Poyner Mental Health Services 14453 SE 29th St. Suite D Choctaw, Oklahoma 73020 405-741-2844 / (Fax) 405-733-1334

INTAKE

Patient Name: _____ Birth Date: _____ Age: _____

Contact and Message Phone #:_____ Full Address: _____
Number Street City & State Zip Code

Emergency contact name, relationship & phone number: _____

- Please describe any relevant history and the problems the patient is having: _____

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- How long has the patient been experiencing these problems? _____

Please check the specific problems the patient is *currently* experiencing

Suicidal thoughts/actions		Severe anger outbursts		Hyperactivity/Inattention	
Sadness/low mood		Destruction of property		Divorce	
Sleep problems		Cutting/cruelty/fires		Marital	
Appetite problems		Illegal behaviors		Parenting	
Isolation		Addictions/drug abuse		Child's behavior	
Little interest in activities		Unreasonable fears		Occupational	
Low energy		Intrusive thoughts		Childhood problems	
Irritability		Repetitive thoughts/actions		Health/Medical problems	
Excessive worry/anxiety		Elevated mood/energy		Low self-esteem	
Argumentative		Sexual/gender/promiscuity		Legal	
Trauma		Problems with friends		I am applying for disability	
Overly stressed		Family relationships		Other:	

Has the patient ever been diagnosed with a mental illness? Circle One: **YES NO** If YES, please name the illness and when it was diagnosed:

Has the patient ever been hospitalized with mental health problems? Circle One: **YES NO** If YES, please describe:

Has the patient ever had counseling? Circle One: **YES NO** If YES, when?

Has the patient ever attempted suicide and/or purposely cut or burned self? Circle One: **YES NO** If YES, describe:
Has the patient ever experienced any trauma, such as abuse or other traumatic event? Circle One: **YES NO** If YES, describe generally:
Please list any serious medical or developmental problems the patient has had and/or is currently experiencing:
Please list *any* medication the patient is currently taking: If the patient is having substance abuse problems, please discuss this in session.
Please describe any family problems the patient has had and/or is currently experiencing:
Please list any relationship, school or occupational problems the patient is having:
Please provide any other information you believe is important to understanding the patient and the patient's problems:

For Clinician Use Only

Date of Intake: Time: Present at Intake:

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The limits of confidentiality/consent to treatment were addressed and acknowledged: □ Yes