Please Read:

Thank you for your interest in TAN Behavioral Health Services. Unfortunately, we cannot serve everyone who seeks care with us due to limitations on the number of people we can serve, whether the nature of the care needed exceeds our capacity or expertise, and for similar reasons. Mental health care is a very limited resource, and our team of providers has limited appointment availability. You may have a condition that our current staff cannot treat in a manner deemed most beneficial to you. Sometimes referrals are a better option.

For us to determine if our services are in sync with your needs, please fill out the attached information packet. The health history you provide will help our team of providers to determine the nature and acuity of your needs, as well as whether the services we offer address your needs and whether we have current availability to offer those services promptly.
This preliminary assessment is required to determine if you will be accepted for TAN Behavioral Health services. Please be as thorough as possible when completing this intake packet. Leaving sections of this form blank or providing limited information could result in your request for services being denied due to insufficient information.

If it is determined that TAN Behavioral Health has the staff and availability to address your mental health needs, then you will be contacted for scheduling with our eligibility and scheduling staff. The information collected in this intake packet would then be considered part of your initial evaluation, which in turn, would feed into the comprehensive diagnostic and treatment planning evaluation, which gathers more complete information to allow a full diagnosis and adequate basis for treatment plan development.

NOTE: WE MAY NOT CONTINUE YOUR CURRENT MEDICATIONS.
Thank you again for considering the Lester Daigle Behavioral Health Team at TAN. We will contact you shortly to let you know if we will be able to accept you as a patient with us. We may not be able to notify you regarding your acceptance for one or two weeks, so we encourage you to continue to check on other resources in the meantime.
Sincerely,

Lester Daigle Behavioral Health Services Team

PLEASE NOTE ARE WE ARE NOT AN EMERGENCY SERVICE. IF YOU OR SOMEONE YOU KNOW IS EXPERIENCING A MENTAL HEALTH EMERGENCY, PLEASE GO TO THE NEAREST EMERGENCY ROOM FOR EVALUATION.

Intake Questionnaire for New Patients (Adult)

This questionnaire is for the purpose of getting to know you better to provide the best possible mental health services.
Please complete this form as honestly and completely as possible.
All information that you provide us will be confidential as required by state and federal law.

Date: ______________________ **Social Security Number**: __________________________

Name: _____________________ **Date of Birth**: _______________ **Age**: _________

Home Address: ___________________________ **City/State/Zip code**: _______________________

Home Phone: _____________________________ **Cellular/Alternate Phone**: _________________

Marital Status: single married separated divorced remarried engaged widowed cohabiting

If applicable, please complete the following:
Partner's Name: ___________________ **Partner's Age**: _______

Partner's Occupation: ____________________

IF YOU HAVE CHILDREN, PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

____
____
____
____
____

How long has this been going on? ______________________________
____
____

What made you come in at this time? ______________________________

Initials: ___________ *DOB:* ___________

What do you hope to gain from this evaluation and/or counseling?

___

___

___

If you had difficulties in the past, what have you done to cope? Was it helpful?

___

___

___

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

- [ ] Difficulty falling asleep
- [ ] Difficulty staying asleep
- [ ] Difficulty getting out of bed
- [ ] Not feeling rested in the morning

Average hours of sleep per night: __________

- [ ] Persistent loss of interest in previously enjoyed activities
- [ ] Withdrawing from other people
- [ ] Spending increased time alone
- [ ] Depressed Mood
- [ ] Feeling Numb
- [ ] Rapid mood changes
- [ ] Irritability
- [ ] Anxiety
- [ ] Panic attacks
- [ ] Frequent feelings of guilt
- [ ] Avoiding people, places, activities or specific things
- [ ] Difficulty leaving your home
- [ ] Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: ____________________
- [ ] Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- [ ] Outbursts of anger

- [ ] Worthlessness
- [ ] Hopelessness
- [ ] Sadness
- [ ] Helplessness
- [ ] Fear
- [ ] Feeling or acting like a different person

- [ ] Changes in eating/appetite
- [ ] Eating more
- [ ] Eating less
- [ ] Voluntary vomiting
- [ ] Use of laxatives
- [ ] Excessive exercise to avoid weight gain
- [ ] Binge eating
- [ ] Are you trying to lose weight? ______
- [ ] Weight gain: ________lbs
- [ ] Weight loss: ________lbs.

