INSTRUCTIONS

Please download this form to your computer and complete all information that pertains to you. If it does not apply to you, skip the question. Once completed, email a digital copy of the form to:

revstacie@maturingthroughthewordllc.com

Or print the completed form and fax it to:
Fax: 651-389-9396

Payment for counseling sessions can be made in person, through Apple Pay, or in the Store section tab of the website.

Questions? Please call toll-free:
Phone: 1-800-974-8208

MATURING THROUGH THE WORD, LLC™
MENTAL HEALTH INTAKE FORM

Please complete all information on this form and email it back to:
revstacie@maturingthroughthewordllc.com

Date

First Name

Last Name

Phone Number

Email

Street Address

City

State

Zip Code

Date of Birth

What are the problems you are currently facing?

1.

2.

3.

What are your treatment goals?

1.

2.

3.

4.

Who recommended you to Maturing Through The Word, LLC?

CURRENT SYMPTOMS CHECKLIST

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

SUICIDE RISK ASSESSMENT

Have you ever had feelings or thoughts that you no longer wanted to live? _____

If YES, please answer the following. If NO, please skip to the next section.

How often do you have these thoughts? _____

When was the last time you had these thoughts? _____

Has anything happened recently to make you feel this way? _____

If YES, briefly explain _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?

1	2	3	4	5	6	7	8	9	10

Have you ever thought about 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 or weapons? If YES, please explain below

PAST MEDICAL HISTORY

List ALL current prescription medications and how often you take them

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements

Medication Name	Total Daily Dosage	Estimated Start Date

Please list/explain current medical problems

Please list/explain past medical problems, non-psychiatric hospitalization, or surgeries

FAMILY MEDICAL HISTORY

Is there any additional personal or family medical history?

PAST PSYCHIATRIC HISTORY

If you have had psychiatric treatment please describe reason, when, by whom, and nature of treatment.

If you have had Psychiatric Hospitalization describe for what reason, when and where.

YOUR EXERCISE LEVEL

Do you exercise regularly?

How often do you exercise?

How much time do you spend when you exercise?

What kind of exercise(s) do you do?

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family been diagnosed with or treated for mental health?

SUBSTANCE USE

Have you ever been professionally treated for alcohol or drug use or abuse?

If yes, for which substances?

Where were you treated and when?

How many days per week do you drink any alcohol?

What is the least number of drinks you will drink in a day?

What is the most number of drinks you will drink in a day?

In the past year, what is the largest amount of alcohol you have consumed in one day?

Have you ever felt you ought to cut down on your drinking or drug use?

Have people annoyed you by criticizing your drinking or drug use?

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

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

Do you think you may have a problem with alcohol or drug use?

Have you used any street drugs in the past 3 months?

If yes, which ones?

Have you ever abused prescription medication?

If yes, which ones and for how long?

How many caffienated beverages do you drink a day?

FAMILY BACKGROUND AND CHILDHOOD HISTORY

Were you adopted? Where did you grow up?

Did your parents' divorce? 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 first moved out from home?

TRAUMA HISTORY

Have you ever been abused emotionally, sexually, physically or by neglect?

If yes, describe when, where and by whom