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 therapy(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? _____