

Mental Health Intake Form

Personal Information

Name: _____ Date: _____
Address: _____
Phone: _____ Email: _____
DOB: _____ Sex: _____
Primary Physician: _____ Phone: _____
Current Therapist: _____ Phone: _____

Complaint

What is your major complaint? _____
Start Date: _____ Have you previously suffered from this complaint? _____
Previous therapist(s) seen for complaint: _____
Previous treatment for complaint: _____
Aggravating Factors: _____
Relieving Factors: _____

Current Symptoms (Check All That Apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Appetite Issues | <input type="checkbox"/> Avoidance | <input type="checkbox"/> Crying Spells |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Excessive Energy | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Guilt |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Irritability | <input type="checkbox"/> Libido Changes |
| <input type="checkbox"/> Loss of Interest | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Risky Activity |
| <input type="checkbox"/> Sleep Changes | <input type="checkbox"/> Suspiciousness | <input type="checkbox"/> | <input type="checkbox"/> |

Medical History

Exercise Frequency: _____ Exercise Type(s): _____
Allergies: _____
What medications are you currently using? _____
Previous diagnoses/mental health treatment: _____
Previously treated by: _____
Previous medications: _____
Dates treated: _____
Previous medical conditions: _____
Previous surgeries: _____

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? _____
Did your parents divorce? _____ If yes, how old were you? _____
Did your parents remarry? _____ 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? _____
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? _____ Who? _____

Have any committed suicide? _____ Who? _____

Describe any neglect you suffered, and by whom: _____

Trauma suffered and by whom: _____

Abuse suffered and by whom: _____

Highest education level completed: _____

Date completed and location: _____

Have you ever served in the military? _____ If yes, where? _____

Dates of service: _____ Highest rank achieved: _____

Present Situation

Work: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Are you married? _____ If yes, date of marriage: _____

Are you divorced? _____ If yes, date of divorce: _____

Prior marriages? _____ If yes, how many? _____

What is your sexual orientation? _____ Are you sexually active? _____

How is your relationship with your partner? _____

Do you have children? _____ 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? _____

What is your level of involvement? _____

Have you ever been arrested? _____ When and why? _____

Have You Ever Tried the Following (Check All That Apply)

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Hallucinogens (LSD)
<input type="checkbox"/> Heroin	<input type="checkbox"/> Methamphetamines	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Stimulants (Pills)
<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Methadone	<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Pain Killers

If yes to any, list frequency/dates of use: _____

Have you ever been treated for drug/alcohol abuse? _____ If yes, when? _____

For which substances? _____

Do you smoke cigarettes? _____ If yes, how many per day? _____

Do you drink caffeinated beverages? _____ If yes, how many per day? _____

Have you ever abused prescription drugs? _____ If yes, which ones? _____

Anything Else You Want the Doctor to Know

Signature

Date