To help us provide the best treatment for you, please answer the questions on this form and return it to the clinic as soon as possible to assist us with scheduling your first appointment.

Name: ___________________________________________________Date:_________________________
Address: ___________________________________________________________________________________
Phone: ________________________________________Email: ____________________________________
DOB: ________________________________________ Sex: ______________________________________
Primary Physician:______________________________ Phone:____________________________________

Current Therapist:______________________________ Phone:____________________________________

**Complaint**

What is your major complaint?________________________________________________________________
Start Date:__________________ Have you previously suffered from this complaint?__________________
Previous therapist(s) seen for complaint:_________________________________________________________
Previous treatment for complaint:_______________________________________________________________
Aggravating Factors:___________________________________________________________________________
Relieving Factors:_____________________________________________________________________________

**Current Symptoms (Check All That Apply)**

| | | | |
|---|---|---|---|
| ☐Anxiety | ☐Hallucinations | ☐Irritability | ☐Risky Activity |
| ☐Appetite Issue | ☐Loss of Interest | ☐Panic Attacks | ☐Sleep Changes |
| ☐Avoidance | ☐Excessive Energy | ☐Racing Thoughts | ☐Suspiciousness |
| ☐Crying Spells | ☐Fatigue | ☐Guilt | ☐ |
| ☐Depression | ☐Impulsivity | ☐Libido Changes | ☐ |

**Medical History**

Exercise Frequency:__________________________________ Exercise Type (s):________________________
Allergies:_____________________________________________________________________________________
What medications are you currently using? _____________________________________________________
Previous diagnoses/mental health treatment:____________________________________________________
Previously treated by:__________________________________________________________________________
Previous medications:__________________________________________________________________________
Dates treated:_________________________________________________________________________________
Previous medical conditions:___________________________________________________________________
Previous surgeries:_____________________________________________________________________________

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**Family History**

Were you adopted?_______ If yes, at what age? _____________Foster care? _____ How long?________
How is your relationship with your mother? ______________________________________________
How is your relationship with your father? _______________________________________________
Siblings and their ages: ______________________________________________________________
Are your parents married?__________________ Divorced?______________________________________
Did your parents remarry?________________________ If yes? How old were you? _________________
If a patient is a minor under 18 years old and parents are divorced, who is medical decision maker?
_______________________________________________________________________________________
Who raised you? _______________________________ Where did you grow up? ____________________
If patient is a minor under 18 years old, school attending? __________________ grade ____________
special education?_______________________________________________________________________
Family member medical conditions:_______________________________________________________
Family member mental conditions:________________________________________________________
Treated with medication?_______________________________________________________________
Medications:_________________________________________________________________________

**Early Development**

How often did you move and where? ______________________________________________________
How old were you when you left home? ___________________________________________________
Have any immediate family members died? _________________ Who? __________________________
Have any completed suicide?________________________________ Who? ________________________
Describe any neglect you suffered, and by whom:___________________________________________
Trauma suffered and by whom:___________________________________________________________
Abuse suffered and by whom:____________________________________________________________
Highest education level completed:__________ Date completed and location:_____________________
Have you ever served in the military?_________ If yes, where?_________________________________
Date of service: _____________________________ Highest Rank achieved ________________________

**Present Situation**

Work: ☐Full-time ☐Part-time ☐Student ☐Unemployed ☐Disabled ☐Retired
Are you married?___________________________ If yes, date of marriage:________________________
Are you divorced?___________________________If yes, date of divorce:_________________________
Prior marriages?____________________________ If yes, how many?______________________________
What are your preferred pronouns? ______________

Patient Information

YUMA REGIONAL MEDICAL CENTER

Behavioral Health Intake Information Form
Department: Behavioral Health
C360#: 002486
Date: 12/23

To help us provide the best treatment for you, please answer the questions on this form and return it to the clinic as soon as possible to assist us with scheduling your first appointment.

How is your relationship with your partner?_____________________________________________________
Do you have children? _____________________Dates of Birth:_______________________________
How is your relationship with your child(ren)?_____________________________________________
List anyone else who lives with you: _____________________________________________________
Are you a member of a religion/spiritual group? ____________________________________________
What is your level of involvement? ________________________________________________________
Have you ever been arrested? _______________________ When and why?________________________
Are you under court ordered treatment? ___________________________________________________

**Have You Ever Tried the Following? (Check All That Apply)**

| | | | |
|---|---|---|---|
| ☐Heroin | ☐Methamphetamines | ☐ Cocaine | ☐ Stimulants (Pills) |
| ☐Ecstasy | ☐Methadone | ☐Tranquilizers | ☐Pain Killers |
| ☐Tobacco | ☐Marijuana | ☐Hallucinogens | ☐Alcohol |

If yes to any, list frequency/dates of use:
____________________________________________________
Have you ever been treated for drug/alcohol abuse? ___If yes, when? ____________________________
For which substances?______________________________________
Do you smoke cigarettes? _____If yes, how many per day? _______
Do you drink caffeinated beverages? ____If yes, how many per day? ____________________________
Have you ever abused prescription drugs?_____________ If yes, which ones?______________________

**Anything Else You Want the Doctor to Know**

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Signature** ________________________________________________ **Date** _______________________

**Legal Guardian Name** ______________________ **Signature**______________________ **Date**__________