

**MENTAL HEALTH CLIENT INTAKE FORM**

Disclaimer: Thank you for your interest in being a client of [CLINIC'S NAME]. 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.

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| **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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **REASONS FOR VISIT** |

**What are the problems for which you are seeking help?**

**Current Symptoms**:(check all that apply)

Racing thoughts  Depressed mood  Impulsivity

Sleep pattern   
 disturbance

Avoidance  Excessive worry

Forgetfulness

Unable to enjoy   
 activities

Fatigue

Suspiciousness  Loss of interest  Change in appetite

Anxiety attacks  Excessive guilt  Increased risky behavior

Increased irritability  Increased libido  Hallucinations

Excessive energy  Decreased libido  Decreased need for   
 sleep

Crying spell  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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

*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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PERSONAL AND FAMILY MEDICAL HISTORY** |

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

Thyroid disease

Anemia

Liver disease

Chronic fatigue

Kidney disease

Diabetes

Asthma/respiratory problems

Stomach or intestinal problems

Cancer

Fibromyalgia

Heart disease

Epilepsy or seizures

Chronic pain

High cholesterol

High blood pressure

Head trauma

Liver problems

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

You  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

You  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

You  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

You  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

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You  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

You  Family member (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Reason Date Hospitalized Where

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Medication Date. Dosage Side Effects

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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?**

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| **SUBSTANCE USE** |

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

-If yes, for which substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-If yes, where were you treated and when? Date: \_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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? \_\_\_\_\_\_

-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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 during this illness, or does the involvement make things more difficult or stressful for you?**  More helpful  Stressful

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

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| **ACKNOWLEDGMENT** |

Signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature (if required) [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_