Brighter Minds Health
Smarter Medication Management for Brighter Days

CLIENT INTAKE FORM

Adult Form

CLIENT INFORMATION			
How did you hear about our office?			
Full Name:		Preferred Name:	
Address:			
Phone Number:		Email:	
Birthdate:	Age:		
Sex:	Gender Identity:	Pronouns:	
Race:	Ethnicity:	Marital Status:	
Spouse Name:		Spouse Phone Number:	
Spouse Email:			
Primary Care Doctor:		Phone:	Last visit:
Therapist:		Phone:	Last visit:

RESPONSIBLE PARTY INFORMATION			
Name:	DOB:	Phone:	
Physical address:		Email:	
Primary insurance company:		ID#:	
Policy Holder's name:		DOB:	
Secondary insurance company:		ID#:	
Policy Holder's name:		DOB:	

EMERGENCY CONTACT INFORMATION (IF DIFFERENT THAN SPOUSE LISTED ABOVE)	
Name:	Phone:
Relationship to client:	
Name:	Phone:
Relationship to client:	

PRESENTING PROBLEM
Describe what problem(s) you are seeking treatment for at this time:

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When did this/these problem(s) begin?
What do you think may have caused these problems?
Why are you seeking treatment today?
What have you tried in the past?
What goals do you hope to achieve with treatment?
List current mental health treatment:

Current medications:	Dose:	Response:

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PREVIOUS DIAGNOSES

During childhood/adolescent years, did you experience:

PAST MENTAL HEALTH HISTORY

List any past treatment/counseling:

Past mental health medications :	Response/side effects :

Have you ever attempted suicide? ◯Yes ◯No

If so, describe methods and dates:

Have you had thoughts of hurting others? ◯Yes ◯No

Have you had past psychiatric hospital stays or drug/alcohol abuse treatment? ◯Yes ◯No

If yes, location and dates:

Have you ever used...

Tobacco / Nicotine
- ☐ Smoke
- ☐ Chew
- ☐ Vape

How many a day?

- ☐ Alcohol
- ☐ Heroin
- ☐ Marijuana
- ☐ Diet pills
- ☐ Herbal Supplements
- ☐ OTC Medications
- ☐ Caffeine
- ☐ Cocaine
- ☐ Opiates/oxycontin
- ☐ Meth
- ☐ Laxatives
- ☐ Others
- ☐ Ecstasy
- ☐ Sedatives/downers
- ☐ Inhalants

FAMILY HISTORY

Mother's name: Living ◯Yes ◯No

Father's name: Living ◯Yes ◯No

Sibling(s) + Age(s):

Relationship ◯Good ◯Fair ◯Poor

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Has any blood relative had any of the following conditions

☐ Depression	☐ Seizures	☐ Suicide
☐ Anxiety	☐ Schizophrenia	☐ Alcohol/drug abuse
☐ OCD	☐ Bipolar disorder	☐ Autism
☐ Developmental Disabilities	☐ Dementia	☐ ADD/ADHD

SOCIAL HISTORY

Who do you live with?
Where were you raised?

Physical Activity?

Sleep?

Diet?

Hobbies?

Highest Level of Education:
Occupation:

Any Children? ◯ Yes ◯ No *if so, how many?*
Any Pets? ◯ Yes ◯ No

Are you adopted? ◯ Yes ◯ No *if so, how old were you?*

Are your parents divorced? ◯ Yes ◯ No *if so, how old were you?*

Have you been abused? ◯ Yes ◯ No *if so, how old were you?*
Type of Abuse ☐ Physical ☐ Sexual ☐ Verbal ☐ Neglect

Any Significant Trauma? ◯ Yes ◯ No
if so, what was the trauma and how old were you?

MEDICAL HISTORY

Any Allergies to Medication? ◯ Yes ◯ No
if so, what medication?

Are you sexually active? ◯ Yes ◯ No Partners are... ◯ Male ◯ Female ◯ Both
Do you use birth control? ◯ Yes ◯ No

Females Only

Menstrual Cycle : ☐ Regular Cycle ☐ Irregular Cycle ☐ Pelvic Pain ☐ PMS

Currently Pregnant? ◯ Yes ◯ No Weeks:

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Any Current Health Concerns? ○ Yes ○ No
If so, what?

