Tidal Mental Health
80 Washington St, Ste C-17, Norwell, MA 02061
Tel: (781) 773-8905 • Fax: (781) 261-9633
www.tidalmentalhealth.com

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a checkmark so it will go quickly. You may need to ask family members about your family history. Thank you!

Who is completing this form? ( ) patient ( ) other
If other, relationship to patient: _____
(if you are not the patient, please fill out the form with the patient's information)

Name _____ Date _____
Is there another name you prefer to go by? ( ) Yes ( ) No
If yes, what is it? _____

Date of Birth _____ Primary Care Physician _____

When was your last physical? _____
When was your last lab work completed? _____
Were there any concerns or abnormal findings? _____
Current Therapist/Counselor Therapist's Phone _____

What are the problem(s) for which you are seeking help?
1. _____
2. _____
3. _____

What are your treatment goals?
_____
_____
_____
_____

Current Symptoms Checklist:

( ) Depressed mood	( ) Change in appetite	( ) Excessive guilt
( ) Unable to enjoy activities	( ) Fatigue	( ) Impulsivity
( ) Sleep pattern disturbance	( ) Decreased libido	( ) Decrease need for sleep
( ) Loss of interest	( ) Racing thoughts	( ) Excessive energy
( ) Concentration/forgetfulness	( ) Increase risky behavior	( ) Increased irritability
( ) Attention Issues	( ) Increased libido	( ) Crying spells
( ) Excessive worry	( ) Anxiety attacks	( ) Avoidance
( ) Hallucinations	( ) Suspiciousness	( ) Other _____

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Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) 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? _____
On a scale of 1 to 10, with 10 being the strongest, how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? ( ) Yes ( ) No
If yes, please explain. _____

Medical History

Height: _____ Weight: _____ Allergies: _____

List ALL current prescription medications and how often you take them: (if none, write none)
Medication Name Total Daily Dosage Prescribed By Why Was It Prescribed?
_____
_____
_____
Which of these medications is/are helpful, Which are not and Why?
_____
Current over-the-counter (OTC) medications or supplements:
_____
_____
Past medical problems, injuries, non-psychiatric hospitalization, or surgeries:
_____
_____
Current medical problems: _____
Are you being treated for these problems: ( ) Yes ( ) No
If yes, please describe: _____
Do you see any medical specialists other than your primary care provider? ( ) Yes ( ) No
If yes, please describe: _____
Do you have any current physical limitations or disabilities? ( ) Yes ( ) No
If yes, please describe: _____

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Have you ever had an EKG? ( ) Yes ( ) No
If yes, when? _____ Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

Do you have any concerns about your physical health you would like to discuss? ( ) Yes ( ) No
If yes, please describe: _____

Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise? _____ How much time/day do you exercise? _____
What kind of exercise do you do? _____

For Women Only: Date of last menstrual period: _____
Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No
Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method: _____
How many times have you been pregnant? _____ How many live births? _____

Personal and Family Medical History

	You	Family	Which Family Member?
Thyroid Disease	( )	( )	_____
Anemia	( )	( )	_____
Liver Disease	( )	( )	_____
Chronic Fatigue	( )	( )	_____
Kidney Disease	( )	( )	_____
Diabetes	( )	( )	_____
Asthma/respiratory problems	( )	( )	_____
Stomach or intestinal problems	( )	( )	_____
Cancer	( )	( )	_____
Fibromyalgia	( )	( )	_____
Heart Disease	( )	( )	_____
Epilepsy or seizures	( )	( )	_____
Chronic Pain	( )	( )	_____
High Cholesterol	( )	( )	_____
High blood pressure	( )	( )	_____
Head trauma	( )	( )	_____
Sleep Apnea	( )	( )	_____
Other: _____	( )	( )	_____

Is there any additional personal or family medical history? ( ) Yes ( ) No
If yes, please explain:

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History

Outpatient treatment ( ) Yes ( ) No
If yes, please describe when, by whom, and nature of treatment:
Reason Dates Treated By Whom

_____

_____

Inpatient psychiatric hospitalization ( ) Yes ( ) No
If yes, please describe when, by whom, and nature of treatment:
Reason Dates Treated By Whom

_____

_____

Partial hospitalization program ( ) Yes ( ) No
If yes, please describe when, by whom, and nature of treatment:
Reason Dates Treated By Whom

_____

_____

Past Psychiatric Medications

If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember):

Antidepressants	**Dates**	**Dosage**	**Response / Side-Effects**
Prozac	_____	_____	_____
Zoloft	_____	_____	_____
Luvox	_____	_____	_____
Paxil	_____	_____	_____
Celexa	_____	_____	_____
Lexapro	_____	_____	_____
Effexor	_____	_____	_____
Cymbalta	_____	_____	_____
Wellbutrin	_____	_____	_____
Remeron	_____	_____	_____
Serzone	_____	_____	_____
Anafranil	_____	_____	_____
Pamelor	_____	_____	_____
Tofranil	_____	_____	_____
Elavil	_____	_____	_____
Other: _____	_____	_____	_____

Mood Stabilizers	**Dates**	**Dosage**	**Response / Side-Effects**
Tegretol	_____	_____	_____
Lithium	_____	_____	_____

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Depakote	_____	_____	_____
Lamictal	_____	_____	_____
Trileptal	_____	_____	_____
Topamax	_____	_____	_____
Other: _____	_____	_____	_____

Antipsychotics	**Dates**	**Dosage**	**Response / Side-Effects**
Seroquel	_____	_____	_____
Zyprexa	_____	_____	_____
Geodon	_____	_____	_____
Abilify	_____	_____	_____
Clozaril	_____	_____	_____
Haldol	_____	_____	_____
Risperdal	_____	_____	_____
Latuda	_____	_____	_____
Other: _____	_____	_____	_____

