

# 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**

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Signature

Date