Brilliance Revealed Mental Health, Inc

Tel: (470) 249-8821
Fax: (470) 558-2846
www.brillancerevealed.com

MENTAL HEALTH INTAKE FORM

PERSONAL INFORMATION		
Name:	Date:	
Address:		
Phone:	Email:	
Age:	Date of Birth:	Gender:
Primary Physician:		Phone:
Current Therapist:		Phone:

COMPLAINT			
What is your major complaint?			
Start Date:	Have you previously suffered from this complaint?	☐ Yes	☐ No
Previous therapist(s) seen for complaint:			
Previous treatment for complaint:			
Aggravating Factors:			
Relieving Factors:			

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		

CURRENT MEDICATIONS (Over-the-Counter and Prescription)				
Name	Dosage	Frequency	Length of Time	Reason for Taking

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MEDICAL HISTORY	
Exercise Frequency:	Exercise Type(s):
Allergies:	
Previous diagnoses/mental health treatment:	
Previously treated by:	
Previous medications:	
Dates treated:	
Previous medical conditions:	
Previous surgeries:	

FAMILY HISTORY		
Were you adopted? ☐ Yes ☐ No		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? ☐ Yes ☐ No		
Did your parents divorce? ☐ Yes ☐ No		If yes, how old were you?
Did your parents remarry? ☐ Yes ☐ No		If yes, how old were you?
Who raised you?		Where did you grow up?
Family member medical conditions:		
Family member mental conditions:		
Treated with medication? ☐ Yes ☐ No		
Medications:		

EARLY DEVELOPMENT			
Where did you grow up?			
How often did you move and where?			
How old were you when you left home?			
Have any immediate family members died?	☐ Yes	☐ No	Who?
Have any committed suicide?	☐ Yes	☐ No	Who?
Describe any neglect you suffered and by whom:			
Trauma suffered and by whom:			
Abuse suffered and by whom:			

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Highest level education completed:	
Date completed and location:	
Have you ever served in the military? ☐ Yes ☐ No	If yes, where?
Dates of service:	Highest rank achieved:

PRESENT SITUATION

Work:					
☐ Full-Time	☐ Part-Time	☐ Student	☐ Unemployed	☐ Disabled	☐ Retired
Are you married? ☐ Yes ☐ No		If yes, date of marriage:			
Are you divorced? ☐ Yes ☐ No		If yes, date of divorce:			
Prior marriages? ☐ Yes ☐ No		If yes, how many?			
What is your sexual orientation?		Are you sexually active? ☐ Yes ☐ No			
How is your relationship with your partner?					
Do you have children? ☐ Yes ☐ No		Dates of birth:			
How is your relationship with your child(ren)?					
List anyone else who lives with you:					
Are you a member of a religion/spiritual group? ☐ Yes ☐ No					
What is your level of involvement?					
Have you been arrested? ☐ Yes ☐ No		When and why?			

HAVE YOU EVER TRIED THE FOLLOWING (check all that apply)

☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)
☐ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants (Pills)
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain Killers
If yes to any, list frequency/dates of use:			
Have you ever been treated for drug/alcohol abuse? ☐ Yes ☐ No		If yes, when?	
For which substances?			
Do you smoke cigarettes? ☐ Yes ☐ No		If yes, how many per day?	
Do you drink caffeinated beverages? ☐ Yes ☐ No		If yes, how many per day?	
Have you ever abused prescription drugs? ☐ Yes ☐ No			
If yes, which ones?			

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ANYTHING ELSE YOU WANT THE DOCTOR TO KNOW?

_____ _____

Signature Date