

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 name 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"/> Difficulties with _____ | <input type="checkbox"/> Irritability | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Identity 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

Insurance Frequency: _____ Exercise Typical: _____
Allergies: _____
What medications are you currently using? _____
Previous (de)psychosomatic health treatment: _____
Previously treated by: _____
Previous medications: _____
Doses 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? _____