently to make you feel this way? ______________________________

Would anything make it better? ____

Have you ever thought about how you would kill yourself? ______________________________

Is the method you would use readily available? ___________________________________

Is there anything that would stop you from killing yourself? __________________________

Have you ever tried to kill or harm yourself before?

____

Do you have access to guns? If yes, please explain. ________________________________

Current Psychiatric Medications: Please list Name, Dose and Times of Day

____
____
____
____

Past Psychiatric Medications: Please list Name, Dose and What you remember about the effect.

____
____
____
____

Psychiatric Hospitalization () Yes () No If yes, describe for what reason, when and where.

Reason	Date Hospitalized	Where

Substance Use:
Have you ever been treated for alcohol or drug use or abuse? Yes No
If yes, for which substances? When?

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	______________
Cocaine	( )	( )	______________
Stimulants (pills)	( )	( )	______________
Heroin	( )	( )	______________
LSD or Hallucinogens	( )	( )	______________
Marijuana	( )	( )	______________
Pain killers (not as prescribed)	( )	( )	______________
Methadone	( )	( )	______________
Tranquilizer/sleeping pills	( )	( )	______________
Alcohol	( )	( )	______________
Ecstasy	( )	( )	______________

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Past Psychiatric Medications: Please list Name, Dose and What you remember about the effect.

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