



MENTAL HEALTH CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client . This form is used to collect information about new clients and for internal purposes only. The information you provide is confidential and will be treated accordingly.

PERSONAL INFO

Name: _____ Date: _____ Date of Birth: _____

Primary Care Physician: _____

-Do you give permission for ongoing regular updates to be provided to your primary care physician? Yes No

Current Therapist/Counselor: _____

Therapist Phone: _____

REASONS FOR VISIT

What are the problems for which you are seeking help?

Current Symptoms: (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Racing thoughts <input type="checkbox"/> | <input type="checkbox"/> Fatigue | Increased libido |
| Depressed mood <input type="checkbox"/> | <input type="checkbox"/> Suspiciousness | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Excessive energy |
| <input type="checkbox"/> Sleep pattern disturbance | <input type="checkbox"/> Change in appetite <input type="checkbox"/> | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Avoidance | Anxiety attacks | <input type="checkbox"/> Decreased need for sleep <input type="checkbox"/> |
| <input type="checkbox"/> Excessive worry <input type="checkbox"/> | <input type="checkbox"/> Excessive guilt | Crying spell |
| Forgetfulness <input type="checkbox"/> | <input type="checkbox"/> Increased risky behavior <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Unable to enjoy activities | Increased irritability <input type="checkbox"/> | _____ |

SUICIDE RISK ASSESSMENT

Have you ever had feelings or thoughts that you didn't want to live? Yes

No If yes, please answer the following. If no, please skip to the next section.

-Do you **currently** feel that you don't want to live? Yes No

-How often do you have these thoughts? _____

-When was the last time you had thoughts of dying? _____

-Has anything happened recently to make you feel this way? Yes No -On a scale of 1 to 10, how strongly do you feel these thoughts? _____

-Would anything make it better? Yes No

-Have you ever thought about how you would kill yourself? Yes No

-Is the method you would use readily available? Yes No

-Have you planned a time for this? Yes No

-Is there anything that would stop you from killing yourself? Yes No

-Do you feel hopeless and/or worthless? Yes No

-Have you tried to kill or harm yourself before? Yes No

-Do you have access to firearms? If yes, please explain below. Yes No

PAST MEDICAL HISTORY

Do you have any allergies? If yes, specify them:

_____ **Current Weight:** _____ **Current Height:** _____

List any prescription medication that you are currently taking and how often you are taking them:

Medication Total Daily Dosage Estimated Start Date

Current over-the-counter medication or supplements: _____

Current medical problems: _____

Past medical problems, nonpsychiatric hospitalization, or surgeries:

Have you ever had an EKG? Yes No

If yes, when? _____ How was the EKG? Normal Abnormal Unknown

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For women only

Date of last menstrual period: _____ **Birth control method:** _____

Are you currently pregnant or do you think you might be pregnant? Yes No **Are you**

planning to get pregnant in the near future? Yes No

How many times have you been pregnant? _____ **How many live births?** _____

Any concerns about your physical health that you would like to discuss? Yes No

If yes, please specify:

Date of last physical exam: _____ **Location:** _____

PERSONAL AND FAMILY MEDICAL HISTORY

Check any that apply to you or a member of your family (specify who if selected):

- | | |
|--------------------------------|---|
| Thyroid disease | High blood pressure |
| Anemia | Head trauma |
| Liver disease | Liver problems |
| Chronic fatigue | Other: _____ |
| Kidney disease | <input type="checkbox"/> You <input type="checkbox"/> Family member |
| Diabetes | (_____) <input type="checkbox"/> You <input type="checkbox"/> Family member |
| Asthma/respiratory problems | member (_____) <input type="checkbox"/> You <input type="checkbox"/> Family member |
| Stomach or intestinal problems | Family member (_____) <input type="checkbox"/> You <input type="checkbox"/> Family member |
| Cancer | You <input type="checkbox"/> Family member |
| Fibromyalgia | (_____) <input type="checkbox"/> You <input type="checkbox"/> Family member |
| Heart disease | member (_____) <input type="checkbox"/> You <input type="checkbox"/> Family member |
| Epilepsy or seizures | Family member (_____) <input type="checkbox"/> You <input type="checkbox"/> Family member |
| Chronic pain | You <input type="checkbox"/> Family member |
| High cholesterol | (_____) <input type="checkbox"/> You <input type="checkbox"/> Family member |

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Any other additional personal or family medical history?

