Mental Health Intake Form

Personal Information

Name:	Sex:	Date of Birth:	Date:
Phone:	Address:	Email:	SSN:
Primary Physician:	Phone:		
Current Therapist:	Phone:		
Current Medications:			
Emergency Contact:			

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)

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

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☐ Other:					

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?	

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Who raised you?	
Where did you grown 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?	

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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/Ages:	
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)

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☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)	☐ Stimulants (Pills) Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain Killers
☐ Heroin	☐ Methamphe-tamine	☐ Cocaine	☐ Other				

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?	

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Anything Else You Want the Clinician to Know:

_____
PRINT NAME of Individual or Legal Representative

_____
SIGNATURE of Individual or Legal Representative DATE

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