Mental Health Intake Form

Please note: information provided on this form is protected as confidential information. Leave blank any question you would rather not answer, or would prefer to discuss with me in person. If a question does not apply please indicate so.

Personal Information

Name:_____ Date:_____
Parent/Legal Guardian (if under 18):_____
Address:_____
Phone:_____ Ok to leave message on vm? Yes/No and Ok to text? Yes/No
Email:_____ Ok to email: Yes/No
*Please note: Email correspondence is not considered to be a confidential medium of communication.
DOB:_____ Age:_____ Gender:_____
Highest education level completed:_____
Date completed and location:_____
Have you ever served in the military?_____ If yes, where?_____
Date of service:_____ Highest rank achieved:_____
Are you married?_____ If yes, date of marriage:_____
Are you divorced?_____ If yes, date of divorce:_____
Separated?_____ _____ If yes, date of separation:_____
Widowed?_____ If yes, date of death:_____ Never Married?_____
Domestic Partnership?_____ If yes, start date:_____
What is your sexual orientation?_____ Are you sexually active?_____
Are you currently in a romantic relationship?_____ If yes, for how long?_____
On a scale of 1-10(with 1 being poor and 10 being exceptional), how would you rate your relationship?
_____
Do you have children?_____ Dates of Birth_____
How is your relationship with your child(ren)?_____
List anyone else who lives with you:_____
Do you consider yourself to be spiritual or religious?_____
If yes, describe your faith or belief:_____
_____
What is your level of involvement?_____
Have you ever been arrested?_____ When and why?_____
Are you currently employed? Yes/No
If yes, what is your current employment situation?_____
_____
Do you enjoy your work? Is there anything stressful about your current work?_____
_____

What do you consider to be some of your strengths?_____
_____
What do you consider to be some of your weaknesses?_____
_____
What would you like to accomplish out of your time in therapy?_____
_____
_____

Referred By (if any):_____
Emergency Contact:_____
Relationship:_____
Phone #:_____
Permission to contact in the event of an emergency? _____
Client signature:_____ Date signed:_____

Complaint

What is your major complaint?_____
Start Date:_____ Have you previously suffered from this complaint?_____
Have you previously received any type of mental health services(psychotherapy, psychiatric)?
_____
Previous therapist name:_____
Are you currently taking any prescription medication? _____
If yes, please list:_____
Have you ever been prescribed psychiatric medication?_____
If yes, please list and provide dates:_____
_____

Current Symptoms (Check All That Apply)

__ Anxiety __ Appetite Issues __ Avoidance __ Crying Spells
__ Depression __Excessive Energy __ Fatigue __ Guilt
__ Hallucinations __ Impulsivity __ Irritability __ Libido Changes
__ Loss of Interest __ Panic Attacks __ Racing Thoughts __ Risky Activity
__ Sleep Changes __Suspiciousness

Anything else?_____
_____
_____

Medical History

Current physical health status:_____
Please list any specific health problems past or present:_____
_____
Exercise frequency:_____ Exercise type(s)_____
_____
Please list any difficulties you experience with your appetite or eating problems:_____
_____
Are you currently experiencing overwhelming sadness, grief/ bereavement?_____
_____
Do you drink alcohol?_____ How often?_____ How much/week?_____
How often do you engage in recreational drug use?_____
Please list all substances taken past and present:_____
_____
Have you ever abused prescription drugs?_____ If yes, which ones?_____
_____

Family History

Were you adopted?_____ If yes, at what age?_____
How is your relationship with your mother?_____
How is your relationship with your father?_____
Siblings and their ages:_____
Are your parents married?_____ Divorced?_____ If yes, how old were you?_____
Did your parents remarry?_____
If yes, how old were you?_____
Who raised you?_____ Where did you grow up?_____
How often did you move and where?_____
How old were you when you left home?_____
Family member medical conditions:_____
_____
Have any immediate family members died?_____ Who?_____
_____
Have any died by suicide?_____ Who?_____
Any other suicide attempts, past or present?_____ Who?_____
_____
Describe any neglect you suffered, and by whom:_____
_____
Trauma suffered and by whom:_____
_____

Abuse suffered and by whom:_____
_____
History of Alcohol/substance abuse ?_____ Who?_____
History of Domestic Violence?_____ Who?_____
Please list any family mental conditions:_____
_____

Anything else you want to add? _____
_____
_____