Chronic Pain? ○ Yes ○ No
If yes, who treats it:

Any Surgeries? ○ Yes ○ No
if so, what surgeries?

Please check what applies to you.

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Asthma
- ☐ Bone Fractures
- ☐ Cancer
- ☐ Chronic Fatigue Syndrome
- ☐ Colitis/Irritable Bowel
- ☐ Constipation
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Head Injury
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Rhythm Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Loss of consciousness
- ☐ Lupus
- ☐ Nausea/Vomitting
- ☐ Other _____
- ☐ Seizures
- ☐ Serious Injuries
- ☐ Sexual Dysfunction
- ☐ Sinus Infections
- ☐ Thyroid Problems
- ☐ Ulcers

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Beck's Depression Inventory

ADULT FORM

Directions: Please rate yourself by marking the box that best describes how you have felt yourself over the past 6 months. When completing this form, please think about the **PAST 6 MONTHS.**

1. SADNESS
- ◯ I do not feel sad
- ◯ I feel sad
- ◯ I am sad all the time and I can't snap out of it
- ◯ I am so sad and unhappy that I can't stand it

2. PESSIMISM
- ◯ I am not particularly discouraged about the future
- ◯ I feel discouraged about the future
- ◯ I feel I have nothing to look forward to
- ◯ I feel the future is hopeless and that things cannot improve

3. PAST FAILURE
- ◯ I do not feel like a failure
- ◯ I feel I have failed more than the average person
- ◯ As I look back on my life, all I can see is a lot of failures
- ◯ I feel I am a complete failure as a person

4. LOSS OF PLEASURE
- ◯ I get as much satisfaction out of things as I used to
- ◯ I don't enjoy things the way I used to
- ◯ I don't get real satisfaction out of anything anymore
- ◯ I am dissatisfied or bored with everything

5. GUILTY FEELINGS
- ◯ I don't feel particularly guilty
- ◯ I feel guilty a good part of the time
- ◯ I feel quite guilty most of the time
- ◯ I feel guilty all of the time

6. PUNISHMENT FEELINGS
- ◯ I don't feel I am being punished
- ◯ I feel I may be punished
- ◯ I expect to be punished
- ◯ I feel I am being punished

7. SELF-DISLIKE

- ○ I don't feel disappointed in myself
- ○ I am disappointed in myself
- ○ I am disgusted with myself
- ○ I hate myself

8. SELF-CRITICISM

- ○ I don't feel I am any worse than anybody else
- ○ I am critical of myself for my weaknesses or mistakes
- ○ I blame myself all the time for my faults
- ○ I blame myself for everything bad that happens

9. SUICIDAL THOUGHTS OR WISHES

- ○ I don't have any thoughts of killing myself
- ○ I have thoughts of killing myself, but I would not carry them out
- ○ I would like to kill myself
- ○ I would kill myself if I had the chance

10. CRYING

- ○ I don't cry any more than usual
- ○ I cry more now than I used to
- ○ I cry all the time now
- ○ I used to be able to cry, but now I can't cry even though I want to

11. IRRITABILITY

- ○ I am no more irritated by things than I ever was
- ○ I am slightly more irritated now than usual
- ○ I am quite annoyed or irritated a good deal of the time
- ○ I feel irritated all the time

12. LOSS OF INTEREST

- ○ I have not lost interest in other people.
- ○ I am less interested in other people than I used to be.
- ○ I have lost most of my interest in other people.
- ○ I have lost all of my interest in other people.

13. INDECISIVENESS

- ○ I make decisions about as well as I ever could.
- ○ I put off making decisions more than I used to.
- ○ I have greater difficulty in making decisions more than I used to.
- ○ I can't make decisions at all anymore.

14. SELF-IMAGE

- ○ I don't feel that I look any worse than I used to.
- ○ I am worried that I am looking old or unattractive.
- ○ I feel there are permanent changes in my appearance that make me look unattractive
- ○ I believe that I look ugly.

