E. Joseph Mental Health Services, LLC

Client Intake Form (Therapy & Medication Management)

Thank you for choosing E. Joseph Mental Health Services, LLC. This form is designed to help us better understand your needs and provide the best care. All information is confidential and protected under HIPAA guidelines.

#I. Client Information

Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Age: _____

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say ☐ Other: _____

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ ☐ Mobile ☐ Home ☐ Work

Email Address: _____

May we contact you via (check all that apply):* ☐ Phone Call ☐ Text ☐ Email

Emergency Contact Name: _____

Relationship: _____

Phone Number: _____

#II. Services Requested (Check all that apply)

☐ Individual Therapy

☐ Family Therapy

☐ Couples Therapy

☐ Medication Management (Psychiatric Evaluation & Medication Prescriptions)

☐ Other: _____

#III. Insurance Information (if applicable)

Insurance Provider: _____

Policy/Member Number: _____

Group Number: _____

Policy Holder Name (if different): _____

Policy Holder DOB: _____

Relationship to Client: _____

#IV. Referral and Reason for Seeking Services

Who referred you? ☐ Physician ☐ Family/Friend ☐ Self ☐ Online ☐ Insurance ☐ Other: _____

Primary reason for seeking services (check all that apply):

☐ Anxiety ☐ Depression ☐ ADHD ☐ Bipolar Disorder ☐ PTSD/Trauma

☐ Anger ☐ Substance Use ☐ Stress ☐ Relationship/Family Issues

☐ Grief/Loss ☐ Medication Management ☐ Other: _____

Brief description of your main concern(s):

_____

_____

#V. Mental Health & Medical History

Have you received mental health treatment before? ☐ Yes ☐ No

If yes, when and where? _____

Current medications (include dosage and prescribing doctor):

_____

Allergies to medications: ☐ Yes ☐ No

If yes, list: _____

Current medical conditions (e.g., diabetes, hypertension):

_____

Any history of hospitalizations for psychiatric reasons? ☐ Yes ☐ No

If yes, explain: _____

#VI. Medication Management Information (Complete if seeking Medication Management Services)

Are you currently taking psychiatric medications? ☐ Yes ☐ No

If yes, list medications, dosages, and prescribing provider:

_____

Have you ever taken psychiatric medications in the past? ☐ Yes ☐ No

If yes, which ones and why were they discontinued?

_____

Do you have any concerns or hesitations about taking psychiatric medications?

_____

Any family history of mental health disorders? (Specify relation and condition):

_____

#VII. Risk Assessment

Are you currently experiencing thoughts of self-harm or harming others? ☐ Yes ☐ No

If yes, explain: _____

Any past suicide attempts or self-injurious behaviors? ☐ Yes ☐ No

If yes, please describe: _____

#VIII. Substance Use History

Do you currently use alcohol, tobacco, or drugs? ☐ Yes ☐ No

If yes, type and frequency: _____

Past substance use history: ☐ Yes ☐ No

If yes, please explain: _____

Previous treatment for substance use? ☐ Yes ☐ No

If yes, when and where? _____

#IX. Family, Social, and Work History

Relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Children (names & ages): _____

Occupation/Employment status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired

Employer (if applicable): _____

Support system (family, friends, community, church, etc.):

_____

#X. Treatment Goals

What would you like to achieve through therapy and/or medication management?

_____

_____

#XI. Consent for Treatment & Signature

- I voluntarily consent to participate in mental health services, including therapy and/or psychiatric evaluation and medication management as appropriate.

- I understand that all information is confidential and will only be released as permitted by law or with my written consent.

- I understand that I have the right to discontinue treatment at any time.

Client Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

#For Office Use Only

Clinician/Provider Assigned: _____

Date of First Appointment: _____

Insurance Verified: ☐ Yes ☐ No

Diagnosis (if applicable): _____

Treatment Plan Initiated: ☐ Yes ☐ No