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

☐Bariatric surgery clearance
☐Other surgical clearance
☐Gender affirmation evaluation
☐Counseling or Therapy
☐Substance Abuse Treatment
☐Psychiatric diagnosis/ medication management/ treatment

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

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

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 of 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:

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