15. WORK
- ○ I can work about as well as before.
- ○ It takes an extra effort to get started at doing something.
- ○ I have to push myself very hard to do anything.
- ○ I can't do any work at all.

16. CHANGES IN SLEEPING PATTERN
- ○ I can sleep as well as usual.
- ○ I don't sleep as well as I used to.
- ○ I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- ○ I wake up several hours earlier than I used to and cannot get back to sleep.

17. FATIGUE
- ○ I don't get more tired than usual.
- ○ I get tired more easily than I used to.
- ○ I get tired from doing almost anything.
- ○ I am too tired to do anything.

18. CHANGES IN APPETITE
- ○ My appetite is no worse than usual.
- ○ My appetite is not as good as it used to be.
- ○ My appetite is much worse now.
- ○ I have no appetite at all anymore.

19. CHANGES IN WEIGHT
- ○ I haven't lost much weight, if any, lately.
- ○ I have lost more than five pounds.
- ○ I have lost more than ten pounds.
- ○ I have lost more than fifteen pounds.

20. PHYSICAL HEALTH CONCERNS
- ○ I am no more worried about my health than usual.
- ○ I am worried about physical problems like aches, pains, upset stomach, or constipation.
- ○ I am very worried about physical problems and it's hard to think of much else.
- ○ I am so worried about my physical problems that I cannot think of anything else.

21. CHANGES IN SEX DRIVE
- ○ I have not noticed any recent change in my interest in sex.
- ○ I am less interested in sex than I used to be.
- ○ I have almost no interest in sex.
- ○ I have lost interest in sex completely.

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Screen for Adult Anxiety Related Disorders (SCAARED)

ADULT FORM

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or Very True or Often True" for your child. Choose the responses that describes your child for the **LAST 3 MONTHS.**

0-- Not True/Hardly Ever True
1-- Somewhat True/Sometimes True
2-- Very True/Often True

1. (PN) When I feel nervous, it is hard to breathe..... ◯0 ◯1 ◯2
2. (PN) I get headaches when I am at school, work, or in other public places..... ◯0 ◯1 ◯2
3. (SC) I don't like to be with people I don't know well..... ◯0 ◯1 ◯2
4. (SP) I get nervous if I sleep away from home..... ◯0 ◯1 ◯2
5. (GD) I worry about other people liking me..... ◯0 ◯1 ◯2
6. (PN) When I get anxious, I feel like passing out..... ◯0 ◯1 ◯2
7. (GD) I am nervous..... ◯0 ◯1 ◯2
8. (GD) It is hard for me to stop worrying..... ◯0 ◯1 ◯2
9. (PN) People tell me that I look nervous..... ◯0 ◯1 ◯2
10. (SC) I feel nervous with people I don't know well..... ◯0 ◯1 ◯2
11. (PN) I get stomachaches at school, work, or in other public places..... ◯0 ◯1 ◯2
12. (PN) When I get anxious, I feel like I am going crazy..... ◯0 ◯1 ◯2
13. (SP) I worry about sleeping alone..... ◯0 ◯1 ◯2
14. (GD) I worry about being as good as other people..... ◯0 ◯1 ◯2
15. (PN) When I get anxious, I feel like things are not real..... ◯0 ◯1 ◯2

16. (SP) I have nightmares about something bad happening to my parents..... ◯0 ◯1 ◯2

17. (PN) I worry about going to school, work, or into public places..... ◯0 ◯1 ◯2

