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 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? ______________________________