|  |
| --- |
|   **Intake Form** |
|  |

 **R**ehabilitation **R**esearch and **T**raining **C**enter on Health and Function
of People with Intellectual and Developmental Disabilities

Thank you for participating in this research study to understand the mental health of adults with intellectual disability.

You or a person who knows you the best will complete this form ***before meeting with the clinician***.

If your caregiver/staff is filling out the form, the person who completes the form should 1) **speak English** and 2) have known you **at least for one year.**

1. **Do you have any worries about your mental health?** **If so, please write about your worries.**

|  |
| --- |
|  |
|  |
|  |

1. **Who is your Primary Care Physician (PCP)?**

|  |
| --- |
|  |

1. **Please write any mental health provider that you are seeing. (Name / Type of Provider / Reason for Visits).**

|  |
| --- |
| *Example: Dr. Jane Smith, Psychologist, for depression.* |
|  |
|  |
|  |
|  |

1. **Please write down any medication change in last three months.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Dose** | **Reason for Prescription** |
| *Example* | *Medication X* | *1 tablet (75mg)/day* | *Depression* |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

1. **Please circle “yes” to any of the sleeping problems you have.**

|  |  |
| --- | --- |
| I have a hard time falling asleep | YES / NO |
| I often wake up in the middle of the night | YES / NO |
| I have a hard time waking up in the morning | YES / NO |
| I feel sleepy and tired even after a long sleep.  | YES / NO |
| I have nightmares or night terrors | YES / NO |
| Others (*Please explain*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Recently, I have lost a lot of weight even though I was not trying to lose weight. (If YES, approximately how many pounds: \_\_\_\_\_\_\_\_\_lbs) | YES / NO |
| Recently, I have lost my appetite. | YES / NO |
| Recently, I have gained a lot of weight.(If YES, approximately how many pounds: \_\_\_\_\_\_\_\_\_lbs) | YES / NO |
| Recently, I have an increased appetite. | YES / NO |
| Others (*Please explain*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. **Please circle “yes” to any of the problems with eating you have.**

|  |
| --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FOR MORE INFORMATION, PLEASE CONTACT:**

Margaret Rosencrans, PhD
Postdoctoral Researcher
The Ohio State University Nisonger Center
1581 Dodd Dr.
Columbus, OH 43210
Email: Margaret.Rosencrans@osumc.edu
Telephone: (614)