When your mother was pregnant with you, were there any complications during the pregnancy or birth? Yes No

If yes, please specify:

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PSYCHIATRIC HISTORY

Outpatient Treatment? Yes (if yes, specify the details below) No

Reason Date Treated By Whom

Psychiatric Hospitalization? Yes (if yes, specify the details below) No

Reason Date Hospitalized Where

List any psychiatric medication you have taken, the dates, dosage, and any side effects:

Medication Date Dosage Side Effects

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family been treated for:

Bipolar disorder Depression Anxiety Anger Suicide Schizophrenia
Post-traumatic stress Alcohol abuse Violence Other: _____

If any of the options were selected, specify the family member and the corresponding problem:

Has any family member been treated with psychiatric medication? If yes, who was treated, what medications did they take, and how effective was the treatment?

SUBSTANCE USE

Have you ever been treated for alcohol or drug use? Yes No

-If yes, for which substances? _____ -If yes, where were you treated and when? Date: _____ Location: _____

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How many days per week do you drink alcohol? _____

What is the least and the most # of drinks you will drink in a day? Least: _____ Most: _____

What is the most alcohol you have consumed in a day in the ^{eSign} last 90 days?

_____ **Have you ever felt you should cut down on your drinking or drug use?**

Yes No **Have people annoyed you by criticizing your drinking or drug use?** Yes

No **Have you ever felt bad or guilty about your drinking or drug use?** Yes No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? Yes No

Do you think you may have a problem with alcohol or drug use? Yes No

Have you used any street drugs in the past 3 months? Yes No

-If yes, which ones? _____

Have you ever abused prescription medication? Yes No

-If yes, which ones and for how long?

_____ **Have you ever tried any of the following?**

Substance If so, how long and when did you last use?

- Methamphetamine _____
- Cocaine _____
- Stimulants (pills) _____
- Heroin _____
- LSD or Hallucinogens Marijuana _____
- Painkillers (not as prescribed) _____
- Methadone _____
- Tranquilizer/sleeping pills Alcohol _____
- Ecstasy _____
- Other: _____
- _____
- _____
- _____
- _____
- _____
- _____

PERSONAL HABITS

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Have you ever smoked cigarettes? Yes No

-Currently? Yes No

If yes, how many packs per day on average? _____ How many years have you smoked? _____

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-In the past? Yes No

If yes, how many years did you smoke? _____ When did you quit? _____

Do you exercise regularly? Yes No

-How many days a week? _____ How much time each day? _____

-What kind of exercise do you do? _____

PERSONAL DETAILS

Were you adopted? Yes No Where did you grow up? _____

List your siblings and their ages:

Name Age

What is/was your parent's occupation? Father: _____ Mother: _____

Did your parents divorce? Yes No

-If yes, what age were you? _____ Who did you live with? _____

Describe your father and your relationship with him:

Describe your mother and your relationship with him:

How old were you when you left home? _____

Has anyone in your immediate family died? If yes, specify who and when:

Do you have a history of being abused emotionally, sexually, physically, or by neglect? If yes, describe when, where, and by whom:

Highest education level attained? _____

Employment status: Working Student Unemployed Disabled

Retired -How long have you been in your present position? _____

-If working or retired, what is/was your occupation?

_____ -What location do/did you work?

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Have you ever served in the military? Yes No

-If yes, what branch? _____ When did you serve? _____

-Were you honorably discharged? Yes No Other:

Marital status: Married Partnered Divorced Single Widowed -How long have you been in your present status? _____ -If not married, are you currently in a

relationship? Yes No If yes, how long? _____ -If you have a partner or spouse, what is their occupation? _____ -Describe your relationship with your partner or spouse:

Have you had any prior marriages? Yes No

-If so, how many? _____ How long were/was the marriage(s)? _____

Are you sexually active? Yes No **What is your sexual orientation?**

Do you have any children? Yes No

If yes, specify their age and gender:

Age Gender

Describe your relationship with your children:

List everyone who currently lives with you:

Have you ever been arrested? Yes No **Any pending legal problems?** Yes No

Do you belong to a particular religion or spiritual group? Yes No If yes, what is the level of your involvement? _____

Do you find your involvement helpful towards your mental health, or does the involvement make things more difficult or stressful for you? Helpful

Stressful

Is there anything else that you would like us to know?

Signature: _____ Date: _____

Print Name: _____

Guardian Signature (if required) _____ Date: _____

Print Name: _____

Emergency Contact: _____ Phone Number: _____