Well Nourished LLC
Integrative Psychiatry
Wellnourishedpsych.com

Phone: (720) 513-1215
Fax: (720) 547-6960
Address: 12157 W Cedar Dr. Suite 200 Lakewood, CO 80228

Client Demographics

Name: _____ Date:_____
Address: _____
City: _____
State: _____ Zip: _____

Telephone #: _____ Can this number receive texts? No / Yes
May we leave confidential voice-mail messages for you at any of the above numbers? No / Yes (specify): Home / Cell

Email Address: _____

Would you like appointment reminders by email? Yes / No
Would you like appointment reminders by text? Yes / No

Age: _____
Date of Birth: _____

What is your gender identity?: _____ Pronouns: _____

Place of Employment: _____
Occupation: _____
Marital Status: _____

Emergency Contact
Name: _____ Relationship: _____Phone #: _____

Insurance:
Plan: Medicaid / Self Pay / Commercial _____
ID#: _____
Group #: _____
Policy Holder's Name: _____

Primary Care Physician_____
Current Therapist/Counselor_____

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Mental Health Intake Form

*Please complete all information on this form and email to **office@wellnourishedpsych.com**

What are the problem(s) for which you are seeking help?

What are your treatment goals?

Current Symptoms Checklist:

Depressed mood	Increase risky behavior	Change in appetite
Racing thoughts	Avoidance	Excessive energy
Excessive worry	Loss of interest	Excessive guilt
Unable to enjoy activities	Increased or decreased libido	Increased irritability
Impulsivity	Hallucinations	Fatigue
Anxiety attacks	Concentration/forgetfulness	Crying spells
Sleep pattern disturbance	Suspiciousness	

Other:

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Suicide Risk 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 feel that 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?

Do you feel hopeless and/or worthless?

Have you ever tried to kill or harm yourself before?

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Medication History:

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

Current over-the-counter medications or supplements:

Current medical problems:

Past medical problems, nonpsychiatric hospitalization, or surgeries:

Lifestyle:

Your Exercise Level: Do you exercise regularly? Yes / No

How many days a week do you get exercise?

What kind of exercise do you do?

How would you describe your diet?

Any history of Eating Disorder? Yes / No

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Past Psychiatric History:
Outpatient treatment Yes / No If yes, Please describe when, by whom, and nature of treatment.

Psychiatric Hospitalization Yes / No If yes, describe for what reason, when and where.

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

Bipolar disorder Yes / No
Schizophrenia Yes / No
Depression Yes / No
Post-traumatic stress Yes / No
Anxiety Yes / No
Alcohol abuse Yes/ No
Anger Yes / No
Substance abuse Yes / No
Suicide Yes / No
Violence Yes / No

Other:

If yes, who had each problem?

Has any family member been treated with psychiatric medication? Yes / No If yes, who was treated, what medications did they take, and how effective was the treatment?

Substance Use: Have you ever been treated for alcohol or drug abuse? Yes / No

If yes, for which substances?
If yes, where were you treated and when?

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For women only:

Date of last menstrual period:

Are you currently pregnant or do you think you might be pregnant? Yes / No
Are you planning to get pregnant in the near future? Yes / No

How many times have you been pregnant?

How many live births?