

# 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)

- |   |   |  |   |
|---|---|--|---|
| <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"/> Hallucinations   | <input type="checkbox"/> Impulsivity      | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Libido 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

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? \_\_\_\_\_