18. (PN) When I get anxious, my heart beats fast..... ◯0 ◯1 ◯2

19. (PN) I get shaky..... ◯0 ◯1 ◯2

20. (SP) I have nightmares about something bad happening to me..... ◯0 ◯1 ◯2

21. (GD) I worry about things working out for me..... ◯0 ◯1 ◯2

22. (PN) When I get anxious, I sweat a lot..... ◯0 ◯1 ◯2

23. (GD) I am a worrier..... ◯0 ◯1 ◯2

24. (GD) When I worry a lot, I have trouble sleeping..... ◯0 ◯1 ◯2

25. (PN) I get really frightened for no reason at all..... ◯0 ◯1 ◯2

26. (SP) I am afraid to be alone in the house..... ◯0 ◯1 ◯2

27. (SC) It is hard for me to talk with people I don't know well..... ◯0 ◯1 ◯2

28. (PN) When I get anxious, I feel like I am choking..... ◯0 ◯1 ◯2

29. (GD) People tell me that I worry too much..... ◯0 ◯1 ◯2

30. (SP) I don't like to be away from my family..... ◯0 ◯1 ◯2

31. (GD) When I worry a lot, I feel restless..... ◯0 ◯1 ◯2

32. (PN) I am afraid of having anxiety (or panic) attacks..... ◯0 ◯1 ◯2

33. (SP) I worry that something bad might happen to my family..... ◯0 ◯1 ◯2

34. (SC) I feel shy with people I don't know well..... ◯0 ◯1 ◯2

35. (GD) I worry about what is going to happen in the future..... ◯0 ◯1 ◯2

36. (PN) When I get anxious, I feel like throwing up..... ◯0 ◯1 ◯2

37. (GD) I worry about how well I do things..... ◯0 ◯1 ◯2

38. (PN) I am afraid of going outside or into crowded places by myself..... ◯0 ◯1 ◯2

39. (GD) I worry about things that have already happened..... ◯0 ◯1 ◯2

40. (PN) When I get anxious, I feel dizzy..... ◯0 ◯1 ◯2

41. (SC) I feel nervous when I am with other people and I have to do something while they watch me (for example: read aloud, speak, play a sport)..... ◯0 ◯1 ◯2

42. (SC) I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well..... ◯0 ◯1 ◯2

43. (SC) I am shy..... ◯0 ◯1 ◯2

43. (GA) When I worry a lot, I feel irritable..... ◯0 ◯1 ◯2

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Adult ADHD Self-Report Scale

Directions: Please rate yourself by marking the box that best describes how you have felt and conducted yourself over the past 6 months. When completing this form, please think about your behaviors in the **PAST 6 MONTHS.**

0-- Never 1-- Rarely 2-- Sometimes 3-- Often 4-- Very Often

1.How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

2. How often do you have difficult getting things in order when you have to do a task that requires organization?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

3. How often do you have problems remembering appointments and obligations?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

6. How often do you feel overly active and compelled to do things, like you were driven by a motor?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

7. How often do you make careless mistakes when you have to work on a boring or difficult project?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

9. How often do you have difficult concentrating on what people say to you, even when they are speaking to you directly?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

10. How often do you mistake or have difficulty finding things at home or at work?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

11. How often do you get distracted by activity or noise around you?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?

☐ 0 - Never ☐ 1 - Rarely ☐ 2 - Sometimes ☐ 3 - Often ☐ 4 - Very Often

13. How often do you feel restless or fidgety?

◯ 0 - Never ◯ 1 - Rarely ◯ 2 - Sometimes ◯ 3 - Often ◯ 4 - Very Often

14. How often do you have difficulty unwinding and relaxing when you have time to yourself?

◯ 0 - Never ◯ 1 - Rarely ◯ 2 - Sometimes ◯ 3 - Often ◯ 4 - Very Often

15. How often do you find yourself talking too much when you are in social situations?

◯ 0 - Never ◯ 1 - Rarely ◯ 2 - Sometimes ◯ 3 - Often ◯ 4 - Very Often

16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to before they can finish themselves.

