**JH TREAT Depression Clinic Intake Form for New Patients**

*Please fill out all applicable parts of this form and e-mail to JHTREATDC@jhmi.edu or fax to 443-769-1217. Please attach additional sheets if necessary.*

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact (name and number):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for coming in for evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family Psychiatric History**

|  |  |  |
| --- | --- | --- |
| Family Member: | Current age or age at death (specify year and cause of death, if known): | Please list any problems with mental health or substance abuse: |
| Father |  |  |
| Mother |  |  |
| Sibling (provide name) |  |  |
| Sibling (provide name) |  |  |
| Sibling (provide name) |  |  |
| Sibling (provide name) |  |  |

Has there been any mental illness, substance abuse, or suicide in your extended family? If so, please provide details here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Personal History**

Where were you born and raised?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your family's ethnic background?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any problems with your birth, development, or childhood health (please specify)?\_\_\_

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Were there any problems at home when you were growing up (please specify)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been sexually, physically, or emotionally abused? If so, please specify and give dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How far have you gone is school so far? Please list all degrees, including date received, major, and institution from which you graduated. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did you ever repeat a grade or require special education?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you ever suspended or expelled from school, or did you get into any other significant trouble at school?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you get into any trouble outside of school (fights, fire setting, cruelty to animals, theft, etc.)?

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What jobs have you had in the past, and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you working or in school now? If so, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your current sources of financial support?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you live alone? If not, with whom do you live?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been married? If so, give dates of marriage and (if relevant) separation/divorce:\_

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If you've had any relationship problems, including sexual problems, please specify:\_\_\_\_\_\_\_\_\_\_\_

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Please list your closest supports (friends, family, caretakers), if any:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been pregnant? If you terminated one or more pregnancies, please specify dates. If you have children, please list their names and ages and specify if they have any physical or mental health problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever had problems with the law (please specify)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any financial problems, such as debt?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a religion, and if so, how important is it to you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any hobbies or activities that give you pleasure:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical History**

Please list current and past medical problems (with dates), including history of seizures, head trauma, or loss of consciousness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list names and doses of all current medications, including over-the-counter or herbal:\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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For women only, please give date of last menstrual period and specify whether your periods are regular, whether they are associated with any pain, and whether they are associated with any changes in your mood . If you are on a birth control pill, please specify which one and indicate whether it has any effect on your mood:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any drug allergies (including your reaction to the drug):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any of the following problems or tests you have had in the last year. If given a choice (weight loss or gain, e.g.), please circle applicable symptom(s). Where appropriate, please indicate what body part was tested (X-ray: chest, e.g.).

|  |  |  |
| --- | --- | --- |
| [ ] Fatigue  | [ ] Fever | [ ] Weight loss or gain  |
| [ ] Night sweats  | [ ] Enlarged lymph nodes  | [ ] Heat or cold intolerance  |
| [ ] Excessive urination  | [ ] Excessive thirst  | [ ] Excessive appetite  |
| [ ] Hair loss  | [ ] Vision problems  | [ ] Light hurts your eyes |
|  [ ] Hearing problems  | [ ] Ear pain or discharge  | [ ] Severe nosebleeds  |
| [ ] Mouth ulcers  | [ ] Persistent hoarseness  | [ ] Daily cough  |
| [ ] Shortness of breath | [ ] Asthma/wheezing  | [ ] Chest pain/discomfort |
| [ ] Skipped/irregular heartbeat  | [ ] Fainting episode/black-out | [ ] Swollen legs or feet  |
| [ ] Leg pain with walking  | [ ] Difficulty swallowing | [ ] Heartburn |
| [ ] Frequent belly pain | [ ] Abdominal bloating | [ ] Nausea and/or vomiting |
| [ ] Diarrhea  | [ ] Constipation  | [ ] Change in bowel habits |
| [ ] Blood in stool  | [ ] Black or tarry stools  | [ ] Light or clay-colored stools  |
| [ ] Loss of appetite  | [ ] Jaundice (yellow skin or eyes)  | [ ] Trouble urinating  |
| [ ] Blood in urine |  [ ] Dark or cola-colored urine |  [ ] Abnormal vaginal bleeding |
| [ ] Missed menstrual periods  | [ ] Vaginal/penile discharge | [ ] Anemia  |
| [ ] Easy bruising or bleeding | [ ] Persistent rash or itching  | [ ] Moles with changed appearance  |
| [ ] Lump or swelling of testicle  | [ ] Breast lump or new discharge  | [ ] Joint or muscle pain  |
| [ ] Limb weakness  | [ ] Persistent loss of sensation/numbness  | [ ] Headaches  |
| [ ] Dizzy spells  | [ ] Memory problems  | [ ] Coordination problems  |
| [ ] Seizures  | [ ] X-Ray of:  | [ ] CT scan of:  |
| [ ] MRI of:  | [ ] EKG  | [ ] EEG  |
| [ ] Other: | [ ] Other: |  |

