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)

- ☐ 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
- ☐
- ☐

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 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? _____
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)

☐ 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? _____ 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