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INTAKE HISTORY

Name: _____ **Date:** _____

1. MENTAL HEALTH HISTORY

Do you currently have a **therapist**? No Yes – name and phone number:

Have you ever received **outpatient mental health treatment**? No Yes – explain (starting with the most recent) :

Dates	Provider	For What Problem
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Have you ever been **hospitalized** for a mental health related issue? No Yes – explain:

Have you ever felt **suicidal**? No Yes – explain:

Have you ever made a **suicide attempt**? No Yes – describe:

Have you ever deliberately **injured yourself**? No Yes – describe:

Have you ever **injured someone else**? No Yes – describe:

Have you taken any **psychiatric medications in the past?** No Yes. If yes:

Medication	Dose/ Frequency	Dates Taken	Side Effects	Benefits
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2. FAMILY HISTORY

Indicate which blood relatives who have suffered from the following:

Depression _____

Bipolar disorder _____

Anxiety _____

Obsessive/compulsive behavior _____

Schizophrenia or psychosis _____

Suicide or suicide attempt _____

Drug or alcohol problems _____

Memory loss/dementia _____

Other emotional disturbance (describe) _____

Medical diseases that run in your family _____

3. MEDICAL HISTORY

Do you have a **regular medical doctor?** No Yes - name, clinic, and phone number:

Date and reason for last visit:

Date of last blood tests:

Do you see any **medical specialists** or **alternative providers**? No Yes – list names, specialties and what you are being treated for:

Date and reason for last visit(s):

Please briefly describe any **medical problems, current or past that have required treatment** by a doctor or other provider:

Major illnesses/Surgeries:

Minor Illnesses:

Have you ever had a **seizure** or **head injury**? No Yes – explain:

Do you have any **medication allergies**? No Yes – explain:

What method of **contraception** are you using now? _____

Are you currently **sexually active** with others? _____

When sexual, are you active with men, women or both? _____

4. CURRENT PHYSICAL SYMPTOMS/REVIEW OF SYMPTOMS:

Please circle any of the following symptoms that are bothering you currently, or that have been a recent problem:

- | | | | | | |
|--------------------------|-----------------|-----------|---------------------|----------------|----------|
| Shortness of breath | Nausea/vomiting | Fever | Chest pain | Weight gain | Weakness |
| Weight loss | Palpitations | Diarrhea | Blood in stool | Headaches | Tremors |
| Difficulties w/urination | Fatigue | Back pain | Joint pain | Blood in urine | |
| Night sweats | Abdominal pain | Dizziness | Swollen lymph nodes | | |

Other physical symptoms: _____

Have you even been diagnosed with a **chemical dependency** or **alcoholism**? No Yes – describe when and what treatment you have had:

Have you ever been **arrested**, or had any **legal charges** filed against you? No Yes – explain:

Are there any **weapons** kept in your home? No Yes – explain:

6. PERSONAL AND SOCIAL HISTORY

Childhood:

Where were you born and raised?

How many siblings do you have? What are their names and ages?

When you were growing up, were your parents together separated or divorced?

Briefly describe your childhood:

What was school like for you?

Have you ever suffered abuse (physical, sexual or emotional) in childhood, or as an adult?

No Yes – describe:

Adulthood:

Which cities and states have you lived in?

What jobs have you held?

Describe your key relationships:

Current

Describe your living situation:

If you have a spouse or partner, what is his/her name? Briefly describe him or her and your relationship:

If you have children, what are their names and ages?

If you are currently working, where are you working and what is your job?

What are your goals for treatment?