

Behavioral Health Intake Information Form

To help us provide the best treatment for you, please answer the questions on this form and return it to the clinic as soon as possible to assist us with scheduling your first appointment.

Patient's Legal Name: _____ Date of birth: _____

What is the primary reason you are coming to YRMC Behavioral Health?

Do you feel that your primary concern needs urgent or immediate care? Yes No

- | | |
|--|--|
| <input type="checkbox"/> Bariatric surgery clearance | <input type="checkbox"/> Counseling or Therapy |
| <input type="checkbox"/> Other surgical clearance | <input type="checkbox"/> Substance Abuse Treatment |
| <input type="checkbox"/> Gender affirmation evaluation | <input type="checkbox"/> Psychiatric diagnosis/ medication management/ treatment |

Please check all of the symptoms below that apply to you:

- | | |
|---|---|
| <input type="checkbox"/> Loss of interests/ not enjoying things | <input type="checkbox"/> Episodes of crying |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Moody |
| <input type="checkbox"/> Thoughts of suicide or self-harm | <input type="checkbox"/> Angry/easily irritable |
| <input type="checkbox"/> Feeling overly important | <input type="checkbox"/> Eating difficulties |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Concerns with drinking alcohol |
| <input type="checkbox"/> Little need for sleep/ very active | <input type="checkbox"/> Concerns with drug use |
| <input type="checkbox"/> Anxiety worry | <input type="checkbox"/> Past alcohol/ drug use |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Thoughts of hurting others |
| <input type="checkbox"/> Avoid going place/ avoid being with others | <input type="checkbox"/> Feeling suspicious at times |
| <input type="checkbox"/> Checking things repeatedly | <input type="checkbox"/> Having strange experiences |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seeing things |
| <input type="checkbox"/> Feeling helpless/ hopeless | |

Are there other concerns (not listed above) that you want to discuss?

Have you experienced any frequent or intense interest or plan seriously harming or killing yourself or someone else?

Yes No (If yes, do you currently have these thoughts)

Have you ever tried to do something like this in the past? Yes No

If yes, dates? _____

Are you currently under Court ordered treatment? Yes No

Have you been diagnosed with Serious Mental Illness (SMI)? Yes No

Have you previously been admitted to a mental health facility? Yes No

Are you currently enrolled with a Behavioral Health System? (Horizon Health, Community Health Associates, Pathways, Community Bridges) Yes No

Legal History:

Are you currently or previously involved with the legal system? Yes No

If yes, explain: _____



Please select treatment:

- | | | |
|---|---|---|
| <input type="checkbox"/> Adderall | <input type="checkbox"/> Halcion (Triazolam) | <input type="checkbox"/> Rozerem (Ramelteon) |
| <input type="checkbox"/> Ambien (Zolpidem) | <input type="checkbox"/> Klonopin (Clonazepam) | <input type="checkbox"/> Serax (Oxazepam) |
| <input type="checkbox"/> Anafranil (Clomipramine) | <input type="checkbox"/> Lexapro (Escitalopram) | <input type="checkbox"/> Serzone (Nefazodone) |
| <input type="checkbox"/> Artane (Trihexyphenidyl) | <input type="checkbox"/> Librium (Chlordiazepoxide) | <input type="checkbox"/> Sinequan (Doxepin) |
| <input type="checkbox"/> Ativan (Lorazepam) | <input type="checkbox"/> Lunesta (Eszopiclone) | <input type="checkbox"/> Sonata (Zaleplon) |
| <input type="checkbox"/> BuSpar (Buspirone) | <input type="checkbox"/> Luvox, (Fluvoxamine) | <input type="checkbox"/> Strattera (Atomoxetine) |
| <input type="checkbox"/> Celexa (Citalopram) | <input type="checkbox"/> Nardil (Phenelzine) | <input type="checkbox"/> Surmontil (Trimipramine) |
| <input type="checkbox"/> Concerta, Daytrana TD Patch,
Metadate | <input type="checkbox"/> Noctec (Chloral hydrate) | <input type="checkbox"/> Tenex (Guanfacine) |
| <input type="checkbox"/> Cymbalta (Duloxetine) | <input type="checkbox"/> Norpramin (Desipramine) | <input type="checkbox"/> Tofranil (Imipramine) |
| <input type="checkbox"/> Dalmane (Flurazepam) | <input type="checkbox"/> Pamelor (Nortriptyline) | <input type="checkbox"/> Tranxene (Clorazepate) |
| <input type="checkbox"/> Desyrel (Trazodone) | <input type="checkbox"/> Parnate (Tranylcypromine) | <input type="checkbox"/> Unisom (Doxylamine) |
| <input type="checkbox"/> Dexedrine
(Dextroamphetamine) | <input type="checkbox"/> Paxil (Paroxetine) | <input type="checkbox"/> Valium (Diazepam) |
| <input type="checkbox"/> Effexor (Venlafaxine) | <input type="checkbox"/> Pristiq (Desvenlafaxine) | <input type="checkbox"/> Vistaril, Atarax (Hydroxyzine) |
| <input type="checkbox"/> Elavil (Amitriptyline) | <input type="checkbox"/> ProSom (Estazolam) | <input type="checkbox"/> Vivactil (Protriptyline) |
| <input type="checkbox"/> ENSAM Transdermal Patch
(Selegiline) | <input type="checkbox"/> Provigil | <input type="checkbox"/> Vyvanse (Lisdexamfetamine) |
| <input type="checkbox"/> Focalin (Dexmethylphenidate) | <input type="checkbox"/> Prozac, Sarafem (Fluoxetine) | <input type="checkbox"/> Wellbutrin, Zyban (Bupropion) |
| | <input type="checkbox"/> Remeron (Mirtazapine) | <input type="checkbox"/> Xanax (Alprazolam) |
| | <input type="checkbox"/> Restoril (Temazepam) | <input type="checkbox"/> Zoloft (Sertraline) |
| | <input type="checkbox"/> Ritalin (Methylphenidate) | |

