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