Schoolhouse Pediatrics

Sudipti Luthra, M.D., F.A.A.P.
Margaret Centurioni, M.D., F.A.A.P.
John Bevilacqua, D.O., F.A.A.P.
Ian Fecko, M.D., F.A.A.P.
Caitrin Navarro, M.D., F.A.A.P.
Margaret Leary, M.D., F.A.A.P.
Brian Sheridan, M.D., F.A.A.P.

Heather Maroney, M.D., F.A.A.P.
Diane Tenenbaum, M.D., F.A.A.P.
Marc Benison, D.O., F.A.A.P.
Brittany McDonald, F.N.P.
Lindsey Reyman Rizzolo, P.N.P.
Katie McLean, L.M.H.C.
Katie Turner, L.M.H.C.

# Mental Health Intake Form

Name: _____ Date: _____

Date of Birth: _____ Primary Care Physician: _____

What brings you in for counseling?

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

- ○ Depressed mood
- ○ Unable to enjoy activities
- ○ Changes in sleep
- ○ Loss of interest
- ○ Suspiciousness
- ○ Guilt
- ○ Crying spells
- ○ Racing thoughts
- ○ Impulsivity
- ○ Risky behaviour
- ○ Hallucinations
- ○ Change in appetite
- ○ Irritability
- ○ Other:
- ○ Excessive worry
- ○ Anxiety attacks
- ○ Avoidance
- ○ Concentration/forgetfulness
- ○ Increased energy
- ○ Fatigue

**Current Medications:** (name, dose, response)

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

**Past Psychiatric History:**
Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

**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).

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**Substance Use:**
Have you ever used alcohol or drugs? ( ) Yes ( ) No
Have you ever abused prescription medication? ( ) Yes ( ) No
How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

**Tobacco History:**
Have you ever smoked cigarettes? ( ) Yes ( ) No Currently? ( ) Yes ( ) No

**Educational History:**
What is the highest grade you have completed, where do you attend?

**Family Psychiatric History:**
Has anyone in your family been diagnosed with or treated for a mental health condition ( ), substance abuse ( ), anger management ( ), domestic violence ( ) and/or suicide ( ). If yes, who and what medications did they take?

**Trauma History:**
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom:

**Suicide Risk Assessment:**

1. Have you ever had feelings/thoughts that you did not want to live? ( ) Yes ( ) No
   If NO, please skip to the next question. If YES, please answer the following:

   a. Do you currently feel that you don't want to live? ( ) Yes ( ) No
   b. How often have you had these feelings/thoughts?
   c. Has anything happened recently to make you feel/think this way?
   d. On a scale of 1 to 10 (10 being strongest), how strong is your desire to kill yourself currently?
   e. Would anything make it better?
   f. Have you ever thought about how you would kill yourself?
   g. Is the method you would use easily available?
   h. Have you planned a time for this?
   i. Is there anything that would stop you from killing yourself?

2. Is there anything else that you would like us to know?