

Intake

Name: Date: _____

Do not write in this area

Why are you seeking services at this time? _____

How did you hear of this service? Friend GLYP Internet Employer
 Insurance Doctor _____ Other _____

Medical History

Primary Physician _____ Mental Health Physician _____

Do you have any medical problems? No Yes _____

Have you ever sought mental health services before? Therapy Medication

If yes, what for? _____ When? _____

What made it helpful or not? _____

Please list all medications, prescription and non-prescription, and/or any supplements you are taking.

Do you drink alcohol? No Yes if yes, how often? _____

Social History

Marital Status: Married/Partnered Divorced Widowed
 Single/Unpartnered

Children: [name, age] None _____

Other household members:
[name, age, relation] _____

Level of education: High School 2 Yr Degree 4 Yr Degree
 Some College Post-Grad Degree Other _____

Employment: Part-time Full-time School No outside employment

Anything else? _____

Family History

Do not write in this area

Has any member of your family ever been treated for the following? Please check all that apply.

- Diabetes Anxiety Alcohol abuse
 Thyroid problems Depression Drug abuse
 High blood pressure Psychosis Other health problem:
 Heart Problems ADHD _____

Current Symptoms

For the past 2-4 weeks, have you experienced any of the following? Please check all that apply.

- Difficulty sleeping Difficulty concentrating Nervousness Sweats
 Fatigue Memory loss Thoughts of running away Thoughts of dying
 Change in appetite Confusion Irritability Suicidal thoughts
 Weight gain/loss Unusual thoughts Temper outbursts
 Loss of interest Hearing noises Racing heart
 Prolonged sadness Body aches Difficulty breathing
 Frequent crying Chest discomfort Restlessness
 Other _____

Do you have any requests regarding service, at this time? _____

Axis I

Axis II

Axis III

Axis IV

Axis V

Office use only