Ferrell Hospital
DEACONESS ILLINOIS PARTNER
1201 Pine Street |
Eldorado IL 62930
Phone 618-273-3361 | Fax 618-273-2504

Behavioral Health Intake

Name: _____ Date:_____ Date of Birth: _____
Primary Care Provider:_____
Do you give permission for ongoing regular updates to be provided to your primary care physician? ☐ Yes ☐ No

Describe your presenting problem(s) for which you are seeking services.

_____
_____
_____
_____

When did these problems first present themselves?

_____
_____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbances
( ) Loss of interest
( ) Concentration/Forgetful
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increased risky behavior
( ) Increase libido
( ) Decreased need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Paranoia
( ) _____
( ) _____
( ) _____

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 session
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? _____
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? _____

Past Psychiatric History
Have you ever received counseling services in the past? ☐ Yes ☐ No
Reason Dates Treated By Whom
_____
_____
_____
Have you ever received an inpatient psychiatric admission? ☐ Yes ☐ No
Reason Dates Treated By Whom
_____
_____
_____

Have you ever received a mental health diagnosis in the past? ☐ Yes ☐ No
If yes, what was the diagnosis? _____

Exercise Level
Do you exercise regularly? ☐ Yes ☐ No
How many days a week do you get exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

Sleep Patterns
On average, how many hours of sleep do you get a night?_____
When do you go to bed? _____
How long does it take you to fall asleep?_____
Do you wake frequently throughout the night?_____
If yes, what wakes you?_____
Do you snore?_____
Do you ever wake up gasping for air?_____
When do you typically wake for the day?_____

Appetite
Has your appetite or weight changed? ☐ Yes ☐ No
If yes, how? _____
_____
Have you ever had worrisome eating or weight loss behaviors? ☐ Yes ☐ No

Of the following, which have you experienced?
( ) Make myself throw up ( ) Going without food ( ) Use of diet pills ( ) Use of laxatives
( ) Binge Eating ( ) Excessive Exercising

Family Psychiatric History

Please check if anyone in your family has been diagnosed or treated with the following:

( ) Bipolar Disorder	( ) Schizophrenia
( ) Depression	( ) Post-traumatic Stress
( ) Anxiety	( ) Alcohol Abuse
( ) Anger	( ) Other substance abuse
( ) Suicide	( ) Violence

If yes, who had each problem? _____
_____
_____

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?_____
_____
How many days per week do you drink any alcohol?_____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?_____
Have you ever felt the need to cut down on your drinking or drug use? ☐ Yes ☐ No
Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
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? ☐ Yes ☐ No
Do you think you may have a problem with alcohol or drug use? ☐ Yes ☐ No
Have you used any street drugs in the past 3 months? ☐ Yes ☐ No
If yes, which ones? _____
Have you ever abused prescription medication? ☐ Yes ☐ No
If yes, which ones and for how long? _____

Check if you have ever tried the following (Not Prescribed):

	Yes	No	If yes, how long and last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroine	( )	( )	_____
LSD	( )	( )	_____
Marijuana	( )	( )	_____
Pain Killers	( )	( )	_____
Methadone	( )	( )	_____
Sleeping pills	( )	( )	_____
Alcohol	( )	( )	_____
Ecstasy	( )	( )	_____
Other			_____

How many caffeinated beverages do you drink a day? Coffee_____ Sodas_____ Tea____

Have you ever smoked cigarettes ☐ Yes ☐ No
If you currently smoke, how many packs per day? _____ How many years? _____
If you have quit, how many years did you smoke?_____When did you quit?_____
Do you currently use a pipe, cigar, chewing tobacco or vape? ☐ Yes ☐ No
What kind? _____ How often per day on average?_____ How many years?____

Family Background and Childhood History:
Were you adopted? Yes No
Which family members did you reside with in childhood. Please list all: _____
_____
List your siblings and their ages: _____
_____
What was your father's occupation?_____
What was your mother's occupation?_____
Did your parents ever divorce? ☐ Yes ☐ No If yes, how old were you? _____
Describe your father and your relationship with him:_____
_____
_____
Describe your mother and your relationship with her: _____
_____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? ☐ Yes ☐ No
If yes, who and when?_____
_____

Trauma History:
Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you? **Or a**ct in a way that made you feel afraid that you might be physically hurt?
☐ Yes ☐ No
Did a parent or other adult in the household often push, grab, slap, or throw something at you **Or** ever hit you so hard that you had marks or were injured?
☐ Yes ☐ No
Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? **Or** attempt to actually have oral, anal, or vaginal intercourse with you?
☐ Yes ☐ No
Did you often feel that no one in your family loved you or thought you were important or special? **Or** your family didn't look out for each other, feel close to each other, or support each other?
☐ Yes ☐ No
Did you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **Or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
☐ Yes ☐ No
Were your parents ever separated or divorced even if they got back together?
Yes ☐ No
Were any of your parents or other adult caregivers often pushed, grabbed, slapped, or had something thrown at them? **Or** sometimes or often kicked, hitten with a fist, or hit with

something hard? **Or** ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

☐Yes ☐ No

Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

☐Yes ☐ No

Was a household member depressed or mentally ill, or did a household member attempt suicide?

☐Yes ☐ No

Did a household member go to prison?

☐Yes ☐ No

Educational History:

What was your highest grade completed? _____ What school?_____

Did you attend college? _____ What school?_____

What is your highest educational level or degree attained if any?_____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

If employed, how long have you been in your present position?_____

What is/was your last/current occupation?_____

Where do you work?_____

Have you ever served in the military? ☐Yes ☐ No

If yes, what branch and when?_____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed

How long?_____

How would you identify your sexual orientation?

( ) straight/ heterosexual ( ) lesbian/gay/homosexual

( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual

( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation?_____

Have you had any prior marriages? ☐ Yes ☐ No

If so, how many and for how long? _____

Do you have children? ☐Yes ☐ No

If yes, list ages and gender:_____

_____

Describe your relationship with your children:_____

_____

_____

_____

List everyone who currently lives with you:_____

_____

_____

Legal History

Have you ever been arrested? ☐Yes ☐ No

If yes, what were the charges? _____

Do you have any pending legal problems?_____
_____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ☐ Yes ☐ No
If yes, which group?_____

Is there anything else that you would like us to know?
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