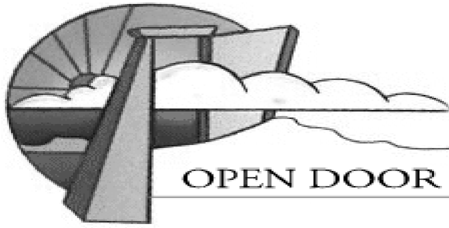
CONFIDENTIAL



Behavioral Health Intake Form

Patient Name:	DOB:
Parent or Guardian:	MR #: (for NCC use)
Phone Number:	Today's Date:
Primary Care Provider:	

1.	Please list the symptoms or concerns that you or your doctor have that brings you into Behavioral Health Services.	
2.	Please list any previous Psychiatrist or counselors you have seen. Please state why you were seen and how long.	
3.	Please list who lives in your home with you.	
4.	Please list other close family members and where they live.	
5.	Please list where you are currently employed or how you support yourself.	
6.	Please list your current medications.	

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ODCHC Form 621.6 (9/05)

7.	Please list any other substances or alcohol that you have used.	

Please fill in the dots or circle answers and provide explanations where needed.

1.	Have other people commented on changes in your mood or behavior?	O Yes	O No
2.	Do you experience sadness, hopelessness, fatigue, changes in sleep, appetite or social habits? (If yes, circle all that apply)	O Yes	O No
3.	Do you have thoughts of hurting yourself?	O Yes	O No
4.	Have you ever hurt yourself before?	O Yes	O No
If yes, please explain:			
5.	Have you ever been hospitalized for mental health reasons?	O Yes	O No
If yes, please explain:			
6.	Have you had thoughts of hurting other people?	O Yes	O No
If yes, please explain:			
7.	Have you ever been in prison or arrested?	O Yes	O No
If yes, please explain:			
8.	Do you experience anxiety, worry, fears, or panic attacks? (If yes, circle all that apply)	O Yes	O No
9.	Do you experience obsessive / recurrent thoughts or behaviors (such as having to check locked doors several times or counting things many times)?	O Yes	O No
10.	Have you ever had an eating disorder?	O Yes	O No
If yes, please explain:			

11.	**Do you experience racing thoughts, excess energy, sleeplessness, or irritability? (If yes, circle all that apply)**	○ **Yes**	○ **No**
12.	**Have you ever seen or heard things other people don't?**	○ **Yes**	○ **No**
13.	**Do you have difficulty expressing yourself because your thoughts are scattered or disorganized?**	○ **Yes**	○ **No**
14.	**Do you have close friends that you spend time with?**	○ **Yes**	○ **No**
15.	**Do you have frequent conflicts with others?**	○ **Yes**	○ **No**
16.	**Do you have any medical problems that impact your functioning?**	○ **Yes**	○ **No**
17.	**Do you experience any significant life stressors such as financial, safety, housing, unemployment, divorce, or custody issues?**	○ **Yes**	○ **No**
If yes, please explain.			
18.	**Have you ever experienced something you consider traumatic?**	○ **Yes**	○ **No**
If yes, please explain.			
19.	**Is there any other information related to your referral to Behavioral Health Services that may be important?**		
20.	**List 3 goals you would like to work on in Behavioral Health Services:**		

Thank you! Do not write below this line.

BHC Comments:

Observations:

Plans:

Behavioral Health Consultant: ____ **Date:** _________