Sedative/Hypnotics	**Dates**	**Dosage**	**Response / Side-Effects**
Ambien	_____	_____	_____
Sonata	_____	_____	_____
Rozerem	_____	_____	_____
Restoril	_____	_____	_____
Trazodone	_____	_____	_____
Melatonin	_____	_____	_____
Other: _____	_____	_____	_____

ADHD medications	**Dates**	**Dosage**	**Response / Side-Effects**
Adderall	_____	_____	_____
Concerta	_____	_____	_____
Ritalin	_____	_____	_____
Strattera	_____	_____	_____
Vyvanse	_____	_____	_____
Focalin	_____	_____	_____
Daytrana	_____	_____	_____
Quillivant	_____	_____	_____
Guanfacine	_____	_____	_____
Tenex	_____	_____	_____
Other: _____	_____	_____	_____

Antianxiety medications	**Dates**	**Dosage**	**Response / Side-Effects**
Xanax	_____	_____	_____
Ativan	_____	_____	_____
Klonopin	_____	_____	_____

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Valium	_____	_____	_____
Tranxene	_____	_____	_____
Buspar	_____	_____	_____
Vistaril	_____	_____	_____
Hydroxyzine	_____	_____	_____
Clonidine	_____	_____	_____
Gabapentin	_____	_____	_____
Other: _____	_____	_____	_____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:
Bipolar disorder ( ) Yes ( ) No
Schizophrenia ( ) Yes ( ) No
Depression ( ) Yes ( ) No
Post-traumatic stress ( ) Yes ( ) No
Anxiety ( ) Yes ( ) No
Alcohol abuse ( ) Yes ( ) No
Anger ( ) Yes ( ) No
Other substance abuse ( ) Yes ( ) No
Suicide ( ) Yes ( ) No
Violence ( ) Yes ( ) No

If yes, who had each problem?
_____
_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No
If yes, who was treated, what medications did they take, and how effective was the treatment?
_____
_____

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Substance Use

How many caffeinated beverages do you drink a day?
Coffee _____ Tea _____ Soda _____ Energy Drinks _____ Other: _____

How you ever smoked cigarettes? ( ) Yes ( ) No Currently? ( ) Yes ( ) No
If currently, how many packs per day on average? _____ For how many years? _____
If in the past, how many years did you smoke? _____ When did you quit? _____
Have you ever smoked a pipe, cigars, e-Cig, vape, JUUL, or used chewing tobacco? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No What kind? _____
How often per day on average? _____ How many years? _____ Nicotine content (vape/JUUL): _____

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? ____
What is the least number of drinks you will drink in a day? ____
What is the most number of drinks you will drink in a day? ____
In the past 3 months, what is the greatest # of alcoholic drinks you've consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? _____
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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Family Background and Childhood History

Were you adopted? ( ) Yes ( ) No
Where did you grow up? _____
What is/was your father's occupation? _____
What is/was your mother's occupation? _____
Did your parents' divorce? ( ) Yes ( ) No
If so, how old were you when they divorced? _____
If your parents divorced, who did you live with? _____

Describe your father and your relationship with him:
_____
Describe your mother and your relationship with her:
_____
List any siblings and their ages:
_____
Describe your siblings and your relationship with each:
_____
Do you still live at home / with family? ( ) Yes ( ) No
If no, how old were you when you left home? _____
Has anyone in your immediate family died? ( ) Yes ( ) No
Who and when? _____

Educational History
Highest Grade Completed? _____
School attended and location: _____
Did you attend college? ( ) Yes ( ) No School attended and location: _____
Major? _____
What is your highest educational level or degree attained? _____
Have you ever had any neuropsychological testing through a school? ( ) Yes ( ) No
Any academic problems, learning disabilities, or additional support (IEP 504 plan or other)? ( ) Yes ( ) No
If yes, please explain:
_____
_____

Occupational History
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation? _____
Where do/did you work? _____
Have you ever served in the military? ( ) Yes ( ) No If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No Other type discharge: _____

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Relationship History and Current Family

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed
How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No
If yes, how long? _____
If you are married or in any relationship, do you feel safe in this relationship? ( ) Yes ( ) No
If no, please explain:
_____
Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation? _____
How would you describe your gender identity? _____
What are your preferred pronouns? _____

What is your spouse or significant other's occupation? _____
Please describe your relationship with your spouse or significant other:
_____
_____

Have you had any prior marriages? ( ) Yes ( ) No
If so, how many? _____ How long? _____

Do you have children? ( ) Yes ( ) No
If yes, list ages and gender:
_____
Please describe your relationship with your children:
_____
_____

What kind of home do you live in? ( ) Single-family ( ) Multi-family ( ) Apartment Complex/Building
Do you own or rent? _____
Please List everyone who currently lives with you:
_____
Do you feel safe where you live? ( ) Yes ( ) No
If no, please explain: _____

Legal History
Have you ever been arrested?? ( ) Yes ( ) No
If yes, briefly describe the circumstances and any legal repercussions:
_____
_____
Do you have any pending legal problems? If so, please describe:
_____

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Spiritual Life

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is your level of involvement? _____
Do you find your involvement helpful or does it make things more difficult or stressful for you?
( ) more stressful ( ) less stressful

Personal Life

What are your hobbies and interests?
_____
_____

What are your strengths and weaknesses?
_____
_____

What motivates you?
_____
_____

Is there anything else that you would like me to know?
_____
_____
_____
_____