- [ ] Difficulty catching your breath
- [ ] Increase muscle tension
- [ ] Unusual sweating
- [ ] Easily started, feeling “jumpy”
- [ ] Increased energy
- [ ] Decreased energy
- [ ] Tremor
- [ ] Dizziness
- [ ] Frequent worry
- [ ] Physical sensations others don’t have
- [ ] Racing thoughts
- [ ] Intrusive memories

Initials: ___________ ***DOB:*** ___________

- [ ] Difficulty concentrating or thinking
- [ ] Large gaps in memory
- [ ] Flashbacks
- [ ] Nightmares
- [ ] Thoughts about harming or killing yourself
- [ ] Thoughts about harming or killing someone else

- [ ] Feeling as if you were outside yourself, detached, observing what you are doing
- [ ] Feeling puzzled as to what is real and unreal
- [ ] Persistent, repetitive, intrusive thoughts, impulses, or images
- [ ] Unusual visual experiences such as flashes of light, shadows
- [ ] Hear voices when no one else is present
- [ ] Feeling that your thoughts are controlled or placed in your mind
- [ ] Feeling that the television or the radio is communicating with you
- [ ] Difficulty problem solving
- [ ] Difficulty meeting role expectations
- [ ] Dependency on others
- [ ] Manipulation of others to fulfill your own desires
- [ ] Inappropriate expression of anger
- [ ] Self-mutilation/cutting
- [ ] Difficulty or inability to say "no" to others
- [ ] Ineffective communication
- [ ] Sense of lack of control
- [ ] Decreased ability to handle stress
- [ ] Abusive relationship
- [ ] Difficulty expression emotions
- [ ] Concerns about your sexuality

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

____
____
____
____

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

☐ No ☐ Yes If so:

Name of therapist: ______________________ Dates of Treatment
Reason for seeking help: ______________________ ______________________

Name of therapist: ______________________ Dates of Treatment
Reason for seeking help: ______________________ ______________________

Name of therapist: ______________________ Dates of Treatment
Reason for seeking help: ______________________ ______________________

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Initials: ___________ *DOB:* ___________

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	Dosage	How long have you been taking it?

Have you been on **PSYCHIATRIC** medication in the past? ☐ No ☐ Yes If YES, please list:

Medication	Dosage	First/Last time you took it	Effect of Medication

Have you been hospitalized for psychiatric reasons? ☐ No ☐ Yes If YES, describe:

Hospital	Dates	Reason

Have you ever attempted suicide? ☐ No ☐ Yes If YES, describe:

____

____

Any past suicidal thoughts and/or ideas? ☐ No ☐ Yes If YES, describe:

____

MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition? ☐ No ☐ Yes If YES, describe:

____

____

____

____

List any PRIOR illnesses, surgeries and/or accidents

____

____

____

List any allergies:

____

____

***Initials:* ____________ *DOB:* ____________**

FAMILY HISTORY

Father: Age: ☐ Living ☐ Deceased Cause of death:
If deceased, HIS age at time of his death____ YOUR age at time of his death______
Occupation: ____________________________ Health: __________________________
Frequency of contact with him: ___________ Are you/Have you been close to him? ______

Mother: Age: ☐ Living ☐ Deceased Cause of death:
If deceased, HER age at time of his death___ YOUR age at time of his death______
Occupation: ____________________________ Health: __________________________
Frequency of contact with him: ___________ Are you/Have you been close to her? _______

