Telepsych Mental Health Intake Form

Please complete all information on this form at least 1 day before your intake visit.

**Please note that any information provided on this form may not be reviewed prior to your appointment, and will be used as an evaluation tool by your provider. If at any time you are at risk of harming yourself or someone else, please call 911 or go to your nearest emergency room. You may also call or text the National Suicide Prevention Hotline at 1.800.273.8255.*

Name: [PatientName]

Date of Birth: [PatientDOB]

Primary Care Physician (and phone number):

Current Psychiatrist: (and phone number):

What is the reason you are seeking care today?

☐ 1. **Mood issues (depression, mood swings)**

☐ 2. **Anxiety issues (worry, panic, nightmares, easily startled)**

☐ 3. **Focus issues (difficulty with attention, concentration)**

☐ 4. **Other**

Suicide Risk Assessment

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

Have you planned a time for this and do you have a plan? ☐ Yes ☐ No

Have you ever tried to kill or harm yourself before? ☐ Yes ☐ No

Do you have any history of self-harming, such as cutting, burning, etc.? ☐ Yes ☐ No

If you are feeling as though you may harm yourself or someone else, please call 911 and/or go to your nearest Emergency Room. You can also call/text the Suicide Prevention Hotline at 800.273.8255

Past Medical History:

Allergies:

Current Weight: Height:

List ALL current prescription or over the counter medications and how often you take them

Medication Name	Total Daily Dosage	Estimated Start Date

Current medical problems:

Past Psychiatric History:

Outpatient treatment: ☐ Yes ☐ No

Psychiatric Hospitalization ☐ Yes ☐ No

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for mental illness: ☐ Yes ☐ No

Has anyone in your family attempted or committed Suicide ☐ Yes ☐ No

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No
If yes, for which substances?

Do you currently drink alcohol? ☐ Yes ☐ No
If yes, type and quantity per day:

Do you currently use cannabis? ☐ Yes ☐ No
If yes, type and quantity per day:

Do you currently use other illicit drugs? ☐ Yes ☐ No
If yes, type and quantity per day:

Have you ever misused prescription medication? ☐ Yes ☐ No
If yes, which ones and for how long?

Tobacco History:

Do you currently use any tobacco or nicotine products (cigarettes, vape, oral pouches)? ☐ Yes ☐ No
If yes, type and quantity per day:

Trauma History:

Do you have a history of being abused emotionally, sexually, physically? ☐ Yes ☐ No
Please describe:

Is there anything else you would like your provider to know? ☐ Yes ☐ No

Signature: **Date: [CurrentDate]**

Guardian signature (if under 18)