◯ 0 - Never ◯ 1 - Rarely ◯ 2 - Sometimes ◯ 3 - Often ◯ 4 - Very Often

17. How often do you have difficulty waiting your turn in situations when turn taking is required?

◯ 0 - Never ◯ 1 - Rarely ◯ 2 - Sometimes ◯ 3 - Often ◯ 4 - Very Often

18. How often do you interrupt others when they are busy?

◯ 0 - Never ◯ 1 - Rarely ◯ 2 - Sometimes ◯ 3 - Often ◯ 4 - Very Often

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OCI-R

Adult Form

The following statements refer to experiences that many people have in their everyday lives. Choose the number that best describes **HOW MUCH** that experience has **DISTRESSED** or **BOTHERED** you during the **PAST MONTH**. The numbers refer to the following labels:
0--Not at all 1--A little 2--Moderately 3--A lot 4--Extremely

1. I have saved up so many things that they get in the way.

◯0 ◯1 ◯2 ◯3 ◯4

2. I check things more than often necessary.

◯0 ◯1 ◯2 ◯3 ◯4

3. I get upset if objects are not arranged properly.

◯0 ◯1 ◯2 ◯3 ◯4

4. I feel compelled to count while I am doing things.

◯0 ◯1 ◯2 ◯3 ◯4

5. I find it difficult to touch an object when I know it has been touched by strangers or certain people.

◯0 ◯1 ◯2 ◯3 ◯4

6. I find it difficult to control my own thoughts.

◯0 ◯1 ◯2 ◯3 ◯4

7. I collect things I don't need.

◯0 ◯1 ◯2 ◯3 ◯4

8. I repeatedly check doors, windows, drawers, etc.

◯0 ◯1 ◯2 ◯3 ◯4

9. I get upset if others change the way I have arranged things.

◯0 ◯1 ◯2 ◯3 ◯4

10. I feel I have to repeat certain numbers.

◯0 ◯1 ◯2 ◯3 ◯4

11. I sometimes have to wash or clean myself simply because I feel contaminated.

◯0 ◯1 ◯2 ◯3 ◯4

12. I am upset by unpleasant thoughts that come into my mind against my will.

◯0 ◯1 ◯2 ◯3 ◯4

13. I avoid throwing things away because I am afraid I might need them later.

◯0 ◯1 ◯2 ◯3 ◯4

14. I repeatedly check gas and water taps and light switches after turning them off.

◯0 ◯1 ◯2 ◯3 ◯4

15. I need things to be arranged in a particular way.

◯0 ◯1 ◯2 ◯3 ◯4

16. I feel there are good numbers and bad numbers.

◯0 ◯1 ◯2 ◯3 ◯4

17. I wash my hands more often and longer than necessary.

◯0 ◯1 ◯2 ◯3 ◯4

18. I frequently get nasty thoughts and have difficulty in getting rid of them.

◯0 ◯1 ◯2 ◯3 ◯4

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Mood Disorder Questionaire

Adult Form

Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...

...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? ◯Yes ◯No

...you were so irritable that you shouted at people or started fights or arguments? ◯Yes ◯No

...you felt much more self-confident than usual? ◯Yes ◯No

...you got much less sleep than usual and found that you didn't really miss it? ◯Yes ◯No

...you were more talkative or spoke much faster than usual? ◯Yes ◯No

...thoughts raced through your head or you couldn't slow your mind down? ◯Yes ◯No

...you were so easily distracted by things around you that you had trouble concentrating or staying on track? ◯Yes ◯No

...you had more energy than usual? ◯Yes ◯No

...you were much more active or did many more things than usual? ◯Yes ◯No

...you were much more social or outgoing that usual, for example, you telephoned friends in the middle of the night? ◯Yes ◯No

...you were much more interested in sex than usual? ◯Yes ◯No

...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? ◯Yes ◯No

...spending money got you or your family in trouble? ◯Yes ◯No

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ◯Yes ◯No

3. How much of a problem did any of these cause you- like being unable to work; having family, money or legal troubles; getting in to arguments or fights?

◯No problems ◯Minor problem ◯Moderate problem ◯Serious problem

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PC-PTSD-5

Adult Form

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide

Have you ever experienced this kind of event? ◯ Yes ◯ No

If yes, answer the questions below.

In the past month, have you...

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to? ◯ Yes ◯ No

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? ◯ Yes ◯ No

3. Been constantly on guard, watchful, or easily startled? ◯ Yes ◯ No

4. Felt numb or detached from people, activities, or your surroundings? ◯ Yes ◯ No

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? ◯ Yes ◯ No