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?			
					No		Yes
					No		Yes
					No		Yes
					No		Yes

During your childhood, did you live any significant period of time with anyone other than your natural parents?
☐ No ☐ Yes If so, please give the persona's name and relationship to you

Name: _________________________________ Relationship to you:_____________________________

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Alcohol Abuse/Misuse							
Drug Use							

SOCIAL HISTORY

Past Marital History

Have you been married previously?_______________If Yes, please describe

When?_____________________ How long? ________________________
When?_____________________ How long? ________________________

Initials: ___________ ***DOB:*** ___________

Education

Highest grade level completed: ___________
Degree obtained, if applicable: ___________
Did you have any disciplinary problems in school? ________
If yes, please explain: ____
Were you considered hyperactive/ADHD in school? ____________
If yes, were/are you on any medication? ________________
If yes, were/are you on any medication? ________________
If so, which medication? ______________________________
What kinds of grades did you get in school? ____________________

Have you served in the military? __________
If yes, please describe briefly: ____
____

What type of discharge (separation) did you get? ___________________________________

Employment

Are you currently employed? ___________________
If yes, employer's name: _______________________
What type of work do you do? _________________________

Employment History (most recent first)

Type of Job	Dates	Reason for Leaving

Have you been arrested? __________
If yes, please describe: ____

Do you have a religious affiliation? ______________
If yes, what is it? _______________________

What kind of social activities do you participate in? _______________________________

Who do you turn to for help with your problems? __________________________________

Have you ever been abused?
☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe: ____
____

Initials: ___________ ***DOB:*** ___________

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? ____________ If yes, age of first use _____________

How much do you drink? ____________________________

How often do you drink? ____________________________

Have you ever passed out from drinking? _______________ How often? _____________________

Have you ever blacked out from drinking? ______________ How often? _____________________

Have you ever had the "shakes"? ______________________ How often? _____________________

Have you ever felt you should cut down on your drinking/drug use? ________________________

Have people annoyed you by criticizing your drinking/drug use? ___________________________

Have you ever felt bad or guilty about your drinking/drug use? _____________________________

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? __________

Do you use tobacco? _____________

If yes, how often? ____________________________

Other Drugs:

Please indicate for each drug listed below

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?

____

____

____

____

____

____

____

____

Initials: ___________ ***DOB:*** ___________

The Holmes-Rahe Scale

Read each of the events listed below and **check the box** next to any even which has occurred in your life **in the last two (2) years.** There are no right or wrong answers. The aim is to identify which of these events you have experienced lately.

Life Events	Life Crisis Units	
Death of Spouse	100	
Divorce	73	
Marital Separation	65	
Gone to jail	63	
Death of close family member	63	
Personal injury or illness	53	
Marriage	50	
Fired at work	47	
Marital reconciliation	45	
Retirement	45	
Change in health of family member	44	
Pregnancy	40	
Sexual Difficulties	39	
Gain of new family member	39	
Business readjustment	39	
Change in financial state	38	
Death of a close friend	37	
Change to different line of work	36	
Increase in arguments with spouse	35	
Mortgage over $100,000	31	
Foreclosure of mortgage or loan	30	
Change in responsibilities at work	29	

Life Events	Life Crisis Units	
Son or daughter leaving home	29	
Trouble with in-laws	29	
Outstanding personal achievement	28	
Spouse begins or stops work	26	
Begin or end school	26	
Change in living conditions	25	
Revision in personal habits	24	
Trouble with boss	23	
Change in work hours or conditions	20	
Change in residence	20	
Change in schools	20	
Change in recreation	19	
Change in church activities	19	
Change in social activities	18	
Mortgage or loan less than $30,000	17	
Change in sleeping habits	16	
Change in number of family get-togethers	15	
Change in eating habits	15	
Vacation	13	
Christmas alone	12	
Minor violations of the law	11	

Your Total Score: ________

Initials: ___________ ***DOB:*** ___________