LIKEMIND Mental Health & Wellness, Inc.

Initial Questionnaire

Demographic/Contact Information

Name

Nickname

Date of Birth

Gender

Comment

Phone Number

Is it okay to leave voicemail at this number? Yes

Is it okay to send texts to this number? Yes

Address (Street/number)

Address (City/State/Zip)

Email

Is it okay to send emails to this address? Please Select One

Insurance Provider & Number*

Amount of Co-pay (if known)

Referral Source

Comments

Race/Ethnicity

Relationship Status

Employment Status

Emergency Contact

Relationship to you

Phone number

Past/Current Mental Health Issues or Symptoms

What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

When did you first notice these problems?

What are your goals for treatment?

_____

_____

_____

What mental health services are you interested in? Please Select One

Comments

Current Symptoms

Comments

Any thoughts/feelings of wanting to hurt or kill yourself (past or present)? Please Select One

Past Please Select One

Present Please Select One

Please explain.

Any current or past self-injurious behavior (cutting, burning, etc.)? Please Select One

Past Please Select One

Present Please Select One

Please explain.

Have you received mental health services in the past? Please Select One

If yes:

Name of provider/facility

Location of treatment

Approximate dates of treatment

Reason for treatment

Medical History

Please list any current medical problems

Past medical problems/hospitalizations/surgeries (including approximate dates)

Problems with your gestation, birth, or early history as a young child?

Medication Name	Dosage	Estimated Start Date

Please list ALL current prescription medications and over-the-counter medications

Personal and Family Medical/Mental Health History

Diagnosis	You	Family	Which family member?
Heart Disease			_____
Cancer			_____
Epilepsy/Seizures Thyroid Problems			_____
Brain Injury			_____
Depression			_____
Anxiety Disorder			_____
ADHD			_____
Bipolar Disorder			_____
Autism/Asperger's			_____
Autoimmune illness			_____
Substance abuse			_____
Learning Disorders			_____
Other Diagnosed condition			_____
Domestic Violence			_____
			_____

Suicide Attempts _____
OCD _____
Sexual Abuse _____
Physical Abuse _____
Verbal/Emotional Abuse _____
Eating Disorder _____

Substance Use

Do you currently smoke cigarettes? Please Select One

If so, how many per day?

Did you smoke cigarettes in the past?

If so, when did you quit?

How many caffeinated drinks do you have in a day? Coffee/Tea _____ Soda _____

Have you ever used the following?

Alcohol ☐
Marijuana ☐
Painkillers (not as prescribed) ☐
Cocaine ☐
Crack ☐
Heroin ☐
Methamphetamines ☐
LSD ☐
Other ☐
None ☐

If yes, how much, how frequently, and when was your last use?

Do you struggle with stopping any of the following behaviors?

Gambling ☐ Shopping ☐ Video Games ☐ Social Media ☐ Overeating ☐ Restricted Eating ☐

Excessive Exercise ☐

Comments

Legal History

Have you ever been arrested?

Have you ever had a DUI/OUI?

Have you ever been incarcerated?

Childhood and Family History

Were you adopted?

Did your parents divorce?

If so, your age at the time of the divorce? _____

How would you describe your relationship with your family?

Trauma History

Have you ever experienced physical, emotional, or sexual abuse or assault?

If yes, when and describe briefly what happened?

Are you satisfied with your current employment status?

Have you ever been fired from a job?

If so, why?

Have you served in the armed forces?

Educational/Occupational History

What is the highest grade that you completed?

Describe your typical academic performance

If employed, what is your occupation/job?

How long have you been in your present position?

Are you questioning your gender identity or do you identify as transsexual?

Do you have any children? If so, list names and ages

List all who currently live with you

Are you satisfied with current friendships?

Financial Stress

Do you currently experience financial stress?

Which of the following applies?

What do you consider your strengths?

Please list any additional information you would like to provide?

Please attach a photograph of your Insurance ID.

Name Date

Please save this form to your computer, and then click the submit button below. At the next screen, drag and drop your saved Initial Questionnaire onto the secure file transfer window.

CLICK HERE TO SUBMIT