Please list past surgeries (including dates):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list names and numbers for all your doctors, including specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Substance History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Substance: | Current use (specify amount/frequency): | Maximum use (specify dates): | Last use: | Age of onset: | Have you ever tried to quit? |
| Alcohol |  |  |  |  |  |
| Nicotine |  |  |  |  |  |
| Caffeine |  |  |  |  |  |
| Marijuana |  |  |  |  |  |
| Other street drug (please specify) |  |  |  |  |  |
| Other street drug (please specify) |  |  |  |  |  |

**Past Psychiatric History**

|  |  |  |
| --- | --- | --- |
| Approximate Dates of Past Outpatient Mental Health Treatment | Names and contact information (if available) of past providers | Your symptoms at the time |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Approximate Dates of Past Psychiatric Hospitalizations | Name of hospital | Reason for admission |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Approximate Dates of Past Emergency Room Visits for Mental Health | Name of Hospital | Reason for visit |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Approximate Dates of Past Treatment with Psychiatric Medication | Name and dose of medication | How well did the medicine work for you (please include benefits and side effects)? |
|  |  |  |
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Have you ever intentionally hurt yourself before? If so, please give approximate dates and describe what you did: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever attempted suicide before? If so, please give approximate dates and describe what you did:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been violent toward another person or intentionally hurt a person or pet before? If so, please give approximate dates, and describe what you did:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have access to a gun or other means to kill or injure yourself or another person? If so, what do you have, and where is it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently having any thoughts of hurting or killing yourself or someone else? If so, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Please respond yes or no to the following questions:*

Have you ever experienced 2 weeks or more of sad mood or emotional numbness and changes in your energy level, self-attitude, sleep, appetite, concentration, or ability to experience pleasure?

Have you ever had thoughts of suicide or of not wanting to go on with life?

Have you ever experienced a few days or more during which you’ve had remarkably more energy than usual and have felt that you could get by on less sleep?

Do you experience intrusive thoughts or images that you recognize as being absurd or extreme, but that keep coming into your head like a broken record?

Do you repeatedly engage in any mental or physical action that you recognize as being absurd or extreme, but that you feel you need to do in order to prevent harm or distress?

Do you have any extreme fears that cause you to avoid the things or situations that you fear?

Have you ever had the sudden onset of the following symptoms: shortness of breath, racing heart, nausea, dizziness, sweating, feeling that things are unreal, fear of dying or going crazy?

Have you ever experienced a traumatic situation such as sexual or physical abuse, a natural disaster, an accident, or other terrifying experience?

If you’ve experienced a traumatic situation in the past, does it affect your life today?

Have you ever heard sounds or seen things that were hard to explain?

Have you ever worried that people are out to get you, or that you’re guilty of something terrible?

Do you have concerns about your weight or body image?

Have you ever restricted calories, binged, induced yourself to vomit, or used diuretics or laxatives?

**Sleep Quality**

Do you have difficulty falling or staying asleep?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other problems with sleep\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you snore?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you excessively sleepy during the day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personality**

How would you describe your personality?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How would others describe you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Goals for treatment**

What do you hope I can do for you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What goals do you have for the future?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***THANK YOU FOR COMPLETING THIS FORM!***