

Mental Health Intake Form

Please fill out the following form if you are interested in seeing a provider here at The Student Health Center to prescribe medications. You will be contacted to schedule an appointment.

Name:

Date of Birth:

Student ID Number:

What is the reason for your interest in scheduling an appointment at the Health Center? _____

1. Have you seen a psychiatrist in the past?
 - Yes. If so, for how long?
 - o For a consultation (i.e., 1-2 visits total)
 - o Every 1-3 months for < 1 year
 - o Every 1-3 months for > 1 year
 - No

2. Are you currently taking psychiatric medications?
 - Yes. If so, please list the name of the medication, the dose, the frequency, and how long you have been taking it (i.e., fluoxetine 40 mg for the last 2 months).
 - Medication list:

 - No

3. Have you ever been prescribed and taken psychiatric medications in the past?
 - Yes. If so, please circle all classes of medications that apply. Please circle the exact medication if you recall the name. In addition, please write down as many details as you can remember (i.e., I took Abilify 10 mg daily for 3 months, but stopped because of the side effects):
 - Antidepressants: (fluoxetine, sertraline, paroxetine, escitalopram, citalopram, fluvoxamine, bupropion, duloxetine, venlafaxine, desvenlafaxine, vilazodone, levomilnacipran, vortioxetine, buspirone).
Additional info:

 - As needed medication for anxiety: (alprazolam, lorazepam, clonazepam, diazepam, hydroxyzine, propranolol).
Additional info:

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<https://www.ithaca.edu/student-health-services>

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- ADHD medications: (methylphenidate, amphetamine, atomoxetine, clonidine, guanfacine, bupropion).

Additional info:

- Sleep medications: (trazodone, mirtazapine, zolpidem, prazosin).

Additional info:

- Mood Stabilizers: (lithium, lamotrigine, Depakote, Latuda).

Additional info:

- Antipsychotics: (risperidone, aripiprazole, quetiapine, olanzapine, ziprasidone).

Additional info:

- No.

4. Have you ever been evaluated in the Emergency Room for a mental health emergency?

- Yes. If so, please provide details: _____

- No.

5. Have you ever been hospitalized on a psychiatric unit?

- Yes. If so, please provide details (when, what hospital, how long the hospitalization was, reason for the hospitalization):

- No.

6. Have you ever received psychotherapy on a regular basis (every one to two weeks)?

- Yes. If so, for how long? Please circle one.

- 1-2 sessions
- 1-3 months
- 3-6 months
- 6-12 months
- > 12 months

- No.

7. Have you ever attempted suicide or come close to attempting suicide (i.e., prepared, planned)?

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- Yes. If so, please provide details: _____

- No.

8. Have you ever self-harmed to help feel better? Self-harm includes cutting, burning, choking, or hitting yourself.

- Yes. If so, please provide details: _____

- No.

9. Have you ever used marijuana on a daily basis for greater than two weeks?

- Yes. If so, when did you last use? _____
- No.

10. Have you ever used any other illicit drug on a daily basis for greater than two weeks?

- Yes. If so, what drug and when did you last use? _____

- No.

11. Have you ever been addicted to or misused prescription or over-the-counter drugs?

- Yes. If so, when, and where? For what substance? _____

- No.

Your care and the information you share with us are confidential. There are limits to confidentiality. We are required by law to share information if there is a risk of serious harm to yourself or to others.

Signature: _____ Date: _____