STARFISH EXPERIENCE INC.

SHEILA. KAMINSKI, LCSW •
NJ LCSW: 44SC043877000
Psychotherapy and Counseling

Telephone: 201-594-9900

MENTAL HEALTH INTAKE FORM

Name:_____ Date:_____

Date of Birth:_____ Primary Care Physician:_____

Do you give permission to have your PCP receive updates? ( ) Yes ( ) No

What are the problems for which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals?

1. _____
2. _____
3. _____

Current symptoms checklist: (Check once for any symptoms present, twice for major symptoms)

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

SUICIDE 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 f**eel as if 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, (10 being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought of 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: _____

_____

FAMILY BACKGROUND AND CHILDHOOD HISTORY

Were you adopted? ( ) Yes ( ) No Where did you grow up? _____

List your siblings and their ages: _____

_____

What was your father's occupation? _____

What 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: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

TRAUMA HISTORY

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No

If yes, please describe at what age(s), where and by whom: _____

_____

_____

_____

EDUCATIONAL HISTORY

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____ When? _____

OCCUPATIONAL HISTORY

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

Occupation: _____ How long in present position? _____

Where do you work? _____

Have you served in the Military? ( ) Yes ( ) No Honorable Discharge? ( ) Yes ( ) No

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? _____

Are you sexually active? ( ) Yes ( ) No

How would you describe your sexual orientation? _____

( ) Straight/heterosexual ( ) lesbian/gay/homosexual ( ) Bisexual ( ) Transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

_____

_____

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

Do you have any children? ( ) Yes ( ) No If yes, list ages and genders: _____

_____

_____

_____

Describe your relationship with your children: _____

_____

_____

_____

List everyone who lives with you: _____

_____

SUBSTANCE USE:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, which substances? _____

_____

_____

If yes, where were you treated and when? _____

_____

Have you ever attended a 12 step program? ( ) Yes ( ) No

LIST ALL CURRENT PRESCRIPTION MEDICATIONS:

*_____ *_____

*_____ *_____

*_____ *_____

*_____ *_____

PAST PSYCHIATRIC HISTORY:

OUT-PATIENT TREATMENT ( ) Yes ( ) No IF YES:

Reason Dates treated By whom

_____

_____

_____

_____

IN-PATIENT TREATMENT ( ) Yes ( ) No IF YES:

Reason Dates treated By whom

_____

_____

_____

_____