Truesdale Medical Center Mental Health Intake Form

Thank you for choosing Truesdale for your mental health care. Please complete this form to the best of your ability, using the back side for extra space if needed. If there are any answers that you would prefer to discuss in person, please indicate using an * in the answer space. TMC is a person-positive practice. This means we do not make efforts to overly pathologize, shame, or minoritize your personal experience. Please feel invited to bring your whole self to your sessions.

Name you use: _____ Is this your legal name? ☐Yes☐No

Phone _____ Can we leave voicemails?☐Yes☐No Can we text? ☐Yes☐No

Pronouns _____ Email _____

What brings you to therapy at this time?

_____

What are your goals or hopes for therapy?

_____

Have you seen a mental health professional before?☐Yes☐No If yes, was it a good experience?

_____

Specify all medications and supplements you are presently taking, or write "see chart" if you are an established TMC patient.

_____

If taking prescribed medication, who is your prescribing MD?
Please include doctor name and phone number. If your prescriber is in our office, simply write "TMC."

_____

Who is your primary care physician? Please include physician's name and phone number. If in our office, simply write "TMC."

_____

Do you drink alcohol and/or use recreational drugs? If so, please describe.

_____

What is your level of education? Highest grade/degree and type of degree.

_____

If you are in a relationship, please describe the nature of the relationship and time together.

_____

 LAST NAME: _____

Describe your current living situation.

_____

Do you have a documented disability?

_____

Have you ever been hospitalized for a mental health condition?

_____

Is there a history of mental health concerns in your family? If so, please describe.

_____ ☐

Please circle any symptoms or experiences that you have had in the last six months:

☐ Difficulty falling asleep	☐ Difficulty staying asleep `	☐ Difficulty getting out of bed
☐ Not feeling rested in the morning	☐ Loss of interest in activities	☐ Withdrawing from other people
☐ Spending increased time alone	☐ Depressed Mood	☐ Feeling Numb
☐ Rapid mood changes	☐ Irritability	☐ Anxiety
☐ Panic attacks	☐ Frequent feelings of guilt	☐ Fear of leaving home
☐ Fear of certain objects or situations	☐ Avoiding certain people or places	☐ Outbursts of anger
☐ Worthlessness	☐ Repetitive behaviors	☐ Intrusive thoughts
☐ Sense of helplessness	☐ Feeling like a different person	☐ Changes in eating/appetite
☐ Binging and purging	☐ Use of laxatives	☐ Excessive exercise
☐ Difficulty catching breath	☐ Increased muscle tension	☐ Easily startled or irritated
☐ Decreased energy	☐ Increased energy	☐ Difficulty controlling spending
☐ Obsessions	☐ Trauma responses	☐ Dizziness
☐ Unexplained physical sensations	☐ Lack of need for sleep	☐ Feeling "wired"
☐ Feeling detached from yourself	☐ Unusual visual experiences	☐ Unusual audio experiences
☐ Paranoias	☐ Difficulty completing tasks	☐ Difficulty meeting expectations
☐ Dependency on others	☐ Manipulation of others	☐ Non-suicidal self-injury
☐ Excessive skin picking/popping	☐ Inability to say "no"	☐ Fear of negative reactions of others
☐ Difficulty handling stress	☐ Abusive relationship	☐ Difficulty expressing emotion

Other symptoms not listed:

_____

Do you feel safe at home? ☐ Yes ☐ No Have you felt unsafe at home before? ☐ Yes ☐ No Please explain as you are able:

_____

What are your social and hobby activities?

_____

What are three strengths you have?

_____

What else would you like me to know?

_____

 LAST NAME: _____

Do you currently have an intent to harm yourself or someone else or are you experiencing similar urges?

_____

Please indicate that you understand, or please address any questions or concerns in session:

- ☐ At TMC, mental health conditions are treated with an intention to work toward management of symptoms and, when possible, recovery. You can and should expect support and encouragement toward these goals.
- ☐ Sessions are scheduled at the beginning of an hour and typically last 45-50 minutes. Intake sessions are typically structured as to give you and your provider an opportunity to cover necessary information.
- ☐ If you have a chart at TMC already, it will be referenced as needed, but not necessarily before your first session.
- ☐ If you are using insurance to pay for your sessions, your provider may be required to assign a diagnosis and create a treatment and discharge plan.
- ☐ Some concerns or diagnoses, substance use, and specific needs are best met by additional or other providers. Your provider may refer you to a higher level of care in addition to or instead of your care at TMC, or may refer you to a provider who specializes in your areas of concern. This is part of your provider's ethical obligation to provide the best possible care.
- ☐ Some periodic assessments may be conducted to help your provider best serve you.
- ☐ Your provider will keep progress notes in your chart and may also take session notes that are recorded separately.
- ☐ Your provider's ability to speak on your behalf to outside parties such as employers is addressed on a case-by-case basis
- ☐ Your provider may be required to supply records if they are subpoenaed by court.
- ☐ Records for minors 15 and under are legally accessible by legal guardians. Your provider has a responsibility to manage this sensitively and inquisitively.
- ☐ Minors who are 16 or older can consent to confidential mental health care without access by legal guardians to session content or progress and session notes.
- ☐ Patients 16 years and older who have a legal guardian or third party as their financial guarantor should understand that charges, EOBs, and session dates/times/lengths will necessarily be disclosed to these parties.
- ☐ The No Surprises Act of 2021 means that you have the right to be informed of treatment costs. Please discuss with our administrative staff if you do not already understand your financial obligation prior to your first appointment.
- ☐ Your provider may consult with your primary care physician or other providers you disclose. Please indicate here with your initials if you DECLINE this consultation between your providers. _____
- ☐ You agree not to misrepresent symptoms or conditions in an effort to benefit yourself or someone else, or to discredit your provider or Truesdale Medical Center.
- ☐ Your provider is required to notify authorities if you disclose an intention to harm yourself or someone else, or if you disclose known current abuse or neglect of a minor or vulnerable adult.

Signature _____ Date _____

Print Legal Name _____